STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMP				
AND PLAN	OF CORRECTION	157586	B. WI		00	11/19/	
		137300	D. 111			11/19/	2015
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				MO, IN 46902		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG G 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
Bldg. 00							
Bidg. 00	recertification steaded survey Facility #: 0112 Medicaid #: 200 Survey Dates: N 13, 16, 17, 18, a Partial Extended 10, 12, and 13, 2	284 0849420 November 5, 6, 9, 10, 12, and 19, 2015 d Dates: November 6, 9,	G 0	000	Please accept this plan of correction as our credibleallegation of complian Submission ofthis plan of correction does not indicate wagree with the findings notedthroughout this survey report.		
	Census Service Type: Skilled: 4455 Home Health Aide Only: 0 Personal Care Only: 0 Total: 4455 Sample: RR w/HV: 10 RR w/o HV: 10 Total: 20 Great Lakes Caring is precluded from						
	Great Lakes Car providing its ow						

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

TITLE

Any defiency statement 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.

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YJL511

Facility ID: 011284

(X6) DATE

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		00	COMPLETED 11/19/2015			
	PROVIDER OR SUPPLIER LAKES CARING	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	competency evaluation program for a period of 2 years beginning November 19, 2015 to November 19, 2017, for being found out of compliance with the Conditions of Participation						
	42 CFR 484,14 Organization, services, and administration; 484.18 Acceptance of Patients, Plan of Care, Medical Supervision; 484.20 Reporting OASIS information; 484.30 Skilled Nursing Services; 484.36 Home Health Aide Services; and 484.48: Clinical Records.						
G 0111 Bldg. 00	484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS The patient has the right to confidentiality of the clinical records maintained by the HHA.						
	Based on record review and interview, the agency failed to ensure the confidentiality of medical records by allowing an acquired agency to provide services to 26 of 73 active patients listed on both the South Bend branch active	G 0111	G 111 To ensure the confidentiality of medical records and complian with 484.10(d) the following interventions have been implemented:				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		157586	B. W	ING		11/19/2	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			WEBSTER ST		
GREAT I	LAKES CARING				MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	· ·		DATE
	_	he acquired agency's			acontractual arrangem		
	^	et (# 16, 26, 27, 28, 29,			was secured between the age		
		4, 35, 36, 37, 38, 39, 40,			referred to as Community Hor		
	41, 42, 43, 44, 4	5, 46, 47, 48, 49, 50, and			Health Network of Indiana, LL		
	51), for 1 of 1 re	ecord reviewed chosen			dba Great Lakes Caring CCN		
	from the parent	agency's Outcome			157586 (agency) and the		
	Assessment and	Information Set (OASIS)			acquired agency of AC and Associates dba Great Lakes		
	report (# 16); an	d failed to ensure an			Caring(acquired agency) to		
		agreement was in place			provide the agency services s	such	
	_	e office in Michigan to			as PT, OT, SLP, SN, MSW ar	nd	
	-	lata to the State agency			HHA.		
	for 1 of 1 agence	0 ,					
	ler rer rugene.	, .			0000000000000000000000000000000000		
	Findings include	<u>.</u>			was secured between the Gre		
	1 manigs merado	··			Lakes Caring Corporate office		
	1 Dyning inton	view on 11/5/15 at 1.40			and the agency to submit OAS	SIS	
	_	view on 11/5/15 at 1:40			data to the state.		
	· ·	strator stated that some					
		outh Bend patients were			•□□□□□□□ As of December 3 2015-All agency South Bend	ra	
		gency in Warsaw that had			branch patients were assigned	_{d to}	
		y the Great Lakes			the correct South Bend RN		
	_	nese patients were listed			Clinical Supervisor.		
	on the South Be	nd branch active patient					
	list and also on t	the acquired agency's			• As of November		
	active patient lis	t due to the acquired			15th, 2015 – no new patients were accepted to service for t	ho	
	agency did not a	accept the insurance			agency that would normally be		
	plans. The Adm	ninistrator stated that the			admitted to the acquired agen		
	acquired agency	had its own provider			provider number.		
	number.	•					
	namoer.				• • • • • • • • • • • • • • • • • • •		
	2. During interview on 11/6/15 at 10:15				'acquired agency's' patients w discharged from the agency.	/ere	
	AM, the Administrator stated there was				discharged north the agency.		
	1	an agreement for the			A weekly audit to assure		
		to provide services to the			compliance with G 111 will be	;	
		_			performed by the		
	South Bend pati	ents. The Administrator			administrator/designee on 100	0%	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		lì í	IULTIPLE CO UILDING	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	157586	B. W		00	11/19/	
		157 580	Б. W			11/19/	2015
NAME OF F	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
GREATI	AKES CARING				WEBSTER ST 10, IN 46902		
	•		1	<u> </u>	10, 111 +0302		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CV MUST BE RECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ed agency staff were			of all new South Bend admiss	ions	
	Great Lakes emp	U ,			with a SOC date on or after		
	Administrator st	-			November 15th for a period of	8	
		ired the agency provider			weeks. After 8 consecutive weeks of 100% compliance, the	10	
		th Bend branch provided			audit will decrease to 10%	10	
	· ·	counties already serviced			quarterly and will be complete		
	by the acquired a	-			through the clinical record rev	ew	
		ated the revenue for			process. (Exhibit 1)		
		patients would go to the					
		ich. The Administrator					
		cies allocate speech					
	1	n them, but the acquired					
		ot bill the patients. The					
	" "	ated the staff at the					
		did have access to the					
		of the patients they					
		for, even though the					
	_	o listed on the South					
	Bend branch ros						
		•					
	A. The South	Bend active roster was					
		he acquired agency's					
		oss referenced on 11/5					
		tients listed on the South					
		er and also the acquired					
	agency list inclu	•					
	# 26, start of	care date (SOC)					
	10/27/15	, ,					
	# 27, SOC 10)/29/15					
	# 28, SOC 10						
	# 29, SOC 7/						
	# 30, SOC 9/2						
	# 31, SOC 8/	14/15					
	1		1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLE	
		157586	B. W	ING		11/19/2	2015
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
	07777				WEBSTER ST		
GREAT	AKES CARING			KOKON	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	# 32, SOC 9/2						
	# 33, SOC 10						
	# 34, SOC 11						
	# 35, SOC 9/2						
	# 36, SOC 10						
	# 37, SOC 10						
	# 38, SOC 9/						
	# 39, SOC 9/						
	# 40, SOC 10						
	# 41, SOC 10	0/10/15					
	# 42, SOC 8/	12/15					
	# 43, SOC 11	/1/15					
	# 44, SOC 10	0/22/15					
	# 45, SOC 10	0/31/15					
	# 46, SOC 3/2	24/15					
	# 47, SOC 9/	14/15					
	# 48, SOC 9/2	29/15					
	# 49, SOC 9/2	28/15					
	# 50, SOC 7/3	8/15, and					
	# 51, SOC 9/2	26/15.					
	B. During in	terview on 11/6/15 at					
	10:15 AM, the A	Administrator provided					
	the South Bend	only roster. The					
	Administrator st	ated this roster was only					
	the patients for v	whom South Bend					
	-	This roster failed to					
	evidence patient						
	1						
	3. During interv	riew on 11/6/15 at 11:12					
	AM, the Administrator indicated the						
	acquired agency had their own						
		nd Clinical Supervisor,					
	but she was also	-					
	Cat blie was also						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			l í	JILDING	<u>00</u>	COMPL 11/19/	ETED
NAME OF I	PROVIDER OR SUPPLIER		_		DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT I	_AKES CARING				IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	4. During interv AM, the Administaff at the acquired Great Lakes empriviolation of confereords. The Adsouth Bend branchose counties becaused Great Lake agency's provide 2014. 5. The clinical rewas reviewed on was chosen from Deteriorating Wollisted as having head South Bend branche territory servagency. The pathospice on 5/8/1. A. On 11/16/Administrator stamaintains the charches provided services agency. B. During in	iew on 11/6/15 at 11:30 strator stated since the red agency were all ployees, there was not a dentiality of medical ministrator stated the ch was approved for effore other provider aired. The Administrator es acquired the Warsaw r number in October, ecord for patient # 16 11/9 and 11/16/15 and the OASIS list for bund Status and was nad been a patient of the ch. Patient # 16 lived in iced by the acquired ient was discharged to 5. 115 at 11:35 AM, the ated the acquired agency arts for all the patients rvices for and patient # services by the acquired terview on 11/16/15 at dministrator stated					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	IULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W		<u>00 </u>	11/19/	
	PROVIDER OR SUPPLIEF	<u> </u>	<u> </u>	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID	•	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	A T.C.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DATE
	patient # 16 is m	nanaged by the acquired					
		South Bend branch had					
	no involvement	in the care.					
	C. The alex	-f d-t-d					
	C. The plan	or care dated th start of care date					
		ed orders for skilled					
		ime a week for 9 weeks					
	• • •	visits for pain, falls,					
	respiratory/cardi						
		gastrourinary, and					
	integumentary c	omplications; Physical					
	Therapy (PT) 1	time for 1 week then 2					
	times a week for	r 4 weeks; Occupational					
	Therapy (OT) 1	time for 1 week then 2					
		r 3 weeks then 1 time for					
	· ·	l Social Worker 1 time					
		1 visit every 2 weeks for					
	· ·	Health Aide (HHA) 2					
		1 week then 3 times a					
	week for 2 week	AS.					
	D The reco	rd evidenced patient # 16					
		N services from the					
		on 3/23, 4/14, 5/1, and					
	5/5/15 by emplo	yee QQ; 3/30, 4/3, 4/7,					
	4/10, 4/13, 4/17,	, 4/21, 4/24, 5/6, and					
	5/8/15 by emplo	yee NN; and 4/28/15 by					
	employee PP.						
	F The reces	rd evidenced patient # 16					
		HA services from the					
		on 3/25, 3/27, 3/30, 4/1,					
	1 2 3	/15, 4/17, 4/21, 4/24,					
	l ' ' '		1				ı

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	IULTIPLE CO. UILDING	NSTRUCTION 00	COMPL			
1111212111	or condition	157586	B. W		00	11/19/		
				STREET A	DDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹	3115 S WEBSTER ST					
GREAT I	LAKES CARING			KOKOM	IO, IN 46902			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
		8/15 by employee WW;						
	and 5/1 by empl	oyee LL.						
	F The reco	rd evidenced patient # 16						
		Services from the						
	_	on 3/26/15 by employee						
		, 4/10, 4/13, 4/17, 4/20,						
	and 5/1/15 by er	nployee UU.						
		rd evidenced patient # 16						
	_	Γ services from the						
	acquired agency	on 4/2 by employee CC.						
	6 During interv	view on 11/13/15 at 12:40						
		strator stated the OASIS						
	1	done by the nurses or						
		ne Corporate office in						
		ts the data to the State						
	agency.							
	_	view on 11/16/15 at 10:30						
	· ·	istrator stated the agency						
		nd agreement or contract						
		ffice to submit OASIS						
	data to the State	agency.						
	8. The agency's	policy titled "Encoding						
	1	DASIS Data," # B-250,						
		2015 stated, "GLC will						
		port all OASIS data						
	_	lance with federal						
	regulations. GLC and agents acting on							
	behalf of GLC v	vill ensure confidentiality						
	of all client spec	ific information in the						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO JILDING	NSTRUCTION 00	COMPL		
THINDTERM	or condition	157586	B. W		00	11/19/	
		107000		CTREET	DDDEGG CITY CTATE ZID CODE	11710	2010
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	clinical record."						
		policy titled "Minimum					
	1	osures of Protected					
		on," # C-385, reviewed					
	March 2015 state						
	recurring disclos						
		GLC has identified					
		ealth information it					
		ne and recurring basis					
		ed to treatment. 2. GLC					
		he minimum amount of					
		n that is needed to					
		ose of these requests					
	Non-routine disc	elosures of health					
	information 3	3. GLC relies on					
	representations t	hat the information					
	requested is the	minimum a mount					
	necessary if the	request if from a public					
	official, a health	care provider, a health					
	plan, a profession	nal providing service to					
	GLC as a busine	ss associate, or a					
	· ·	provides appropriate					
		Disclosures of entire					
	medical records	GLC does not disclose					
	an individual's en	ntire medical record in					
	fulfillment of an	y request not related to					
	treatment for any	reason unless a					
	justification for s	such a disclosure is					
	documented."						
	10 The !	a maliana dida di NOVI minat					
		s policy titled "Clinical					
		ntiality," # C-880,					
	reviewed March	2015 stated, "1.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
ANDILAN	or connection	157586	B. W		00	11/19/	
		107000			DDDEGG CITY CTATE TID CODE	11/10/	2010
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
	Authorized users	s will be identified as:					
	b. Staff member	rs and contract staff					
	providing and su	pervising client care."					
	11. The agency'	s policy titled					
	"Client/Family F	Rights &					
	Responsibilities,	" # C-390, reviewed					
	March 2015 state	ed, "Privacy and					
	Security- You ha	eve the right to:					
	Confidentiality of	of written, verbal and					
	electronic protec	ted health information					
	including your n	nedical records,					
	information abou	at your health, social and					
	financial circum	stances or about what					
	takes place in yo	ur home State of					
	Indiana Addendı	ım: Sec. 3. (a) The					
	patient or the pat	tient's legal					
	representative ha	as the right to be					
	informed of the j	patient's rights through					
	effective means	of communication. The					
	home health age	ncy must protect and					
	•	cise of these rights and					
	shall do the follo	owing: (2) Maintain					
		howing it has complied					
	_	ments of this section					
		lity of the clinical records					
	_	e home health agency.					
		agency shall advise the					
		ency's policies and					
	•	ding disclosure of					
	clinical records.'	•					
		4					
	12. The agency	-					
	"Management of	electronic Data," #					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586		UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Physical Security limit access to an computer network with a confirmed Data Security Pothis policy applied or created by entipurisdiction of Gnot limited to, da Branches support systems departm Computer Security effort will be madata and facilities need-to-know." 13. The agency' Supervision," # 0 2015 stated, "Pother therapeutic under the supervision, The Reg Manager will be ongoing supervision of GLC. It will the administ responsibilities by organization. Purequirement of stand provide supervision. To assist aff delivering services. To assist as a computer services. To assist as a computer services.	LC. This includes but is at a maintained within: 1. Ited by GLC information ent Basic Code of ity Ethics 1. Every de to restrict access to so to those people with a spolicy titled "Clinical C-300, reviewed March licy Skilled nursing and exervices are provided ision of a Registered ional Director/Clinical available to provide sion during the operating Under no circumstances crative or supervisory be delegated to another arpose. To meet the tate/federal guidelines ervision and direction to ag home health care						

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AND PLAN	OF CORRECTION		B. W		00	COMPL	
		157586	B. W			11/19/	2015
	ROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING			KOKOM	IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	that care is direc						21112
	achievement of s	goals, and that services					
	_	ed on client need and in					
	_	the physician's Plan of					
	Care Specia	I Instructions 1. The					
	Regional Directo	or/Clinical Manager shall					
	be responsible for	or the quality of care					
		pervision of all staff					
	1 0 1	eutic services, including					
		e/she will also be					
	-	rganizing and directing					
		functions. 2. The					
	_	or/Clinical Manager shall					
		ay-to-day operation of					
	Administrator. 3	and work with the					
		participate with the					
		or/Clinical Manager in all					
	_	at to the professional					
		ed. This includes the					
		qualification and the					
	assignment of pe	-					
G 0121	484.12(c)						
	COMPLIANCE W						
Bldg. 00	PROFESSIONAL	STD					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLETE			TED
		157586	B. Wl	NG		11/19/2015	
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
CDEATI	AKES CARING				MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		staff must comply with					
	accepted professional standards and principles that apply to professionals						
	furnishing service						
		ration, interview, and	G 0	121	To ensure compliance with		12/24/2015
		ne agency failed to ensure		121	accepted professional standar	ds	12/2 1/2015
		d infection control			484.12(c) the following		
					interventions have been		
	guidelines for 6				implemented: All skilled		
	observations. (#	1, 4, 6, 7, 8, and 9)			nursing staff received education by 12/24/15 on infection control		
	Findings include:				and documentation requireme		
	i mamgs merade	·•			for wound care procedures. The education also included a han		
	1 During home	visit for patient #1 on			on return demonstration in a s		
					lab for wound care, and infecti		
		AM, employee C, home			control with wound care. · All		
	`	A) failed to place her			home health aides completed	a	
		barrier prior to placing it			mandatory in-service by 12/24		
	on the client's cu	ishioned glider rocker			with review of policy N-120 ba	g	
	chair. Employee	e C then proceeded to			technique, and policy N-100		
	obtain vital sign	s including blood			Standard Infection Control Procedures for Home Care. The Control of the Care o	ne	
	pressure, temper	rature, and pulse.			in-service included hands on		
		ed to clean the blood			demonstration by the home		
	1	or to using and prior to			health aide staff for bag		
	placing back into	_			technique. · All clinical staff v		
	placing back into	o bug.			educated by 12/24/15 on police	· .	
	2 Danie 1.	minit Commetions IIA			N-120 bag technique and police	, ,	
	1	visit for patient #4 on			N-100, Standard Infection Cor Procedures for Home Care with		
		0 PM, employee E,			focus on cleaning equipment		
		al nurse, was observed			procedure between patients, u		
	changing 3 wet t	to dry wound dressings.			of barrier and hand washing p		
					to and after all patient care.		
	A. During di	ressing change for the			Clinical supervisors will compl		
	_	und, employee E failed			onsite home supervisory visits		
	1 ^	r use hand sanitizer after			with 10% of all direct care field	1	
		d dressing and prior to			staff monthly to visualize evidence that the proper infection	tion	
		• .			control techniques and		
	1	oves, and after cleansing			compliance with G 121 are		
	I the wound and n	prior to applying Santyl	ı		1		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	· ′	JILDING	nstruction 00	(X3) DATE : COMPL 11/19/	ETED
	PROVIDER OR SUPPLIER		•	3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG	B. During dr patient's hip wou wash hands or us removing the old donning new glot the wound and p C. During dr patient's left toe failed to wash ha after removing the to donning new glot cleansing the wood by	essing change for the and, employee E failed to se hand sanitizer after I dressing and prior to eves, and after cleansing rior to applying Santyl. essing change for the wound, employee E ands or use hand sanitizer the old dressing and prior gloves, and after		TAG	followed until 100% compliance met. Ongoing compliance will completed through the annual onsite supervisory visit proces (Exhibit 2)	be	DATE
	vital signs, and p	orior to placing back into					

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 11/19/2015			PLETED	
	PROVIDER OR SUPPLIEF	2	3115	EET ADDRESS, CITY, STATE, ZIP COI 5 S WEBSTER ST KOMO, IN 46902	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION DATE
	clinical bag.	visit for patient # 8 on				
	11/12/15 at 1:30 failed to clean the before and after	PM, employee I, HHA, ne blood pressure cuff obtaining vital signs, and back into clinical bag.				
	6. During home visit for patient # 9 on 11/13/15 at 9:30 AM, employee J, physical therapy assistant, failed to clean the blood pressure cuff before and after obtaining vital signs, and prior to placing back into clinical bag.					
	11/13/15 at 12:4 stated the agency to wipe with alco but the blood pro- be washed daily The Administrat	none interview on 0 PM, the Administrator y policy for equipment is ohol in between patients, essure cuff only needs to unless it is visibly soiled. For stated staff should be izer or washing hands in hanges.				
	Technique," # N stated, " The blo belt are kept in a cleaned with cav day, and as nece All other reusable the bag should b	policy titled "Bag f-120, revised 5/6/11 od pressure cuff and gait a separate pocket and are vicide at the end of each ssary if items are soiled. le items removed from the cleaned with provided efore returning to the bag.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
GREAT L	AKES CARING			KOKOMO, IN 46902			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Never return one	e time use items to the					
	bag, even if not used such as gloves						
	when in a client'	s home, place the bag on					
	a clean and dry s	surface."					
	,						
	9. The agency's	policy titled "Hand					
		130, revised 5/16/11					
	l C,	The need for hand					
		s on the type, intensity,					
		• • • • • • • • • • • • • • • • • • • •					
duration, and sequence of activities.							
Before and after handling dressings or							
	touching open w	ounds."					
	10 The second	1					
	"	's policy titled "Pressure					
		Change," # G-160,					
		014 stated, "Procedure					
	4. Put on clean	gloves and remove old					
	dressing and disc	card 6. Wash hands.					
	7. Don clean	pair of gloves 11.					
	Cleanse wound l	bed. 12. Wash hands.					
	13. Don clea	n gloves."					
		-					
	11. The agency'	's policy titled					
		Wet-to-Dry dressing," #					
		2/18/14 stated, "1. Wash					
	·	on clean gloves. 5.					
		ssing 8. Wash					
		Oon clean gloves 13.					
		14. Don clean gloves.					
		gloves and dispose of					
	waste 20. V	Vash hands."					
	10 5	1					
		's policy titled "Standard					
	Infection Contro	ol Procedures for Home					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157586		î ´	JILDING NG	instruction 00	(X3) DATE : COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Care," # N-100,	ratement of deficiencies CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) revised 5/16/11 stated,		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
G 0122	care and after readers and after a second a second after a second a second after a second a s						
Bldg. 00	the agency failed the organization ensure the acquire on the organization agency (see G 12 provision of care South Bend brandelegated to an apatient record reservices by the a 124); failed to ensure 26 of 7 South Bend censure 26 of 7 South Bend censure 26 of 7 South Bend censure 27 services from the acceptance of the G 125); failed to arrangement exists agency to provide	review, and interview, I to ensure accuracy of all chart, and failed to red agency was not listed onal chart for 1 of 1 23); failed to ensure the to 26 of 73 patients on ch active census was not cquired agency for 1 of 1 viewed who received equired agency (see G asure supervision of the ch patient care for 1 of 1 viewed who had received quired agency, and failed 3 active patients on the us were provided e South Bend branch (see o ensure an agreement or sted for the acquired te services to 26 of 73 sted on the South Bend	G 0	122	G 122 To ensure compliance with 484.14 Organization, Services and Administration the followir interventions were implemented. G 123 Individual agency organization charts were created to separate out each distinct provider numedown to the patient care level. Individual agency organization charts were created to separate out each distinct provider numedown to the patient care level. Individual agency organization charts were created to separate out each distinct provider numedown to the patient care level. Individual agency organization charts were created to separate out each distinct provider numedown to the patient care level. Individual agency organization charts and include the ability of the agency parent make arrangements through contractual agreements for certain functions such as billing/payroll, but must provide least 1 of the qualifying service directly through agency employees. Individual agency organization charts were created to separate out each distinct provider numedown to the patient care level.	ee ber to es at	12/24/2015

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	· ′	JILDING	nstruction <u>00</u>	(X3) DATE S COMPL 11/19/	ETED
	PROVIDER OR SUPPLIER		•	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	supervision of the ensure it provide of 73 active patie branch list for 1 reivewed who re acquired agency agreement or arr acquired agency of 73 active patie Bend branch cen Outcomes Asses Set (OASIS) data parent agency or ensure an agreement or sure an agreement or arrangement agency or ensure an agreement of the composition of delegated to an arrangement of the agency's Set to ensure the Souprovided direct of listed on its active to ensure an agreement of the agency's Set to ensure the Souprovided direct of listed on its active to ensure an agreement of the agency's Set to ensure the Souprovided direct of listed on its active to ensure an agreement of the agency's Set to ensure an agreement of the agency	e South Bend branch to d services directly to 26 ents from the South Bend of 1 patient record ceived services from the failed to ensure an angement existed for the to provide services to 26 ents listed on the South sus; failed to ensure the sment and Information a was submitted from the branches; and failed to ent or arrangement orporate office in mit OASIS to the Indiana all the agency's patients IS data collection out of the G 126); failed to ensure care to patients was not cquired agency for 26 of as listed on the South sus (see G 127); the led to ensure supervision outh Bend branch; failed			was educated on the revised Policy B 125 Parent Agency Responsibilities on 12/22/15. A weekly organization chart at will be performed to assure compliance with G 122 by the administrator/designee to assu 100% compliance for a period 4 consecutive weeks. After 4 consecutive weeks of compliance, ongoing compliant with this standard will be completed through annual policy review as organizational chart are imbedded in our policy manual. (Exhibit 3) ===================================	udit ure of ice icy s ==== rd d to	
		ure an agreement or d for the corporate office			Administrator, Directors and Clinical Supervisors were educated on Policies C 121		

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	OF CORRECTION OF CORRECTION 157586	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015
	PROVIDER OR SUPPLIER _AKES CARING	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	in Michigan to submit OASIS data for all patients eligible for OASIS data collection to the State of Indiana for 1 of 1 agency (See G 133); the administrator failed to ensure home health aide skills competency checks included bathing patients for 4 of 5 Home Health Aide files reviewed; failed to ensure the filed skills competencies included transfer and range of motion for 2 of 5 files reviewed; and failed to ensure the acquired agency had an arrangement or agreement for the acquired agency provide HHA services for 4 of 73 patients with HHA services listed on the South Bend branch census (See G134); the administrator failed to ensure all employees had a physical prior to employment for 8 of 173 employee files reviewed; failed to ensure home health aide skills competency checks included bathing patients for 4 of 5 Home Health Aide files reviewed failed to ensure the HHA field skills competencies included transfer and range of motion for 2 of 5 files reviewed; and failed to ensure criminal background checks included the Indiana State Police Repository for 5 of 11 employee files reviewed (See G 141); failed to ensure the nurses communicated changes in length of Peripherally Inserted Central Catheter (PICC) line measurements to the physician for 1 of 1 record reviewed receiving PICC line management; failed to ensure all	TAG	Admission Policy and C 300 Clinical Supervision. A weekly audit to assure compliance with G 124 will be performed by the administrator/designee on 100 of all new South Bend admiss with a SOC date on or after November 15th for a period of weeks. After 8 consecutive weeks of 100% compliance, the audit will decrease to 10% quarterly and will be complete through the clinical record rev process. (Exhibit 1) G 125	DATE O% ions 8 ne d iew rd d to ne e cy's th ent ncy ne C

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 11/19/2015	
	PROVIDER OR SUPPLIER _AKES CARING	STREET. 3115 S KOKOM			
(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 APPROPRIA DEFICIENCY)	DATE	
	disciplines ordered on referral were included on the plan of care and intitiated timely for 1 of 20 records reviewed; and failed to ensure the Home Health Aide reported vital signs to the nurse as ordered on the aide care plan for 2 of 9 records reviewed receiving HHA services (See G 143); and failed to ensure an agreement or arrangement existed for the acquired agency to provide services to 26 of 73 active patients listed on the South Bend branch census; failed to ensure supervision of the South Bend branch to ensure it provided services directly to 26 of 73 active patients from the South Bend branch list for 1 of 1 patient record reviewed who received services from the acquired agency; failed to ensure an agreement or arrangement existed for the acquired agency to provide services to 26 of 73 active patients listed on the South Bend branch census; failed to ensure an agreement or arrangement existed for the acquired agency to provide services to 26 of 73 active patients listed on the South Bend branch census; failed to ensure the OASIS data was submitted from the parent agency or branches; and failed to ensure an agreement or arrangement existed for the corporate office in Michigan to submit OASIS to the Indiana State agency for all the agency's patients eligible for OASIS data collection out of 4455 patients (See G 146).		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	DATE Od III Pere O% ions 6 8 ne d iew th ent ncy ne	
	The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of		Caring(acquired agency) to provide the agency services s as PT, OT, SLP, SN, MSW ar		

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	_ COMPLE	
		157586	_		_ 11/19/2	1015
NAME OF F	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP CO	ODE	
CDEATI	AKES CADINO			S WEBSTER ST		
	AKES CARING			MO, IN 46902	<u>.</u>	
(X4) ID			ID	PROVIDER'S PLAN OF CORR	RECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)	PPROPRIATE	COMPLETION
IAG		,	TAG	HHA		DATE
				ППА		
	ĺ			•====== As of Nover	mber	
	1	•		15th, 2015 – no new pa		
				were accepted to service		
	safe environmen	it.		agency that would norn	-	
				admitted to the acquire	d agency's	
			provider number.			
	4) ID SUMMARY STATEMENT OF DEFICIENCIES		•====== As of 12/23/	/15 – All		
				'acquired agency's' pati		
				discharged from the ag		
				•====== As of Decer	mber 3rd	
				2015-All agency South	Bend	
				branch patients were as	ssigned to	
				the correct South Bend	RN	
				Clinical Supervisor.		
				•====== As of Nover	mber 6th	
				2015, a contractual arra		
				was secured between t		
				Lakes Caring Corporate		
				and the agency to subn	nit OASIS	
				data to the state.		
				•====== As of 12/22/	/15	
				Individual agency organ		
				charts were created to		
				out each distinct provid		
				down to the patient care	e level.	
				•====== On 12/22/15	5 Policy B	
				125 Parent Agency	,	
				Responsibilities, was up	pdated to	
				coincide with the new		
				organization charts and		
				the ability of the agency make arrangements thr		
				contractual agreements	-	
				certain functions such a		
				billing/payroll, but must		

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015		
	ROVIDER OR SUPPLIER AKES CARING	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(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 APPROPRIA DEFICIENCY)	DATE		
			least 1 of the qualifying service directly through agency employees.	es		
			• The Administrator was educated on the revised Policy B 125 Parent Agency Responsibilities, on 12/22/15.			
			A weekly organization chart at will be performed by the administrator/designee to assist 100% compliance with G 126 a period of 4 consecutive week of compliance, ongoing compliant with this standard will be completed through annual policeview as organizational chart are imbedded in our policy manual. (Exhibit 3)	ure for ks. nce		
			A weekly audit to assure compliance with G 126 will be performed by the administrator/designee on 100 of all new South Bend admiss with a SOC date on or after November 15th for a period of weeks. After 8 consecutive weeks of 100% compliance, the audit will decrease to 10% quarterly and will be complete through the clinical record reviprocess. (Exhibit 1)	o% ions 8 ne		
			G 127 On 12/22/15 Policy 125 Parent Agency Responsibilities was updated coincide with the new			

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015
	ROVIDER OR SUPPLIER		3115 S	ADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION)	TAG	organization charts and inclusive ability of the agency pare make arrangements through contractual agreements for certain functions such as billing/payroll, but must provide least 1 of the qualifying servidirectly through agency employees. The Administrator was educated on the revised Policy B 125 Parent Agency Responsibilities on 12/22/15 Color As of November 2015, a contractual arranger was secured between the agreferred to as Community House Health Network of Indiana, L dba Great Lakes Caring CCI 157586 (agency) and the acquired agency of AC and Associates dba Great Lakes Caring(acquired agency) to provide the agency services as PT, OT, SLP, SN, MSW at HHA. Color As of November 15th, 2015 – no new patients were accepted to service for agency that would normally ladmitted to the acquired age provider number. Calculud As of 12/23/15 – 'acquired agency's' patients discharged from the agency.	des ent to de at ces r 6th nent lency ome LC N such and sthe oe ncy's All were
				•	3rd

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	00	СОМ	te survey pleted 9/2015
	ROVIDER OR SUPPLIE	ER	3115 S	ADDRESS, CITY, STATE, ZIP WEBSTER ST MO, IN 46902	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				2015-All agency Sout branch patients were the correct South Ber Clinical Supervisor.	assigned to	
				A weekly organization will be performed by the administrator/designed 100% compliance with a period of 4 consecut After 4 consecutive who compliance, ongoing with this standard will completed through an review as organization are imbedded in our permanual. (Exhibit 3)	the the to assure th G 127 for tive weeks. reeks of compliance be nnual policy nal charts	
				A weekly audit to assisted compliance with G 12 performed by the administrator/designer of all new South Bendwith a SOC date on the November 15th for a weeks. After 8 consequences weeks of 100% compliance will decrease to quarterly and will be of through the clinical reprocess. (Exhibit 1)	ee on 100% d admissions or after period of 8 ecutive diance, the 10% completed	
				G 133 Individual agency org charts were created to out each distinct providown to the patient cate of the	anization o separate ider number are level.	

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	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING B. WING	00	COMPL 11/19/	ETED	
	ROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE	
				coincide with the new organization charts and income the ability of the agency paramake arrangements through contractual agreements for certain functions such as billing/payroll, but must proleast 1 of the qualifying ser directly through agency employees.	rent to gh · · ·vide at		
				• The Administra was educated on the revise Policy B 125 Parent Agenc Responsibilities, and on po C300 Clinical Supervision, 12/22/15.	ed :y olicy		
				• O O O O O O O O O O O O O O O O O O O	ement agency Home LLC CN d es o		
				As of November 15th, 2015 – no new patier were accepted to service for agency that would normally admitted to the acquired approvider number. As of 12/23/15 'acquired agency's' patient	nts or the y be gency's		

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015
	ROVIDER OR SUPPLIEF	3	3115 S	ADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	RECENTORY	A SEC IDENTIFICATION (MATRON)		discharged from the agency. •	ord ord ord ord ord ord ord ord
				with this standard will be completed through annual por review as organizational charare imbedded in our policy manual. (Exhibit 3) A weekly audit to assure	licy ts
				compliance with G 133 will be performed by the administrator/designee on 10 of all new South Bend admiss with a SOC date on or after	0%

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	OO	(X3) DATE SURVEY COMPLETED				
MOLLAN	or condition	157586	B. WING	<u></u>	11/19/2015			
			STREET /	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF P	ROVIDER OR SUPPLIER		3115 S WEBSTER ST					
GREAT L	AKES CARING		KOKOMO, IN 46902					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	-	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE			
	REGOLATION ON			November 15th for a period of weeks. After 8 consecutive weeks of 100% compliance, the audit will decrease to 10% quarterly and will be completed through the clinical record reviprocess. (Exhibit 1) An audit will be performed weeby the administrator/designee assure 100% compliance with 133 and the applicable provide number Clinical Supervisors/Freviewing and locking the OAS for a period of 4 weeks. After consecutive weeks of 100% compliance, the audit will decrease to 50% of all OASIS another 4 weeks. After that 4 weeks of 100% compliance is obtained the audit will decrease 10% quarterly and will be completed through the clinical record review process. (Exhibition)	f 8 ne d iew ekly to G er RNs SIS r 4			
G 0123 Bldg. 00	for the delegation the patient care let writing and are rea Based on record the agency failed the organizational ensure the acquir	N ices furnished, trol, and lines of authority of responsibility down to vel are clearly set forth in	G 0123	G 123 To ensure compliance with 484.14 Organization, Services and Administration, t following interventions have b implemented: · As of 12/22/1 Individual agency organization charts were created to separa out each distinct provider num	een 5 n te			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SUR		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		157586	B. W	ING		11/19/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R			WEBSTER ST	
GREATI	AKES CARING				MO, IN 46902	
					10, 114 40002	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	·	DATE
	Findings include	2.			down to the patient care level. On 12/22/15 Policy B 125	
					Parent Agency Responsibilitie	s
	1. The organiza	tional chart evidenced			was updated to coincide with t	
	the inclusion of	an acquired agency			new organization charts and	
	located in Warsa	aw.			includes the ability of the ager	icy
					parent to make arrangements	
	2. During interv	view on 11/5/15 at 1:40			through contractual agreemen	ts
		strator stated that some			for certain functions such as billing/payroll, but must provide	e at
		outh Bend patients were			least 1 of the qualifying service	
		gency in Warsaw that had			directly through agency	
		y the Great Lakes			employees. The Administra	tor
	1 .	•			was educated on the revised	
		venty six (26) of seventy			Policy B 125 Parent Agency	
	` ' *	its were listed on the			Responsibilities on 12/22/15. weekly organization chart aud	
		nch active patient list and			will be performed by the	
	•	ired agency's active			administrator/designee to assu	ıre
	patient list due to	o the acquired agency did			100% compliance with G 123	for
	not accept the in	surance plans. The			a period of 4 consecutive wee	ks.
	Administrator st	ated that the acquired			After 4 consecutive weeks of	
	agency had its o	wn provider number.			compliance, ongoing complian with this standard will be	ice
					completed through annual poli	icv
	3. During interv	view on 11/6/15 at 10:15			review as organizational chart	
	_	istrator stated there was			are imbedded in our policy	
		an agreement for the			manual. (Exhibit 3)	
		to provide services to the				
		ents. The Administrator				
		corporation acquired the				
		• •				
	agency provider number, the South Bend branch provided coverage of the counties					
		•				
	aiready serviced	by the acquired agency.				
	4. During interview on 11/6/15 at 11:30 AM, the Administrator stated Great					
	Lakes acquired t	the Warsaw agency's				
	provider number	r in October, 2014.				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. Bl	UILDING	NSTRUCTION 00	COMPL	ETED	
		157586	B. W			11/19/	/2015
NAME O	PROVIDER OR SUPPLIER	3		1	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT	LAKES CARING			KOKOM	1O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	AM, the Adminiacquired agency organizational of Clinical Supervital Alternate Adminiagency. The Adsupervisor at the responsible for the patients. 6. During intervent PM, the Adminias managed by the South Bendin involvement in the Taylor of Staff and over the patients. 7. The agency's Agency Responsive tweed March agency will have in relation to cooprovided throughout furnished diagency are monitagency are monitagency are monitagency are monitagency will be uncompliance with Regardless of the	hart, Administrator, and sor, but she was also the histrator for the acquired liministrator stated the South Bend branch is he day to day scheduling reseing care provided for view on 11/16/15 at 12:05 strator stated patient # 16 he acquired agency, and branch had no					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO JILDING	00	(X3) DATE S COMPL		
		157586	B. W	NG		11/19/	2015
	ROVIDER OR SUPPLIER			3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
G 0124 Bldg. 00	through arrangent with the HHA the responsibility for implementing plate Board of director authority and responsibility and the parent or branch determined funct Billing/payroll/in at the parent branch activation of the parent branch activation and the parent branch activation at the parent branch activation and the parent branch activation activation and the parent branch activation and the parent branch activ	r admitting patients and ans of care 4. The rs assumes full legal ponsibility for all agency, regardless if status. 5. Certain tions (ie. htake) will be localized nch. The functions are all on the organizational supervisory functions are nother agency or review, and interview, a to ensure the provision review, and interview, a to ensure the provision review agency for 1 of 1 wiewed (# 16) who is by the acquired agency.	G 0	124	G 124 To ensure compliance with 484.14 Organization, Services and Administration the following interventions have be implemented: · As of Decemb 3rd 2015-All agency South Bebranch patients were assigned the correct South Bend RN Clinical Supervisor. · As of November 15th, 2015 – no new patients were accepted to serve for the agency that would normally be admitted to the acquired agency's provider number. · As of 12/23/15 – A	een er nd I to w	12/23/2015

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	IULTIPLE CO UILDING	INSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	157586	B. W		00	11/19/	
		157 566	Б. "			11/19/	2015
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		1	ADDRESS, CITY, STATE, ZIP CODE		
CDEATI	AKES CARING				WEBSTER ST 10, IN 46902		
	•			<u> </u>	10, 111 40902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		fied as having services		IAG	'acquired agency's'patients w	ere	DATE
		by the acquired agency.			discharged from the agency.	0.0	
	provided to their	by the acquired agency.			· On 12/22/15 the Administrat		
	2 Desmiss a instance	: 11/5/15 at 1.40			Directors and Clinical Supervi		
	_	riew on 11/5/15 at 1:40			were educated on Policies C	121	
		strator stated that some			Admission Policy and C 300 Clinical Supervision. An au-	dit	
		buth Bend branch patients			to assure compliance with G		
	1	an agency in Warsaw			will be performed by the		
		quired by the Great			administrator/designee on 100 of all new South Bend admiss		
	Lakes Corporation. These patients were listed on the South Bend branch active				with aSOC date on or after	10115	
					November 15th for a period of	f 8	
	patient list due to the acquired agency did				weeks. After 8 consecutive		
	•	surance plans for those			weeks of 100%compliance, th	e	
	_	Administrator stated			audit will decrease to 10% quarterly and will be complete	ıd	
	_	agency had its own			through the clinical record rev		
	provider number	•			process. (Exhibit 1)		
	_	riew on 11/6/15 at 10:15					
	· ·	strator stated there was					
		an agreement for the					
		to provide services to the					
		ents. The Administrator					
		corporation acquired the					
	0 1	number, the South Bend					
	_	coverage of the counties					
	already serviced	by the acquired agency.					
		. 11/6/15 . 11 10					
	_	riew on 11/6/15 at 11:12					
	· ·	strator indicated the					
	acquired agency						
	_	nart, Administrator, and					
		sor, but she was also the					
		istrator for the acquired					
	" "	ministrator stated the					
	supervisor at the	South Bend branch is					

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		IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING			COMPLETED 11/19/2015	
NAME OF P	ROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	responsible for the of staff and over the patients on the 5. During interved AM, the Administ Lakes acquired the provider number 6. During interved PM, the Administis managed by the South Bend be involvement in the 7. The agency's Agency Responsive reviewed March agency will have in relation to cooprovided through not furnished direagency are monit Special Instruction policies and proceed occumentation (expected).	ne day to day scheduling seeing care provided for the South Bend census. Siew on 11/6/15 at 11:30 strator stated Great the Warsaw agency's in October, 2014. Siew on 11/16/15 at 12:05 strator stated patient # 16 the acquired agency, and branch had no the care. Policy titled "Parent defined responsibilities ordination of care in branches. All services ectly by the parent tored and controlled ons 1. The HHA's redures, or other forms of e.g., organizational sed to determine			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE .	
	_	this standard. 2. e formal organizational erall responsibility for all					
	services provided through arrangen with the HHA th	d, whether directly, nents or contracts, rests					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIEF	1		1	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT I	_AKES CARING			1	10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE COM	
	implementing pl Board of directo authority and res operations of the parent or branch determined func Billing/payroll/in at the parent branch clearly identified chart." 8. The agency's Policy," # C-12 stated, "Criteria 2. The client mu area served by Co made by local le referrals living s service area depostaffing levels an needs." 9. The agency's Supervision," # 0 2015 stated, "Po other therapeutic under the superv Nurse. The Reg Manager will be ongoing supervisions of GLC. I will the administ responsibilities by	ans of care 4. The rs assumes full legal sponsibility for all agency, regardless if status. 5. Certain					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	r í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	ROVIDER OR SUPPLIER AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	and provide superall staff delivering services. To assipperformance is at that care is direct achievement of gare provided bas accordance with Care Special Regional Director be responsible for provided and supproviding therap contract staff. Heresponsible for of GLC's ongoing for Regional Director coordinate the dathe organization Administrator. Supervisor will provided and Director coordinate the dathe organization activities relevants services furnished.	ppropriately supervised, ted toward the goals, and that services ed on client need and in the physician's Plan of I Instructions 1. The or/Clinical Manager shall or the quality of care pervision of all staff eutic services, including te/she will also be organizing and directing functions. 2. The or/Clinical Manager shall any-to-day operation of and work with the standard or the professional of the professional of the professional of the professional of the qualification and the						
G 0125	484.14							

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING 00 COMPLE B. WING 11/19/2			ETED		
	ROVIDER OR SUPPLIER AKES CARING			3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 00	services provided monitored and cor agency. Based on record		G 0	125	G 125 To ensure compliance v 484.14 Organization, Services	3	12/23/2015
	supervision of the patient care for 1 reviewed who has acquired agency ensure 26 of 73 at South Bend censure	e South Bend branch of 1 patient record and received care from the (# 16), and failed to active patients on the us were provided e South Bend branch.			and Administration, the followi interventions have been implemented: As of Decemb 3rd 2015-All agency South Be branch patients were assigned the correct South Bend RN Clinical Supervisor. As of November 15th, 2015 – no ner patients were accepted to serve for the agency that would	per nd d to w	
	1. During interv PM, the Administ of the current So were serviced by that had been acc Lakes Corporation listed on the Sou patient list due to not accept the interpretation of the 26 patients. The that the acquired provider number	Findings include: 1. During interview on 11/5/15 at 1:40 PM, the Administrator stated that some of the current South Bend branch patients were serviced by an agency in Warsaw that had been acquired by the Great Lakes Corporation. These patients were listed on the South Bend branch active patient list due to the acquired agency did not accept the insurance plans for those 26 patients. The Administrator stated that the acquired agency had its own provider number. 2. During interview on 11/6/15 at 10:15			normally be admitted to the acquired agency's provider number. · As of November 6t 2015, a contractual arrangeme was secured between the age referred to as Community Hon Health Network of Indiana, LL dba Great Lakes Caring CCN 157586 (agency) and the acquired agency of AC and Associates dba Great Lakes Caring(acquired agency) to provide the agency services st as PT, OT, SLP, SN, MSW an HHA. · As of 12/23/15 – All 'acquired agency's 'patients we discharged from the agency. · On 12/22/15 the Administrate Directors and Clinical Supervis were educated on Policies C 1	ent ncy ne C uch d ere or, soors	
AM, the Administrator stated there was not a contract or an agreement for the acquired agency to provide services to the				Admission Policy and C 300 Clinical Supervision. An aud assure compliance with G 125 be performed by the			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	onstruction 00	(X3) DATE : COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER			3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	AM, the Admini supervisor at the responsible for the	iew on 11/6/15 at 11:12			administrator/designee on 100 of all new South Bend admiss with aSOC date on or after November 15th for a period of weeks. After 8 consecutive weeks of 100%compliance, th audit will decrease to 10% quarterly and will be complete through the clinical record reviprocess. (Exhibit 1)	ions 8 e d	
	4. During interview on 11/6/15 at 11:30 AM, the Administrator stated Great Lakes acquired the Warsaw agency's provider number in October, 2014.						
	included 26 of 7	and branch census 3 active patients, 26 were being listed on the census.					
	AM, the Admini acquired agency and supervision provide services on the South Ber	maintains all the records of the patients they to which are also listed and patient list, and managed out of the					
	PM, the Adminis						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	Agency Responsive reviewed March agency will have in relation to cooprovided through not furnished diragency are moni Special Instruction policies and proof documentation (charts) will be use compliance with Regardless of the structure, the overservices provided through arranger with the HHA the responsibility for implementing pleared of director authority and responsibility and responsibility for implementing pleared of the parent or branch determined functions in the parent branch branch that the parent branch is agency with the parent branch agency with the parent branch determined functions.	this standard. 2. e formal organizational erall responsibility for all d, whether directly, ments or contracts, rests at has assumed r admitting patients and ans of care 4. The rs assumes full legal eponsibility for all e agency, regardless if status. 5. Certain							
G 0126 Bldg. 00	484.14 ORGANIZATION, ADMINISTRATIOI If an agency has s								

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		157586	B. WING 11/			11/19/	2015
NAME OF F	PROVIDER OR SUPPLIER			STREET.	ADDRESS, CITY, STATE, ZIP CODE		
					WEBSTER ST		
	AKES CARING			KOKO	MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) ords are maintained for		TAG	DEFICIENCY)		DATE
	each subunit.	orus are maintaineu ioi					
	Based on record	review, and interview,	G 0	126	G 126 To ensure compliance v		12/23/2015
	the parent agenc	y failed to ensure an			484.14 Organization, Services		
		angement existed for the			and Administration, the following interventions were implemented	-	
	_	to provide services to 26			· As of November 6th 2015, a	u.	
		ents listed on the South			contractual arrangement was		
	•	sus; failed to ensure			secured between the agency		
		e South Bend branch to			referred to as Community Hom		
	*	ed services directly to 26			Health Network of Indiana, LLO dba Great Lakes Caring CCN	ا ز	
	•	ents from the South Bend			157586 (agency) and the		
	-	of 1 patient record			acquired agency of AC and		
		ceived services from the			Associates dba Great Lakes		
					Caring(acquired agency) to		
		(# 16); failed to ensure			provide the agency services su		
	_	arrangement existed for			as PT, OT, SLP, SN, MSW an HHA. · As of November 15th		
		ncy to provide services to			2015 – no new patients were	,	
	_	patients listed on the			accepted to service for the		
		ch census; failed to			agency that would normally be		
		omes Assessment and			admitted to the acquired agend	cy's	
		(OASIS) data was			provider number. · As of 12/23/15 – All 'acquired		
		he parent agency or			agency's'patients were		
	branches; and fa				discharged from the agency.		
	_	angement existed for the			· As of December 3rd 2015-All		
	_	in Michigan to submit			agency South Bend branch patients were assigned to the		
	OASIS to the Inc	diana State agency for all			correct South Bend RN Clinica	ı	
	the agency's pati	ents eligible for OASIS			Supervisor. · As of November		
	data collection o	ut of 4455 patients.			6th 2015, a contractual		
					arrangement was secured		
	Findings include	:			between the Great Lakes Cari Corporate office and the agend	-	
					to submit OASIS data to the	- y	
	1. The organizat	tional chart evidenced			state. · As of 12/22/15		
	_	an acquired agency			Individual agency organization		
	located in Warsa				charts were created to separat		
					out each distinct provider num down to the patient care level.		
					down to the patient care level.		

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Facility ID: 011284

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		157586	B. W	ING		11/19/2015
			I	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			1	WEBSTER ST	
CDEATI	GREAT LAKES CARING				MO, IN 46902	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	2. During interv	iew on 11/5/15 at 1:40			On 12/22/15 Policy B 125	
	PM, the Adminis	strator stated that some			Parent Agency Responsibilities	
	of the current So	uth Bend patients were			was updated to coincide with t new organization charts and	ne
		gency in Warsaw that had			includes the ability of the agen	CV
	been acquired by	-			parent to make arrangements	
		ese patients were listed			through contractual agreemen	ts
		•			for certain functions such as	
		nd branch active patient			billing/payroll, but must provide	
		he acquired agency's			least 1 of the qualifying service	es
	active patient lis	t due to the acquired			directly through agency	
	agency did not a	ccept the insurance			employees. • The Administration	tor
	plans. The Adm	inistrator stated that the			was educated on the revised Policy B 125 Parent Agency	
	acquired agency	had its own provider			Responsibilities on 12/22/15.	A
	number.	1			weekly organization chart audi	
	number.				will be performed by the	
	2 Daning interns	: 11/6/15 -+ 10.15			administrator/designee to assu	ıre
	_	iew on 11/6/15 at 10:15			100% compliance with G 126	
	· · ·	strator stated there was			a period of 4 consecutive weel	ks.
	not a contract or	an agreement for the			After 4 consecutive weeks of	
	acquired agency	to provide services to the			compliance, ongoing complian	ce
	South Bend patie	ents. The Administrator			with this standard will be completed through annual poli	CV
	stated when the	corporation acquired the			review as organizational charts	
		number, the South Bend			are imbedded in our policy	
		coverage of the counties			manual. (Exhibit 3) An audit	to
	_	by the acquired agency.			assure compliance with G 126	will
	alleady serviced	by the acquired agency.			be performed by the	
					administrator/designee on 100	
		iew on 11/6/15 at 11:12			of all new South Bend admissi	ons
	· · ·	strator indicated the			with aSOC date on or after November 15th for a period of	8
	acquired agency	had their own			weeks. After 8 consecutive	°
	organizational cl	nart, Administrator, and			weeks of 100%compliance, the	e
	Clinical Supervi	sor, but she was also the			audit will decrease to 10%	
	_	istrator for the acquired			quarterly and will be completed	
		ministrator stated the			through the clinical record revi	ew
	" "	South Bend branch is			process. (Exhibit 1)	
	-	ne day to day scheduling				
	of staff and over	seeing care provided for				1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157586	B. W		<u></u>	11/19/		
	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
GREAT I	_AKES CARING			KOKOM	IO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	the patients.							
	AM, the Admini Lakes acquired t	riew on 11/6/15 at 11:30 strator stated Great the Warsaw agency's in October, 2014.						
	was reviewed on was chosen from Deteriorating W listed as having South Bend branch the territory servagency. The pathospice on 5/8/1	/15 at 11:35 AM, the						
	maintains the ch they provided se	ated the acquired agency arts for all the patients rvices for and patient # most services by the						
	3/23/15, contain nursing (SN) 1 t and 3 as needed respiratory/cardi gastrointestinal/g integumentary contribution	th start of care date ed orders for skilled ime a week for 9 weeks visits for pain, falls,						

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMI	E SURVEY PLETED 9/2015			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	times a week for 1 week; Medical for 1 week then 2 weeks; Home	time for 1 week then 2 3 weeks then 1 time for Social Worker 1 time 1 visit every 2 weeks for Health Aide (HHA) 2 1 week then 3 times a s.						
	was provided SN acquired agency 5/5/15 by emplo 4/10, 4/13, 4/17,	d evidenced patient # 16 I services from the on 3/23, 4/14, 5/1, and yee QQ; 3/30, 4/3, 4/7, 4/21, 4/24, 5/6, and yee NN; and 4/28/15 by						
	was provided HI acquired agency 4/6, 4/8, 4/10, 4/	rd evidenced patient # 16 HA services from the on 3/25, 3/27, 3/30, 4/1, 15, 4/17, 4/21, 4/24, 8/15 by employee WW; byee LL.						
	was provided PT acquired agency	ord evidenced patient # 16 Services from the on 3/26/15 by employee 0.4/10, 4/13, 4/17, 4/20, employee UU.						
	was provided Of acquired agency	d evidenced patient # 16 Γ services from the on 4/2 by employee CC.						
	7. The agency's	policy titled "Parent						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í		NSTRUCTION	(X3) DATE				
AND PLAN	OF CORRECTION		B. W	JILDING	00	COMPL			
		157586	B. W			11/19/	2015		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID	SHMMARVS	FATEMENT OF DEFICIENCIES	1	ID			(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION		
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE		
TAG	Agency Respons reviewed March agency will have in relation to cooprovided through not furnished diragency are monity of the special Instruction policies and proceed documentation (a charts) will be used compliance with Regardless of the structure, the overservices provided through arranger with the HHA the responsibility for implementing plane Board of director authority and responsibility for implementing plane authority and resp	defined responsibilities ordination of care in branches. All services ectly by the parent tored and controlled ons 1. The HHA's redures, or other forms of e.g., organizational sed to determine this standard. 2. this standard. 2. the formal organizational erall responsibility for all did, whether directly, ments or contracts, rests at has assumed and of care 4. The responsibility for all the agency, regardless if status. 5. Certain		TAG	DEFICIENCY)	ALE	DATE		
G 0127 Bldg. 00	484.14(a) SERVICES FURN Part-time or interm	IISHED nittent skilled nursing							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	NG		11/19/	2015
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	service (physical, therapy; medical shealth aide service a visiting basis, in as a patient's homat least one of the through agency enthe second qualify services under arragency or organiz Based on record the agency failed of care to patient acquired agency patients listed or census. Findings include 1. The organization the inclusion of a located in Warsation of the current Sowere serviced by that had been accurated in the Soupatient list due to not accept the incurrents. The	to ensure the provision ts was not delegated to an for 26 of 73 active the South Bend branch ts: tional chart evidenced an acquired agency tw. view on 11/5/15 at 1:40 strator stated that some buth Bend branch patients of an agency in Warsaw quired by the Great on. These patients were th Bend branch active to the acquired agency did surance plans for those of Administrator stated agency had its own	G 0	127	G 127 To ensure compliance of 484.14(a) Services Furnished, following interventions were implemented: As of 12/22/1 Individual agency organization charts were created to separat out each distinct provider num down to the patient care level. On 12/22/15 Policy B 125 Parent Agency Responsibilities was updated to coincide with the new organization charts and includes the ability of the agent parent to make arrangements through contractual agreemen for certain functions such as billing/payroll, but must provide least 1 of the qualifying serviced directly through agency employees. The Administrations was educated on the revised Policy B 125 Parent Agency Responsibilities on 12/22/15. As of November 6th 2015, a contractual arrangement was secured between the agency referred to as Community Hom Health Network of Indiana, LLC dba Great Lakes Caring CCN 157586 (agency) and the acquired agency of AC and	the 5 te ber s he cy ts e at es or	12/23/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		157586	B. W	ING		11/19/2	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			WEBSTER ST		
GREATI	_AKES CARING				//O, IN 46902		
					1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
					Associates dba Great Lakes Caring(acquired agency) to		
		end branch census			provide the agency services si	ıch	
	included 26 of 7	3 active patients, 26 were			as PT, OT, SLP, SN, MSW an		
	identified as acti	ve patients being			HHA · As of November 15th,		
	provided service	es by the acquired agency.			2015 – no new patients were		
	•				accepted to service for the		
	4 During interv	view on 11/6/15 at 10:15			agency that would normally be		
	_	strator stated there was			admitted to the acquired agen	cy's	
	I	an agreement for the			provider number. · As of 12/23/15 – All 'acquired		
		•			agency's'patients were		
		to provide services to the			discharged from the agency.		
	_	ents. The Administrator			· As of December 3rd 2015-All		
	stated when the	corporation acquired the			agency South Bend branch		
	agency provider	number, the South Bend			patients were assigned to the		
	branch provided	coverage of the counties			correct South Bend RN Clinica	al	
	already serviced	by the acquired agency.			Supervisor. A weekly organization chart audit will be		
					performed by the	,	
	5 During interv	riew on 11/6/15 at 11:12			administrator/designee to assu	ıre	
	_	strator indicated the			100% compliance with G 127		
	acquired agency				a period of 4 consecutive weel	ks.	
					After 4 consecutive weeks of		
		hart, Administrator, and			compliance, ongoing complian	ice	
	_	sor, but she was also the			with this standard will be completed through annual poli	01/	
		nistrator for the acquired			review as organizational charts		
	agency. The Ad	ministrator stated the			are imbedded in our policy		
	supervisor at the	South Bend branch is			manual. (Exhibit 3) An audit	to	
	responsible for t	he day to day scheduling			assure compliance with G 127	will	
	of staff and over	seeing care provided for			be performed by the		
	the patients.				administrator/designee on 100		
					of all new South Bend admissi with aSOC date on or after	ons	
	6 During interv	view on 11/6/15 at 11:30			November 15th for a period of	8	
	_				weeks. After 8 consecutive		
	AM, the Administrator stated Great Lakes acquired the Warsaw agency's				weeks of 100%compliance, the	е	
	_	0 5			audit will decrease to 10%		
	provider number	r in October, 2014.			quarterly and will be complete		
					through the clinical record revi	ew	
	7. The agency's	policy titled "Parent			process. (Exhibit 1)		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í		NSTRUCTION OO	i í		
		157586	B. W			11/19/	
AND PLAN	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENT REGULATORY OR Agency Respons reviewed March agency will have in relation to cool provided through not furnished dir agency are monit Special Instruction policies and proof documentation (of charts) will be us compliance with Regardless of the structure, the over services provided through arranger with the HHA the responsibility for implementing pla Board of director authority and res operations of the parent or branch	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ibilities," # B-125, 2015 stated, "The parent defined responsibilities ordination of care a branches. All services ectly by the parent tored and controlled ons 1. The HHA's redures, or other forms of e.g., organizational sed to determine this standard. 2. e formal organizational erall responsibility for all d, whether directly, ments or contracts, rests at has assumed and and of care 4. The rs assumes full legal ponsibility for all agency, regardless if status. 5. Certain	A. Bl	JILDING ING STREET A 3115 S V	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		ETED
	operations of the parent or branch determined funct Billing/payroll/in at the parent bran	agency, regardless if status. 5. Certain					
G 0133	chart."	on the organizational					
	` ,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		r í	JILDING	onstruction 00	(X3) DATE : COMPL 11/19/	ETED	
GREAT L	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 00	The administrator, supervising physic required under particular particular the governing bod professional personal perso	who may also be the sian or registered nurse ragraph (d) of this section, ects the agency's ongoing as ongoing liaison among y, the group of onnel, and the staff. review, and interview, failed to ensure e agency's South Bend ensure the South Bend direct care for 26 of 73 at active patient ensure an agreement or ed for the acquired e services for 26 of 73 at the South Bend branch d to ensure an agreement sted for the corporate an to submit Outcome Information Set (OASIS) at the State of Indiana for the State of Indiana for the serviced agency	G 0	133	G 133 To ensure compliance with 484.14(c) Administrator, the following interventions were implemented: • • • • • • • • • • • • • • • • • • •	te ber / B to es t to e at es	12/23/2015

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLET	ΓED
		157586	B. W	ING		11/19/20	015
NAME OF S	DROVADED OF GLADS 153			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	<			WEBSTER ST		
	AKES CARING		_		лО, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	•======= As of November 6	th	DATE
	_	y an agency in Warsaw			2015, a contractual arrangem		
		quired by the Great			was secured between the age		
	_	on. These patients were			referred to as Community Hor		
		th Bend branch active			Health Network of Indiana, LL	С	
	•	llso on the acquired			dba Great Lakes Caring CCN		
		patient list due to the			157586 (agency) and the acquired agency of AC and		
	acquired agency	did not accept the			Associates dba Great Lakes		
	_	The Administrator			Caring(acquired agency) to		
	stated that the ac	equired agency had its			provide the agency services s		
	own provider nu	mber.			as PT, OT, SLP, SN, MSW ar	nd	
					HHA.		
	3. During interv	view on 11/6/15 at 10:15			•====== As of November		
	_	istrator stated there was			15th, 2015 – no new patients		
		an agreement for the			were accepted to service for t	he	
		to provide services to the			agency that would normally be		
		ents. The Administrator			admitted to the acquired agen	cy's	
	_	corporation acquired the			provider number.		
		number, the South Bend			•====== As of 12/23/15 – A		
		coverage of the counties			'acquired agency's' patients w		
	•				discharged from the agency.		
	alleady serviced	by the acquired agency.					
	4 5				•aaaaaa As of December 3	rd	
	-	view on 11/6/15 at 11:12			2015-All agency South Bend	d to	
	· /	istrator indicated the			branch patients were assigned the correct South Bend RN	J 10	
	acquired agency				Clinical Supervisor.		
	_	hart, Administrator, and			·		
	_	sor, but she was also the			•□□□□□□□ The OASIS review		
		nistrator for the acquired			and lock process was revised	on	
	agency. The Ad	lministrator stated the			12/13/15 to have the specific		
	supervisor at the	South Bend branch is			provider number Clinical Supervisors or RNs review an	d	
	responsible for t	he day to day scheduling			lock their responsible areas	_	
	of staff and over seeing care provided for			OASIS.			
	the patients.	2 2					
					• • • • • • • • • • • • • • • • • • •		
	5. During interv	view on 11/6/15 at 11:30			2015, a contractual arrangem was secured between the Gre		
	1		1		r was secured between the Gre	aı l	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		157586	B. W	ING		11/19/2	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			WEBSTER ST		
CDEATI	_AKES CARING				MO, IN 46902		
GREAT	ARES CARING			KOKON			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	AM, the Admini	strator stated Great			Lakes Caring Corporate office		
	Lakes acquired t	he Warsaw agency's			and the agency to submit OAS data to the state.	SIS	
	provider number	in October, 2014.			data to the state.		
		•			A weekly organization chart at	ıdit	
	6 The South Re	end branch census			will be performed by the	aun	
		3 active patients, 26 were			administrator/designee to assu	ıre	
		-			100% compliance with G 133	for	
		ng provided services the			a period of 4 consecutive weel	ks.	
	acquired agency				After 4 consecutive weeks of		
					compliance, ongoing complian	ice	
	7. During interv	riew on 11/5/15 at 12:15			with this standard will be completed through annual poli	iov	
	PM, the Admini	strator stated the agency			review as organizational charts		
	does not do look	behind OASIS			are imbedded in our policy	3	
	evaluations to se	e if the clinician OASIS			manual. (Exhibit 3)		
		and if the agency gets the			,		
		and if the agency gets the			An audit to assure compliance	:	
	same scores.				with G 133 will be performed b	у	
					the administrator/designee on		
	_	riew on 11/13/15 at 12:40			100% of all new South Bend	_	
	PM, the Admini	strator stated the OASIS			admissions with a SOC date o or after November 15th for a	on	
	submissions are	done by the nurses or			period of 8 weeks. After 8		
	clinicians, and th	ne Corporate office in			consecutive weeks of 100%		
		ts the data to the State			compliance, the audit will		
	agency.				decrease to 10% quarterly and	d l	
	ugency.				will be completed through the		
	O Danin a intan	i 11/16/15 at 10:20			clinical record review process.		
		riew on 11/16/15 at 10:30			(Exhibit 1)		
	-	strator stated the agency			A a guidit will be nearfarmed was	a lebe	
		d agreement or contract			An audit will be performed wee by the administrator/designee		
	with corporate o	ffice to submit OASIS			assure 100% compliance G 13		
	data to the State	agency.			in regards to the applicable		
		•			provider number Clinical		
	10 The agency	s policy titled "Encoding			Supervisors/RNs reviewing an	d	
	10. The agency's policy titled "Encoding				locking the OASIS for a period		
	And Reporting OASIS Data," # B-250, reviewed March 2015 stated, "GLC will				4 weeks. After 4 consecutive		
		·			weeks of 100% compliance, th		
		port all OASIS data			audit will decrease to 50% of a	all	
	collect in accord	ance with federal			OASIS for another 4 weeks.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		157586	B. W	ING		11/19/	2015
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					WEBSTER ST		
GREAT L	LAKES CARING			KOKON	MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	After that 4 weeks of 100%		DATE
	1 -	C and agents acting on			compliance is obtained the au	dit	
		vill ensure confidentiality			will decrease to 10% quarterly		
	_	ific information in the		and will be completed through the			
	clinical record."				clinical record review process. (Exhibit 4)		
	11. The agency's	s policy titled "Parent					
	"	sibilities," # B-125,					
		2015 stated, "The parent					
		defined responsibilities					
	in relation to coo						
	provided through	branches. All services					
		ectly by the parent					
		tored and controlled					
		ons 1. The HHA's					
		edures, or other forms of					
		e.g., organizational					
	charts) will be us						
	· ·	this standard. 2.					
	_	e formal organizational					
	"	erall responsibility for all					
		d, whether directly,					
	_	nents or contracts, rests					
	with the HHA th	· · · · · · · · · · · · · · · · · · ·					
		r admitting patients and					
		ans of care 4. The					
		rs assumes full legal					
		ponsibility for all					
		agency, regardless if					
	_	status. 5. Certain					
	determined func						
		ntake) will be localized					
		nch. The functions are					
	_	on the organizational					
	chart."						

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Event ID:

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Facility ID: 011284

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	ľ í	UILDING	nstruction <u>00</u>	(X3) DATE COMPI 11/19	ETED
	PROVIDER OR SUPPLIER			3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	"Executive Direct signed by the Ad" "Management: 2 provides direction an effort to ensure of services 2 in assuring composition of state for Medicoaching policy development, stamonitoring active departments in a policies and process and provide supervision. Purequirement of sand provide supervision.	aff education and ities 2.10 Assists ssuring all agency redures are adhered to by a locations as s policy titled "Clinical C-300, reviewed March licy Skilled nursing and reservices are provided ision of a Registered ional Director/Clinical available to provide sion during the operating Under no circumstances trative or supervisory be delegated to another arpose To meet the tate/federal guidelines ervision and direction to ag home health care					

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Event ID:

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Facility ID: 011284

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 11/19/2015	
	PROVIDER OR SUPPLIER LAKES CARING	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	that care is directed toward the achievement of goals, and that services are provided based on client need and in accordance with the physician's Plan of Care Special Instructions 1. The Regional Director/Clinical Manager shall be responsible for the quality of care provided and supervision of all staff providing therapeutic services, including contract staff. He/she will also be responsible for organizing and directing GLC's ongoing functions. 2. The Regional Director/Clinical Manager shall coordinate the day-to-day operation of the organization and work with the Administrator. 3. The Clinical Supervisor will participate with the Regional Director/Clinical Manager in all activities relevant to the professional services furnished. This includes the development of qualification and the assignment of personnel."				
G 0134 Bldg. 00	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section,				
	employs qualified personnel and ensures adequate staff education and evaluations. Based on record review, and interview, the administrator failed to ensure home health aide (HHA) skills competency	G 0134	G 134 To ensure compliance with 484.14(c) Administrator, the following interventions have be	12/22/2015 een	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	/2015
		ı		STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8			WEBSTER ST		
GREAT I	LAKES CARING			KOKOMO, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	-	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		bathing patients for 4 of			implemented:		
	5 Home Health	Aide (HHA) files			•=====================================		
	reviewed (C, I, I	N, and P); failed to ensure			September 21, 2015 the skills	.	
	the filed skills competencies included				competency check offs includ		
	transfer and rans	ransfer and range of motion (ROM) for 2			bathing patient, transfer, and		
	`	ed (I and N); and failed			range of motion as well as all		
	to ensure the acquired agency had an				other required skills.		
	arrangement or agreement for the					41-	
	acquired agency provide HHA services				• and a sof November 6 2015, a contractual arrangem		
	for 4 of 73 patients with HHA services				was secured between the age		
	listed on the South Bend branch census.				referred to as Community Hor		
	listed on the South Bend branch census.				Health Network of Indiana, LL	.C	
					dba Great Lakes Caring CCN		
					157586 (agency) and the		
	Findings include	2.			acquired agency of AC and Associates dba Great Lakes		
					Caring(acquired agency) to		
		e C, a HHA, date of hire			provide the agency services s	such	
	4/2/12, first patie	ent contact date 4/7/12,			as PT, OT, SLP, SN, MSW ar		
	failed to evidence	ce the skills competency			HHA		
	was observed pr	oviding care for a patient.					
	A. The docu	ment titled "Summary			•□□□□□□□□ On December 22, 2015 the Competency Based		
		for Skills Demonstration			Skills Checklist for home heal	th	
		d 4/4/12 stated "Where			aides was revised to include:		
	Observed: Lab.				and where the skill was		
	Ousciveu. Lab.				performed, that the skill was		
	D. T. I	1 1 101 11			performed on a patient, the		
		ment titled "Skills			employee who observed thes		
	_	nment Detail," dated			skills, as well as the signature home health aide. The revise		
		evidence how and where			Competency Based Skills	-	
	the annual skills were evaluated and				Checklist will be used for all		
	failed to evidence	ce they were performed			Home Health Aides hired on o	or	
	on a patient.				after December 21, 2015.		
	2 5 7 7	. N. 1111A . 1.4 61.					
		e N, HHA, date of hire			An audit will be performed by		
	1 5/12/14, first pat	tient contact date 5/17/14,	- 1		administrator/designee of 100	1%	I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	WEBSTER ST		
CDEAT	LAKES CARING				MO, IN 46902		
					10, 114 40302		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	of all new home health aides		DATE
		ce the skills competency			hired on or after December 21		
	was observed providing care for a patient.				2015 to ensure compliance wi		
					G 134 and that the Competent		
	A. The docu	ment titled "Competency			Based Skills Checklist is	,	
	Based Skills Ori	entation Checklist for			completed prior to home healt	h	
	Home Health Ai	ide (CHC)," dated			aide seeing patient		
		o evidence bathing was			independently. The audit will	no io	
	observed and co	•			continue until 100% compliand maintained for 4 consecutive	JE 15	
		1			weeks. After 4 weeks of 100%	6	
	B The docu	ment titled "Skills			compliance audit will decrease	e to	
		nment Detail," dated			10% quarterly and will be		
	_	evidence how and where			completed by Human Resource	es.	
		were evaluated and			(Exhibit 5)		
		ee they were performed					
	on a patient.						
	3. Employee fil	e P, HHA date of hire					
	5/26/15, first pat	tient contact date 5/31/15,					
	failed to evidence	ee the skills competency					
		oviding care for a patient.					
	1	tled "Skills Checklist					
		ail," dated 5/26/15 failed					
	1 -	and where the skills					
		and failed to evidence					
	they were perior	med on a patient.					
	4 Employee fil	e I, HHA, date of hire					
		atient contact date					
	_						
	10/20/12, failed to evidence bathing was completed/observed being performed on						
	_	ved being perioritied on					
	a patient.						
	A Thada.	mont titled "Commeter					
		ment titled "Competency entation Checklist for					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	
	PROVIDER OR SUPPLIER		<u> </u>	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902	<u> </u>	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
IAU	Home Health Ai 11/7/12, failed to observed and co	de (CHC)," dated o evidence bathing was mpetencied.		IAG	Balciacty		DATE
	Documentation i	ment titled "Summary for Skills Demonstration d 10/16/12 stated "Where					
	9/21/15, first pat failed to evidence	e S, HHA, date of hire ient contact date 9/26/15, the the skills competency oviding care for a patient.					
	Checklist Assign 9/22/15 failed to the annual skills	ment titled "Skills ment Detail," dated evidence how and where were evaluated and the they were performed					
	PM, employee T they do HHA sk on-boarding in the the next day the to be checked of Employee T indi	icated they do a bed bath n in the lab and verbally					
	PM, employee T	riew on 11/19/15 at 2:00 stated the agency does empetency check off					

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Event ID:

YJL511

Facility ID: 011284

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUII B. WIN	LDING	<u>00</u>	COMPLETED 11/19/2015	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING			KOKOM	O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	and R, due to the with how things	iew on 11/19/15 at 2:05					
	orientation list the baths on it was perequirements in a Administrator inconsection background checkground checkgr	nat does not have the rompted from similar another state. The dicated the criminal k company was called ISPR is included in the					
	PM, employee T	iew on 11/19/15 at 2:30 indicated the annual ies are performed in the nequin.					
	"Home Health A stated, "Job Qual 1. a State-establihealth Aide train the requirements and a competence	s job description titled ide," revised 6/6/14 ifications: Education: ished or other Home ing program that meets of 42 CFR 484.36 (a) y evaluation program, or are program that meets					
	the requirements (e) within the pass competency eval licensure program requirements of 4 with in the last 2	of 42 CFR 484.36 (b) or st 24 months, or 3. a uation program or State					

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Event ID:

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Facility ID: 011284

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	lì í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED
	PROVIDER OR SUPPLIER			3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		ning and competency am prior to providing e."					
	"Executive Direct signed by the Ad" "Management: 2 provides direction an effort to ensure of services 2 in assuring compositate for Medicoaching policy development, star monitoring active departments in a policies and processaff at all branch applicable." 12. The agency "Clinical Supervestated, "Coordinate Provides education clinical practice reimbursement of Supervises and processary to the Registered Practical Nurse, Aide, & office stary continuity of ser Assures complia	aff education and ities 2.10 Assists assuring all agency redures are adhered to by a locations as as job description titled isor," dated 7/20/12 ation of services: 2.4 on and training related to issues and regulation and hanges Supervision provides clinical direction and Nurse, Licensed Therapist, Home Health aff to ensure quality and vices provided 3.6					

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Event ID:

YJL511

Facility ID: 011284

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	D PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
	ROVIDER OR SUPPLIER AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
G 0141	•	opment, staff education, nitoring activities."				
Bidg. 00	supported by appr policies. Personnel records licensure that are	es and patient care are opriate, written personnel include qualifications and kept current.				
	the administrator employees had a employment for reviewed (C, E, I failed to ensure h skills competence bathing patients a Aide (HHA) files P); failed to ensure	review, and interview, failed to ensure all physical prior to 8 of 173 employee files M, N, O, Q, R, and S); come health aide (HHA) y checks included for 4 of 5 Home Health as reviewed (C, I, N, and re the HHA field skills cluded transfer and range	G 0141	G 141 To ensure compliance with 484.14(e) Personnel Files, the following interventions have be implemented: • • • • • • • • • • • • • • • • • • •	een o is first	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	/2015
		ı		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			WEBSTER ST		
GREAT I	_AKES CARING				MO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of motion (ROM	1) for 2 of 5 files			employees will have the requi	red	
	reviewed (I and	N); and failed to ensure				physical examination by a	
	criminal backgro	ound checks included the			physician or nurse practitione prior to the employee's first		
	Indiana State Po	lice Repository (ISPR)			patient contact date. This date	e will	
	for 5 of 11 employee files reviewed (E,				be recorded in the employee		
	N, O, R, and S).	•			personnel file for all employee		
	11, 0, K, and 5).				hired on or after 12/23/2015 b	-	
	Eindings in al. 1				the human resources departm	nent.	
	Findings include:					. ما	
					• and an All employees hire on or after 12/23/2015 shall have		
	1. During interview on 11/19/15 at 12:20				a physical examination by a	ave	
	PM, employee L, Human Resources,				physician or Nurse Practitione	er	
	stated the agency	y does not keep track of			that documents that the emplo		
	official first pati	ent care dates, as the			will not spread infectious or		
	employees are u	sually in the office for			communicable diseases to		
	orientation and s	-			patients. This physical		
		week, so they just say			examination will be document		
		act date is 5 days after			and certified by the physician nurse practitioner on the	Or	
	date of hire.	act date is 5 days after			Certificate of Employee Physi	cal	
	date of fife.				Examination form.	ou.	
	2. Employee fil	e C, a HHA, date of hire					
		ent contact date 4/7/12,			•====== As of 12/23/2015,	all	
		ee the skills competency			education and human resource		
		oviding care for a			staff have been educated on t		
	_	•			new process and human		
	patient; and faile	ed to evidence a physical.			resources staff have also bee		
					educated on the state addend	lum	
		ment titled "Summary			in Policy D-240.		
	Documentation	for Skills Demonstration					
	Checklists" date	d 4/4/12 stated "Where					
	Observed: Lab.	"			•====== As of 12/23/2015,	the	
					personnel records of all		
	B The docu	ment titled "Skills			employees who deliver home		
		nment Detail," dated			health services shall include		
	_				documentation of a limited		
		evidence how and where			criminal history from the India	na	
	I the annual skills	were evaluated and	1		central repository for criminal		I

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CENTERS FO	R MEDICARE & MEDIC	EAID SERVICES			OMB	NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLE	TED
		157586	B. WING		11/19/2	2015
NAME OF	PROVIDER OR SUPPLIEI	₹		ADDRESS, CITY, STATE, ZIP CODE		
ODEAT	LAKEO CADINO			WEBSTER ST		
	LAKES CARING		KUKUI	MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	failed to evidence	ce they were performed		history information.		
	on a patient.			• and any employee who		
				delivers home health services		
	C. The file c	ontained a letter dated		hired prior to 12/23/2015, who		
	4/2/12 from a pl	nysician that stated		may have had documentation		
	_	lemonstrates no clinical		national and local criminal hist		
	1 - 1 - 1	cal exam that would		conducted by a third party ven		
				has a limited criminal history fr		
	suggest a comm	unicable disease."		the Indiana central repository f		
				criminal history information add	aea	
	1 1	e N, HHA, date of hire		to their personnel record.		
	5/12/14, first par	tient contact date 5/17/14,				
	failed to evidence	ce the skills competency		•□□□□□□□ The human resources department is		
	was observed pr	oviding care for a		responsible for conducting the		
	_	evidence the criminal		limited criminal history for all		
	1 *	ck included search		employees who deliver home		
	1	R; and failed to evidence		health services from the Indiar	na	
		x, and failed to evidence		central repository for criminal		
	a physical.			history information. The human	n	
		110		resources department will		
		ment titled "Competency		maintain documentation of the limited criminal history conduc	I	
	Based Skills Ori	entation Checklist for		on every employee who delive		
	Home Health A	ide (CHC)," dated		home health services in the		
	5/13/14, failed to	o evidence bathing was		employee's personnel record.		
	observed and co	mpetencied.				
		•		•□□□□□□□ As of 12/23/2015, a		
	B The docu	ment titled "Skills		human resources staff have be		
		nment Detail," dated		educated on the new process.		
	_	evidence how and where				
		were evaluated and				
		ce they were performed		•====== Beginning		
	on a patient.			September 21, 2015 the skills		
				competency check offs include	ed	
	C. The file c	ontained a copy of a		bathing patient, transfer, and		
		a datad 5/0/14 from a		range of motion as well as all		

prescription note dated 5/9/14 from a

Nurse Practitioner and stated "Free of

other required skills.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
		157586	B. W	ING	11/		/19/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹			WEBSTER ST			
GREAT L	AKES CARING				лО, IN 46902			
		TATEL CENT OF DEPLOYED OF				ı	(775)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG	`	R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
IAU		· · · · · · · · · · · · · · · · · · ·		TAG	· ·		DATE	
	Communicable 1	Disease."			• On December 22, 2015 the Competency Based			
					Skills Checklist for home healt	h		
	4. Employee fil	e P, HHA date of hire			aides was revised to include:			
	5/26/15, first patient contact date 5/31/15,				and where the skill was			
	failed to evidence	ce the skills competency			performed, that the skill was			
		oviding care for a patient.			performed on a patient, the			
	_	tled "Skills Checklist			employee who observed these			
		ail," dated 5/26/15 failed			skills, as well as the signature			
		and where the skills			home health aide. The revised Competency Based Skills			
					Checklist will be used for all			
	were evaluated and failed to evidence				Home Health Aides hired on o	r		
	they were performed on a patient.				after December 21, 2015.			
		e I, HHA, date of hire						
	10/15/12, first pa	atient contact date			An audit will be performed by t	the		
	10/20/12, failed	to evidence bathing was			Vice President of Human Resources or designee of 100	0/_		
	completed/obser	rved being performed on			of all personnel records of	/0		
	a patient.				employees hired on or after			
					12/23/15 who will deliver home	Э		
	A The docu	ment titled "Competency			health services. The audit will	be		
		entation Checklist for			conducted to ensure that each			
					personnel record contains a			
		ide (CHC)," dated			limited criminal history from the	e		
		o evidence bathing was			Indiana central repository for criminal history information			
	observed and co	mpetencied.			conducted on or before the			
					employee's first date of hire wi	ith		
	B. The docu	ment titled "Summary			the Agency until 100%			
	Documentation	for Skills Demonstration			compliance is met for 4			
	Checklists" date	d 10/16/12 stated "Where			consecutive weeks. After 4			
	Observed: Lab.				consecutive weeks of 100%			
					compliance the audit will decrease to 10% of all newly			
	6 Employee fil	e S, HHA, date of hire			hired employees quarterly. At	_{ıdit}		
					results will be provided to the			
		tient contact date 9/26/15,			Administrator immediately afte	er		
		ce the skills competency			each audit is conducted. (Exhi			
	_	roviding care for a			21)			
	patient; and faile	ed to evidence a physical.						

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	NG		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			WEBSTER ST		
GREAT I	AKES CARING				1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	Ī	ID	BROWING BY AN OF CORDECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	1E	DATE
	Checklist Assign 9/22/15 failed to the annual skills failed to evidence on a patient. B. The file of 9/22/15 from a property of the communicable	inal background check ed on 9/14/15 failed to bormation was obtained e E, licensed practical re 7/28/14, first patient 1/14, failed to evidence the bound check included the ISPR; and failed to			An audit will be performed by the administrator/designee of 100% of all new home health aides hired on or after December 21 2015 to ensure compliance with G 141 and that the Competent Based Skills Checklist is completed prior to home health aide seeing patient independently. The audit will continue until 100% compliance maintained for 4 consecutive weeks. After 4 weeks of 100% compliance audit will decrease 10% quarterly and will be completed by Human Resource (Exhibit 5) A weekly audit will be performed by the Vice President of Human Resources or designee of 100 of all personnel records of employees hired on or after 12/23/15 who will deliver home health services. The audit will conducted to ensure that each personnel record contains the "Certificate of Employee Physical Examination" completed prior the first date the employee has direct patient contact until 100 compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% of all newly hired employees quarterly. Au results will be provided to the Administrator immediately afte each audit is conducted. (Exhi 20)	th cy h ce is deto ces. ed an % e be ical to s % udit	

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NAME OF PROVIDER OR SUPPLIER GREAT LAKES CARING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 8. Employee file M, Registered Nurse (RN), date of hire 2/23/15, first patient contact date 2/27/15, failed to evidence a physical. The file contained a copy of a prescription note dated 2/23/15 from a	
GREAT LAKES CARING (X4) ID PREFIX TAG 8. Employee file M, Registered Nurse (RN), date of hire 2/23/15, first patient contact date 2/27/15, failed to evidence a physical. The file contained a copy of a prescription note dated 2/23/15 from a 3115 S WEBSTER ST KOKOMO, IN 46902 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OCMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OCMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OCMPLETION TAG OCMPLETION DATE	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 8. Employee file M, Registered Nurse (RN), date of hire 2/23/15, first patient contact date 2/27/15, failed to evidence a physical. The file contained a copy of a prescription note dated 2/23/15 from a (EACH DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION (RACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ON THE PROPRIATE DEFICIENCY OF COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) ON THE PROPRIATE DEFICIENCY OF COMPLETION OF	
(RN), date of hire 2/23/15, first patient contact date 2/27/15, failed to evidence a physical. The file contained a copy of a prescription note dated 2/23/15 from a	ION
Nurse Practitioner, and stated "Patient free of communicable disease as of 2/3/15 office visit. No job restrictions." 9. Employee file Q, RN, date of hire 7/7/14, first patient contact date 7/12/14, failed to evidence the criminal background check included search through the ISPR; and failed to evidence a physical. A. The criminal background check dated as requested on 6/26/14 failed to evidence the information was obtained from the ISPR. B. The file contained a letter dated 6/30/14 from a physician that stated "Pt was seen in my office today for check up and was found to be free of any Communicable Diseases." 10. Employee file Q, physical therapist, date of hire 11/15/12, first patient contact date 11/20/12, failed to evidence a physical. The file contained a letter dated 11/19/12 from a physician that stated: [employee Q] is a patient in our clinic.	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE COI UILDING	NSTRUCTION 00	COMPL		
		157586	B. W		<u></u>	11/19/	
	PROVIDER OR SUPPLIEF		<u> </u>	3115 S \	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ATE	(X5) COMPLETION DATE
TAU		free of communicable		TAG			DAIL
	Worker, date of contact date 3/3/ failed to evidence background check	le R, Medical Social hire 2/24/14, first patient 14, failed to evidence e the criminal ek included search R; and failed to evidence					
	A. The criminal background check dated as requested on 1/17/14 failed to evidence the information was obtained from the ISPR.						
	2/25/14 from a patient[employe office fro an app	ontained a letter dated hysician that stated "My e R] was last seen in my ointment on 1/15/14. mmunicable disease."					
	PM, employee T they do HHA sk on-boarding in the the next day the to be checked of Employee T indi	ne lab at the office, then HHA is sent with an RN f out in the field. cated they do a bed bath n in the lab and verbally					
		view on 11/19/15 at 2:00 stated the agency does					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL				
		157586	B. W	ING		11/19/			
	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TIVE ACTION SHOULD BE NCED TO THE APPROPRIATE			
	sheets for bathin	mpetency check off g for employees C, I, N, ere was a process change are being done.							
	PM, the Administration list the baths on it was prequirements in Administrator in background checkground checkgrou	view on 11/19/15 at 2:05 strator stated "the nat does not have the crompted from similar another state. The dicated the criminal ek company was called a ISPR is included in the							
	PM, employee L indicate the crim company will be search but it may	view on 11/19/15 at 2:20 , Human Resources, inal background check faxing proof of ISPR / take a couple of hours. t 2:45 PM, the fax was be provided.							
	PM, employee T	view on 11/19/15 at 2:30 indicated the annual ies are performed in the nequin.							
	reviewed March Indiana Addendi Indiana each em	s policy titled ening," # D-240, 2015 stated, "State of um: *In the State of ployee who will have ntact shall have a							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	IULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL				
		157586	B. W	ING	<u> </u>	11/19/			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	physical examination nurse practitioner hundred eighty (that the employer contact. The physical physical physical period of the stated, "Physical period of the stated, "Health of the stated, "Registered Nurse" (The stated of the stated) of the stated of	ation by a physician or or not more than one 180) days before the date has direct patient spical examination shall acope to ensure that the ot spread infectious or iseases to patients." Is job description titled cal Nurse," dated 7/20/12 and Environmental Meet the health the agency." Is job description titled bist," dated 4/16/14 tatus: Meets all by policies and bed to health screening ing Physical and Demands 7. Meet the ents of the agency." Is job description titled see," dated 7/20/12 stated, avironmental Demands health requirements of the							
	"Home Health A "Job Qualification	s job description titled ide," dated 6/6/14 stated, ons: Education: 1. a l or other Home health							

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586		JILDING	NSTRUCTION 00	(X3) DATE : COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
	requirements of competency eva State licensure prequirements of within the past 2 competency eva licensure progra requirements of with in the last 2 must successfull Health Aide trainevaluation progradirect patient can Meets all applications procedures related and required test Environmental I	ogram that meets the 42 CFR 484.36 (a) and a luation program, or 2. a rogram that meets the 42 CFR 484.36 (b) or (e) 4 months, or 3. a luation program or State in that meets the 42 CFR 484.36 (b) or (e) 4 months. Otherwise, y complete a Home in and competency am prior to providing re Health Status: able agency policies and red to health screening regions Physical and Demands 7. Meet the rents of the agency."							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETI			ETED	
		157586	B. WI	NG		11/19/	2015
	PROVIDER OR SUPPLIER AKES CARING SUMMARY ST	FATEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· -	DATE
G 0143 Bldg. 00	484.14(g) COORDINATION All personnel furni liaison to ensure the coordinated effection objectives outlined. Based on record the agency failed communicated of Peripherally Inset (PICC) line means physician for 1 or receiving PICC I failed to ensure a referral were incompared to the agency failed to ensure a referral were incompared to the same of the sa	OF PATIENT SERVICES shing services maintain nat their efforts are lively and support the lin the plan of care. review and interview, lito ensure the nurses thanges in length of cred Central Catheter surements to the fill record reviewed ine management (# 3); all disciplines ordered on luded on the plan of care atted timely for 1 of 20 lith (# 10); and failed to health Aide reported nurse as ordered on the right 2 of 9 records reviewed therefore. (# 2 and 12) Executed of patient # 3, start 3/15, contained a plan of lith 10/23/-12/21/15 with lith Nursing (SN) 1 time at lith 2, 2 times a week for 8 me a week for 1 week, wisits for cardiac, cointestinal, purologic, endocrine, in/wound status changes,	G 0		G 143 To ensure compliance with 484.14(g) Coordination of Patic Services, the following interventions have been implemented: All LPN and RN staff received education by 12/24/15 that included hands on demonstration check offs in a skills lab by RN staff educators. The education included review PICC line procedures, physician otification of abnormal assessment, documentation review, as well as return demonstration of skills includin measurement of PICC line. A PICC measurement service code was created in the electronic medic record software on 12/14/15 to prompt clinicians to complete a PICC measurement at their visual All Home Health Aides attended training by 12/24/15 that included: review policies C-800 Home Health A Documentation and C-751 Hold Health Aide Care Plan, and documentation requirements including notification to the RN/Clinical supervisor of any visigns outside of the ordered	5, of an ag sal a sits.	12/24/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
CDEATI	_AKES CARING				MO, IN 46902		
GREAT	ARES CARING			KOKON			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	lab/venipuncture	e procedure, obtain lab			parameters for the patient.		
	results and repor	t to physician. SN to					
	obtain Vancomy	cin trough week of					
	10/26/15 and BMP [basic metabolic				On 12/22/15, an electronic medical record		
	profile] twice weekly until instructed				software setting was initiated t	hat	
	_	N to change PICC			creates 'worfklow' that flows to		
		terile technique every			the RN Clinical Supervisor		
		2 2			anytime vital signs are		
	week and as needed times 3 for soiled or				documented outside of the		
	loose dressing.				physician ordered parameters		
					AH 11		
	A. The start of care assessment form				•□□□□□□□ All clinical staff well educated by 12/24/15 on polic		
	dated 10/23/15 b	by employee G,			C-360 Coordination of Client	ies	
		e (RN) stated, "Indicate			services, C-635 Physician's		
	_	ed PICC catheter from			orders, and C-660 Care		
	insertion site to				Plans. Education focus include	ed	
					the need to provide all discipling	nes	
	centimeters: 10.	.0.			indicated, detailed and timely		
					physician orders, and updating	3	
	B. The SN V	isit Report dated			the care plan.		
	10/30/15 by emp	ployee G stated, "Indicate			An audit will be performed by t	the	
	length of expose	ed PICC catheter from			administrator/designee to assu		
	insertion site to	catheter hub in			compliance with G 143 of 100		
		0." The record failed to			of all patients with a PICC line		
		sician was notified of			until 100% compliance is met		
	1	longer measurement of			4 consecutive weeks. After 4		
		longer measurement or			consecutive weeks of 100%		
	the PICC line.				compliance the audit will		
					decrease to 10% quarterly and will be completed through the	ا	
		isit Note Report dated			clinical record review process.		
	11/6/15 by empl	oyee G stated, "Indicate			(Exhibit 6) An audit will be		
	PICC Catheter S	Site Assessment: Red			performed by the administrato	r or	
	Indicate length of	of exposed PICC catheter			designee of 100% of HHA visit		
		te to catheter hub in			to ensure compliance with		
		0." The record failed to			reporting as outlined in Policie	S	
		vsician was notified of			C-800 and C-200 until 100%		
					compliance is met for 4		
	the redness at the	e PICC catheter site.			consecutive weeks. After 4		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/19/2015		
	PROVIDER OR SUPPLIEF	2		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	"Indicate length catheter from inshub in centimeter failed to evidence notified of the 3 measurement. E. During in 10:05 AM, the A talked to the nur PICC line at 3 cethe nurse said shows showing unand that the PICC. The clinical reviewed on 11/date was 10/10/10 a plan of care (Pwith orders for 2 visits a week for A. The Aide 10/10-12/8/15 st Require Physicia Blood Pressure 180/50." B. The Visit 10/14/15 by emptores the same and the properties of the same and the properties of the same and the properties are the prope	Care Plan Report dated ated, "Vital Signs that an Notification by SN: Upper 170/90, Lower Note Report dated bloyee C, HHA, stated,			weeks of 100% compliance thaudit will decrease to 10% quarterly and will be complete through the clinical record revprocess. (Exhibit 7) An audit be performed by the administrator/designee of 100 of all new admissions to ensuall ordered disciplines are add to the plan of care until 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance, the audit will decrease to 10% quarterly ar will be completed through the clinical record review process (Exhibit 8)	ed view will 0% Ire ded	
	"Blood Pressure	174/82 Physician					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	JILDING	NSTRUCTION 00	(X3) DATE : COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Contacted: No. said feeling fi failed to evidence nurse of the vital. C. The Visit 10/17/15 by emp. "Blood Pressure Contacted: No. [systolic]: 173 oc." The visit note HHA notified the D. During in 1:45 PM, the Adagency could not the HHAs called 10/17/15 to notif high. 3. The clinical rewas reviewed on care date was 9/2 9/26-11/24/15 cottime a week for	Comments: [patient] ne." The visit note e the HHA notified the signs. Note Report dated cloyee W, HHA, stated, 173/91 Physician Comments: SYS ever 91 DIAS [diastolic] e failed to evidence the e nurse of the vital signs. terview on 11/16/15 at ministrator stated the et find any notes saying the nurses on 10/14 or ey of vital signs being ecord for patient # 10 11/17/15. The start of 26/15. POC dated contained orders for SN 1 I week, 2 times a week			CROSS-REFERENCED TO THE APPROPRIA	TE	
	weeks, 3 as need gastrointestinal/g	a 1 times a week for 7 ed for falls, pain, gastrourinary, respiratory, d skin integrity, diabetes,					
	teaching and into	ecline. Need for skilled ervention related to ervical spine incision. dry. May leave open to e noted.					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	/2015
		l .		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			WEBSTER ST		
GREATI	AKES CARING				10, IN 46902		
		TA TEN CENT OF DEPLOYENCIES	1		10, 11 10002		(W.C.)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110	REGUESTIONT ON	Egg identification		1710			Ditte
	A The Climi	cal Coordination Note					
	_	25/15 stated "Received					
	referral from Cleveland Clinic						
	Start of care tomorrow 9/26/15. Patient						
	will need SN, PT [Physical Therapy], OT						
	[Occupational T	***					
		pertension, diabetes					
	· ·	depression." The record					
	failed to evidence	ee PT and OT were					
	ordered on the POC; failed to evidence						
	PT was ordered	until 10/14/15; and failed					
	to evidence OT	was ordered.					
	B. The Clien	t Coordination Note					
		/12/15 stated, "Patient's					
	•	o inform GLC that					
		and Clinic has ordered					
		y. Informed [caregiver]					
		obtain the order and					
		out for an evaluation."					
	send a therapist	out for all evaluation.					
	C. Desmin a in	4					
	_	terview on 11/17/15 at					
	· ·	Iministrator stated the					
		called the agency on					
		the Cleveland Clinic had					
	-	referral to the agency.					
		or stated she did not see					
		ne patient for the PT and					
	OT services, and	I the OT was not started.					
	4. The clinical r	record for patient # 12					
		1 11/18/15. The start of					
	care date was 7/	19/15. The POC dated					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT I	AKES CARING			1	IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	9/17-11/15/15 co 1 visit a week fo	ontained orders for HHA r 3 weeks.					
	9/17-11/15/15 st Require Physicia	Care Plan Report dated ated, "Vital Signs that an Notification by SN: Upper 170/90, Lower					
	10/28/15 by emp "Blood Pressure Contacted: No. [diastolic]: No The visit note fa	Note Report dated ployee X, HHA, stated, 147/95 Physician Comments: DIAS dizziness from patient." iled to evidence the HHA e of the vital signs.					
	Health Aide: Do reviewed March Home Health Ai for reporting any	policy titled "Home ocumentation," # C-800, 2015 stated, "2. The de shall be responsible changes in the client's er pertinent observations apervisor."					
	Health Aide Car reviewed March	policy titled "Home e Plan," # C-751, 2015 stated, "Policy aide staff will follow the					
	Health Aide Serv	policy titled "Home vices," # C-220, 2015 stated, "Special					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE : COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF P	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING			1	IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Instructions 1. Is services may incobservations of the reporting the rest Nurse/Therapist. 8. The agency's "Responding to Chines," # I-230 st Migration: It is central venous cannother location Certain types of susceptible to cance Clients who are Response: Mease external length of dressing change, detection. Period verification by x performed on all placed catheters. 9. The agency's "PICC Line Dress stated, "PICC Line Dress stated," PICC Line Dress stated, "PICC Line Dress stated," PICC Li	Home Health Aide lude: g. Making he client's condition and ults to the Registered " undated policy titled Complications of PICC tated, "Catheter Tip possible for any type of atheter to migrate to while in the body. clients are more theter tip migration wery active sure and document the of the catheter with each This will assist in early dic catheter tip -ray study should be long-term, centrally " undated policy titled ssing Change," # I-240 he dressing changes will			CROSS-REFERENCED TO THE APPROPRIA	TE	
	catheter exposed gloves Docu Document in the Length of cathete	Note length of 11. Don sterile mentation Guidelines 1. clinical record: d. er visible at exit site. e.					
	Any physician n	otification."					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
GREAT I	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		.TE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	10. The agency	s policy titled f Client Services,"					
		ed March 2015 stated,					
	•	ensure services are					
	-	veen members of the					
		team 3. After the					
	initial assessmen						
	Registered Nurse	e/Therapist shall					
	communicate the	e findings of the initial					
	visit with the Cli	inical Supervisor to					
		ication of the plan of					
		d. Client's need for					
	_	are, e. Need for other					
		referral to community					
	resources."						
	11. The agency'	s policy titled "Physician					
		5, reviewed March 2015					
	stated, "1. When	n the nurse or therapist					
	receives a verbal	l order from the					
	physician, he/sh	e shall write the order as					
	given and then re	ead the order back to the					
		ing that the person					
	_	ler heard it correctly and					
	interpreted the o	rder correctly."					
	 12 The agency!	s policy titled "Care					
		reviewed March 2015					
	stated, "1. Follo						
	assessment, a Ca	-					
	developed with t						
	•	nterventions shall					
	_	e problems identified,					
	services needed	and the client goals for					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157586		ľ í	JILDING	onstruction 00	(X3) DATE : COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) TE."		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
G 0146 Bldg. 00	Services furnished subject to a writter the requirements of this section and section 1861(w) of 1495x(w)). Based on record the parent agency agreement or arracquired agency of 73 active patic Bend branch cen supervision of the ensure it provide of 73 active patic branch list for 1 reviewed who re acquired agency agreement or arracquired agency of 73 active patic branch list for 1 reviewed who re acquired agency of 73 active patic Bend branch cen Outcomes Asses Set (OASIS) data parent agency or ensure an agreen existed for the comparison of the co	R ARRANGEMENTS I under arrangements are in contract conforming with specified in paragraph (f) with the requirements of if the Act (42 U.S.C review, and interview, y failed to ensure an angement existed for the to provide services to 26 ents listed on the South sus; failed to ensure e South Bend branch to d services directly to 26 ents from the South Bend of 1 patient record ceived services from the failed to ensure an angement existed for the to provide services to 26 ents listed on the South sus; failed to ensure an angement existed for the to provide services to 26 ents listed on the South sus; failed to ensure the sment and Information a was submitted from the branches; and failed to ment or arrangement orporate office in mit OASIS to the Indiana all the agency's patients IS data collection out of	G 0	146	G 146 To ensure compliance with 484.14(h) Services Under Arrangements, the following interventions have been implemented: • • • • • • • • • • • • • • • • • • •	ent ncy ne C uch d h ent at	12/23/2015

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. Wl	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
		X.			WEBSTER ST		
GREAT I	LAKES CARING			KOKOMO, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					15th, 2015 – no new patients were accepted to service for t	he	
	Findings include	: :			agency that would normally be		
					admitted to the acquired ager		
	_	tional chart evidenced			provider number.		
		an acquired agency				m al	
	located in Warsa	NW.			•□□□□□□□ As of December 3 2015-All agency South Bend	ıa	
					branch patients were assigne	d to	
	2. The South Be	end branch census			the correct South Bend RN		
	included 26 of 7	3 active patients, 26 were			Clinical Supervisor.		
	identified as also	being listed on the					
	acquired agency census. 3. During interview on 11/5/15 at 12:15				• • • • • • • The OASIS review		
					and lock process was revised 12/13/15 to have the specific	OH	
					provider number Clinical		
	_	strator stated the agency			Supervisors or RNs review ar	nd	
	does not do look	• •			lock their responsible areas		
		ee if the clinician OASIS			OASIS.		
		and if the agency gets the					
	same scores.				• • • • • • • • • • • • • • • • • • •	All	
					'acquired agency's' patients w		
	4 During interv	view on 11/5/15 at 1:40			discharged from the agency.		
	_	strator stated that some					
		outh Bend branch patients			A weekly audit to assure		
		an agency in Warsaw			compliance with G 146 will be	,	
	_	quired by the Great			performed by the		
		on. These patients were			administrator/designee on 10		
	_	on. These patients were ath Bend branch active			of all new South Bend admiss	sions	
					with a SOC date on or after November 15th for a period o	f 8	
	patient list and also on the acquired agency's active patient list due to the acquired agency did not accept the				weeks. After 8 consecutive	. 5	
					weeks of 100% compliance, t	he	
					audit will decrease to 10%		
insurance plans. The Administrator				quarterly and will be complete			
		equired agency had its			through the clinical record rev process. (Exhibit 1)	iew	
	own provider number.		process. (Exhibit 1)				
					An audit will be performed we		
	5. During interv	view on 11/6/15 at 10:15			by the administrator/designee	to	

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AND PLAN	OF CORRECTION		B. W		00	COMPI	
		157586	D. W			11/19	/2015
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
ODEATI	ALCEO OADINO			1	WEBSTER ST		
GREAT	AKES CARING			KOKON	MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	,	a tha	DATE
	· ·	istrator stated there was			assure 100% compliance wit applicable provider number	ruie	
		an agreement for the			Clinical Supervisors/RNs		
		to provide services to the			reviewing and locking the OA		
	_	ents. The Administrator			for a period of 4 weeks. After	er 4	
		corporation acquired the			consecutive weeks of 100%		
	• • •	number, the South Bend			compliance, the audit will decrease to 50% of all OASIS	S for	
	^	coverage of the counties			another 4 weeks. After that		
	already serviced	by the acquired agency.			weeks of 100% compliance is		
					obtained the audit will decrea	ise to	
	6. During interv	view on 11/6/15 at 11:12			10% quarterly and will be completed through the clinical	al.	
	AM, the Admini	istrator indicated the			record review process. (Exhil		
	acquired agency	had their own			Process (Exam	J.C 1,	
	organizational cl	hart, Administrator, and					
	Clinical Supervi	sor, but she was also the					
	Alternate Admir	nistrator for the acquired					
	agency. The Ad	lministrator stated the					
	supervisor at the	South Bend branch is					
		he day to day scheduling					
	_	seeing care provided for					
	the patients.						
	rate Parassass.						
	7 During interv	view on 11/6/15 at 11:30					
		istrator stated Great					
	·	the Warsaw agency's					
	_	r in October, 2014.					
	provider number	m October, 2014.					
	8 During inters	view on 11/16/15 at 12:05					
		strator stated patient # 16					
		•					
	the South Bend	ne acquired agency, and					
	involvement in t	ne care.					
	0. D	: 11/12/15 + 12 40					
	1	view on 11/13/15 at 12:40					
	PM, the Admini	strator stated the OASIS					

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NAME OF PROVIDER OR SUPPLIER GREAT LAKES CARING (NA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG SUBmissions are done by the nurses or clinicians, and the Corporate office in Michigan submits the data to the State agency. 10. During interview on 11/16/15 at 10:30 AM, the Administrator stated the agency does not have and agreement or contract with corporate office to submit OASIS data to the State agency. 11. The agency's policy titled "Encoding And Reporting OASIS Data," # B-250, reviewed March 2015 stated, "GLC will electronically report all OASIS data collect in accordance with federal regulations. GLC and agents acting on behalf of GLC will ensure confidentiality of all client specific information in the clinical record." 12. The agency's policy titled "Parent Agency Responsibilities," # B-125, reviewed March 2015 stated, "The parent agency will have defined responsibilities in relation to coordination of care provided through branches. All services not furnished directly by the parent agency are monitored and controlled Special Instructions 1. The HHA's policies and procedures, or other forms of	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	COMPI		
ANAMO OF PROVIDER OF ROPPLIER GREAT LAKES CARING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) submissions are done by the nurses or clinicians, and the Corporate office in Michigan submits the data to the State agency. 10. During interview on 11/16/15 at 10:30 AM, the Administrator stated the agency does not have and agreement or contract with corporate office to submit OASIS data to the State agency. 11. The agency's policy titled "Encoding And Reporting OASIS Data," # B-250, reviewed March 2015 stated, "GLC will electronically report all OASIS data collect in accordance with federal regulations. GLC and agents acting on behalf of GLC will ensure confidentiality of all client specific information in the clinical record." 12. The agency's policy titled "Parent Agency Responsibilities," # B-125, reviewed March 2015 stated, "The parent agency will have defined responsibilities in relation to coordination of care provided through branches. All services not furnished directly by the parent agency are monitored and controlled Special Instructions 1. The HHA's			157586	B. W	ING		11/19	/2015
CX4-1D SUMMARY STATEMENT OF DEFICIENCIES DISCUSSION CREATED STATEMENT OF DEFICIENCIES CREATED DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG Submissions are done by the nurses or clinicians, and the Corporate office in Michigan submits the data to the State agency. 10. During interview on 11/16/15 at 10:30 AM, the Administrator stated the agency does not have and agreement or contract with corporate office to submit OASIS data to the State agency. 11. The agency's policy titled "Encoding And Reporting OASIS Data," # B-250, reviewed March 2015 stated, "GLC will electronically report all OASIS data collect in accordance with federal regulations. GLC and agents acting on behalf of GLC will ensure confidentiality of all client specific information in the clinical record." 12. The agency's policy titled "Parent Agency Responsibilities," # B-125, reviewed March 2015 stated, "The parent agency will have defined responsibilities in relation to coordination of care provided through branches. All services not furnished directly by the parent agency are monitored and controlled Special Instructions 1. The HHA's 1. The HHA's 1. The STATE 1. The Agency are monitored and controlled Special Instructions 1. The HHA's 1. T	NAME OF P	PROVIDER OR SUPPLIER		-				
REFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) submissions are done by the nurses or clinicians, and the Corporate office in Michigan submits the data to the State agency. 10. During interview on 11/16/15 at 10:30 AM, the Administrator stated the agency does not have and agreement or contract with corporate office to submit OASIS data to the State agency. 11. The agency's policy titled "Encoding And Reporting OASIS Data," # B-250, reviewed March 2015 stated, "GLC will electronically report all OASIS data collect in accordance with federal regulations. GLC and agents acting on behalf of GLC will ensure confidentiality of all client specific information in the clinical record." 12. The agency's policy titled "Parent Agency Responsibilities," # B-125, reviewed March 2015 stated, "The parent agency will have defined responsibilities in relation to coordination of care provided through branches. All services not furnished directly by the parent agency are monitored and controlled Special Instructions 1. The HHA's	GREAT L	AKES CARING						
submissions are done by the nurses or clinicians, and the Corporate office in Michigan submits the data to the State agency. 10. During interview on 11/16/15 at 10:30 AM, the Administrator stated the agency does not have and agreement or contract with corporate office to submit OASIS data to the State agency. 11. The agency's policy titled "Encoding And Reporting OASIS Data," # B-250, reviewed March 2015 stated, "GLC will electronically report all OASIS data collect in accordance with federal regulations. GLC and agents acting on behalf of GLC will ensure confidentiality of all client specific information in the clinical record." 12. The agency's policy titled "Parent Agency Responsibilities," # B-125, reviewed March 2015 stated, "The parent agency will have defined responsibilities in relation to coordination of care provided through branches. All services not furnished directly by the parent agency are monitored and controlled Special Instructions 1. The HHA's	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E RIATE	(X5) COMPLETION
documentation (e.g., organizational	PREFIX	submissions are clinicians, and the Michigan submit agency. 10. During interest 10:30 AM, the Adagency does not contract with correct with correct with correct with correct with correct with agency does not contract with correct with correct with correct with correct with correct with agency does not contract with correct with	done by the nurses or the Corporate office in the trying instance of the Corporate office in the theorem of the Corporate office in the theorem of the Corporate office in the theorem of the Corporate office in the State of the Institute of the		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	RIATE	
		policies and prod documentation (charts) will be us	cedures, or other forms of e.g., organizational sed to determine					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE COI JILDING	NSTRUCTION 00	COMPL			
		157586	B. W		<u></u>	11/19/		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	structure, the over services provided through arranger with the HHA the responsibility for implementing ple Board of director authority and responsibility and responsibilities to the parent or branch determined function billing/payroll/in at the parent branch determined function branch determi	r admitting patients and ans of care 4. The rs assumes full legal ponsibility for all agency, regardless if status. 5. Certain tions (ie. ntake) will be localized nch. The functions are lon the organizational s policy titled "Clinical C-300, reviewed March licy Skilled nursing and a services are provided ision of a Registered ional Director/Clinical available to provide sion during the operating Under no circumstances rative or supervisory be delegated to another arpose To meet the tate/federal guidelines ervision and direction to ag home health care						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	JLTIPLE CO JILDING	nstruction 00	(X3) DATE : COMPL		
		157586	B. WI		<u>00 </u>	11/19/	
	ROVIDER OR SUPPLIER		<u> </u>	3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	are provided base accordance with Care Special Regional Director be responsible for provided and surproviding therape contract staff. He responsible for of GLC's ongoing from Regional Director coordinate the dathe organization Administrator. Supervisor will provided activities relevant services furnished development of cassignment of personal provided assignment of personal provided and surprovided and sur	goals, and that services ed on client need and in the physician's Plan of I Instructions 1. The or/Clinical Manager shall or the quality of care oervision of all staff eutic services, including te/she will also be organizing and directing functions. 2. The or/Clinical Manager shall tay-to-day operation of and work with the or/Clinical Manager in all out to the professional the oryclinical description of the professional of the clinical manager in all of the professional of the clinical control of the professional of the professional of the clinical control of the professional of the professional of the professional of the clinication and the					
G 0156 Bldg. 00	484.18 ACCEPTANCE OF SUPER	F PATIENTS, POC, MED					
	the agency failed	review and interview, I to ensure discipline ded as ordered on the	G 0	156	G156 To assure compliance with		12/24/2015

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GREAT I	PROVIDER OR SUPPLIER _AKES CARING SUMMARY STATEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 ID (X5)				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
	plan of care for 2 of 20 clinical records reviewed (See G 158); ensure all durable medical equipment used by the patients was included on the plan of care for 3 of 10 home visit observations; failed to ensure all disciplines ordered by physician upon referral were initiated at the start of care for 1 of 20 clinical records reviewed; and failed to ensure interventional orders contained a frequency for 1 of 20 records reviewed (See G 159); failed to ensure physicians were notified of patients no longer needing Skilled Nursing services due to goals met for 2 of 20 records reviewed, and failed to notify physician to revise goals met and goals needing revised for pain for 1 of 20 records reviewed (See G 164); and failed to ensure the plan of care contained a frequency of wound care orders for 2 of 2 clinical records reviewed of patients receiving wound care, and failed to ensure the POC included orders for drawing labs from the Peripherally Inserted Central Catheter (PICC) for 1 of 1 record review of patients with PICC lines (See G 166). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.		484.18 Acceptance of Patients POC, Medical Supervision, the following interventions have be implemented: G 158 All clinical staff were educated by 12/24/15 on policy, C-58 Frequencies, and C-660 Plan care. Education focus include the need to provide all discipli and services as ordered by the physician, documentation of missed visits, and the requirement to notify the physician of changes in the plof care including missed visits. An audit will be performed by administrator/designee to assocompliance with G 158 of 100 of all missed visits until compliance is met for 4 consecutive weeks. After 4 weeks of 100% compliance the audit will decrease to quarterly and will be completed through clinical record review process. (Exhibit 9) G159 (N524) All clinical staff received education by 12/24/15 on the requirement to list all DME iter in the home on the 485. Education included the need the add any type of assistive or medical device on the POC. All clinical staff will be	e een ies 5 of dones e an		

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015
	ROVIDER OR SUPPLIER AKES CARING		3115 S	ADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION DATE
				educated by 12/24/15 on p C-360 Coordination of Clies services, C-660 Care Plans C-145 Comprehensive Clies Assessment, and C-635 Physicians orders. Educat focused on adding all discip as indicated at SOC, updat plan of care based on ongo patient assessment and inception of the composition of the c	nt s, ent lion plines ring the print pluding eluding e
				An audit will be performed administrator/designee of 1 to assure compliance with of all 485's that all DME is until 100% compliance is m 4 consecutive weeks. Afte weeks of 100% compliance audit will decrease to 10% quarterly and will be compl through the clinical record process. (Exhibit 10) An audit will be performed administrator/designee to a compliance with G 159 on of all admissions to verify the of care includes all discipling the administrator all discipling the compliance with G 159 on of all admissions to verify the care includes all discipling the compliance with G 159 on of all admissions all discipling the care includes all discipling the	oo% G 159 listed net for r 4 e the eted review by the assure 100% ne plan

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	F OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING B. WING	00	COMPLE S 11/19/2	ETED
	ROVIDER OR SUPPLIE	R	3115 S	ADDRESS, CITY, STATE, ZIP WEBSTER ST MO, IN 46902	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				ordered until 100% c met for 4 consecutive After 4 weeks of 100' compliance, the audi decrease to 10% qua will be completed thre clinical record review (Exhibit 8)	e weeks. % t will arterly and ough the	
				An audit will be performed administrator/designer compliance with G 18 of wound visits to ensure measurements q were detailed orders and compliance duntil 100% of is met for 4 consecut After 4 weeks of 100° compliance the audit decrease to 10% qual will be completed three clinical record review (Exhibit 11)	ee to assure 59 of 100% sure ek, as well as complete und care compliance ive weeks. % will arterly and ough the	
				G164 • G166 • G166	5 on policy of Client Care Plans. In the need to Int condition Ician of Ici	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2015			
NAME OF PROVIDER OR SUPPLIER GREAT LAKES CARING	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S PLAN OF CROSS-RE	D BE COMPLETION DATE			
	they need to be disconting that wound care must be discontinued when wound healed.				
	An audit will be performed administrator/designee to compliance with G 164 or of all admissions and recertification visits to assipatient interventions mated diagnosis on the plan of consecutive weeks. After of 100% compliance, the decrease to 10% quarterliwill be completed through clinical record review proceeding the decrease with G 164 or all skilled nursing visits for updated patient goals whe indicated, and physician notification of updated an specific goals until 100% compliance is met for 4 consecutive weeks. After consecutive weeks of 100 compliance the audit will decrease to 10% quarterliwill be completed through clinical record review proceeding and physician record review proceeding the performed administrator/designee to compliance with G 164 of all skilled nursing visits for interventions and physicial	assure in 100% Bure with are until for 4 4 weeks audit will by and the cess. If by the assure in 50% of in the cess. If by the assure in 50% of in the cess. If by the assure in 50% of in the cess. If by the assure in 50% of in the cess.			

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	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING B. WING	00	COMPLETED 11/19/2015
	ROVIDER OR SUPPLIER		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST	<u>. I</u>
GREAT L	AKES CARING		KOKO	MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	(X5) BE PRIATE COMPLETION DATE
				notification when indicated 100% compliance is met for consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly will be completed through the clinical record review proces (Exhibit 14) An audit will be performed administrator/designee to a compliance with G 164 on of all patients discharged for skilled nursing services to eather physician was notified a discharge until 100% compliance, the audit will decrease to 10% quarterly will be completed through the clinical record review proces (Exhibit 19)	and he ss. by the ssure 100% om ensure of the liance eks. and he
				G166 All LPN and RN staff received education by 12/2 that included hands on demonstration check offs in skills lab by RN staff educa The education included rev PICC line procedures, phys notification of abnormal assessment, documentation review, as well as return demonstration of skills inclumeasurement of PICC line.	4/15, n a tors. iew of sician n

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157586 B. WING				00 COMPLETED 11/19/2015		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING			WEBSTER ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				All skilled nursing staff received education on documentation requirements f wound care, as well as hands competency checks in a skills for wound care, and infection control with wound care, by ar RN preceptor by 12/24/15. An audit will be performed by administrator or designee to assure compliance with G 166 100% of all patients with a PIC line until 100% compliance is for 4 consecutive weeks. Afte consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 6) An audit will be performed by administrator/designee to assure compliance with G 166 of 100 of wound visits to ensure measurements q week, as we detailed orders and complete documentation of wound care provided until 100% compliance is met for 4 consecutive weeks. After 4 weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 11)	on lab the of CC met or 4 d ure % Il as ce s.	
G 0158	484.18 ACCEPTANCE OF	F PATIENTS, POC, MED				

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLET	COMPLETED	
		157586	B. WING 11/19/		11/19/20	015		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER				WEBSTER ST			
	AKES CARING				//O, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE (COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE		DATE	
Bldg. 00	doctor of medicine medicine. Based on record the agency failed visits were proviplan of care (PO records reviewed Findings include 1. The clinical reviewed on 11/3 date was 10/10/1 10/10-12/8/15 co Skilled Nurse (Sweeks, 1 every 2 1 every 4 weeks needed visits for complications. A. The record visit was completed 10/18-21/2015. B. During in 1:45 PM, the Adagency could no notes or SN notes 10/18-21/2015. 2. The clinical record visits agency could no notes or SN notes 10/18-21/2015.	eriodically reviewed by a e, osteopathy, or podiatric review, and interview, I to ensure discipline ded as ordered on the C) for 2 of 20 clinical I (# 2 and 13). Example 16/15. The start of care 16/15. The start of care 16/15. The start of care 16/15 are	G 0	158	G 158 To assure compliance with 484.18 Acceptance of Patients POC, Medical Supervision, the following interventions have be implemented: All clinical staff were educated by 12/24/15 on polic C-121 Admission policy, C-58 Frequencies, and C-660 Plan care. Education focus include the need to provide all disciplir and services as ordered by the physician, documentation of missed visits, and the requirement to notify the physician of changes in the pla of care including missed visits. An audit will be performed by administrator/designee to assocompliance with G 158 of 100 of all missed visits until compliance is met for 4 consecutive weeks. After 4 weeks of 100% compliance the audit will decrease to quarterly and will be completed through clinical record review process. (Exhibit 9)	ies of d nes e	12/24/2015	
		2/15. Diagnosis of						

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	OF CORRECTION	IDENTIFICATION NUMBER:	l í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL	
		157586	B. W	ING	<u> </u>	11/19/	
	PROVIDER OR SUPPLIEF	<u>l</u>	<u> </u>	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	Huntington's Ch 8/30-10/28/15 cot time a week for weeks for 4 weeks for 4 weeks, and 3 as cardiac/respirator gastrourinary/gamental, pain, ski and falls; HHA 2 weeks, then 1 times a week for 1 weeks for 1 weeks for 1 weeks. A. The record for PT on 9/19 1 weeks. The record conducted a visity 9/20-9/26/15, 9/210/4-10/10/15. B. The record HHA conducted of 8/30-9/5/15, as second visit the second wisit the second wisits for missed visits for times a week for 1 weeks.	orea. The POC dated ontained orders for SN 1 1 week, 1 every two ks, 1 every 3 weeks for 3 needed for ory, strointestinal, endocrine, n, wound status changes, 2 times a week for 3 me a week for 2 weeks; time a week for 1 week, for 6 weeks, then 1 time a c; and TO 1 time a week devidenced new orders time a week for 3 ord failed to evidence PT to the week of					
	PT for 9/20-10/1	7/15.					

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 OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING			COMPLETED 11/19/2015	
ROVIDER OR SUPPLIER			3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
AKES CARING SUMMARY STOCKACH DEFICIENCY REGULATORY OR 3. The agency's Policy," # C-121 stated, "Criteria for a Nursing, Therapy Services or Hommust follow a wrestablished and prodiatric medicinal reasonable expendical, nursing rehabilitations not met in the client's expectation shall GLC's personnel adequate and suis services the client. 4. The agency's "Frequencies," # 2015 stated, "1. the home health aphysician to any need to alter the physician or or plan of care and services and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or or plan of care and services are supplied to the physician or plan of care and services are supplied to the physician or supplied t	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) policy titled "Admission , reviewed March 2015 for Client Admission: client receiving Skilled y, Medical Social e Health Aide services itten Plan of Care periodically reviewed by cine, osteopathy, or ne 7. There must be ectation that the client's y, social, or reds can be adequately s home. 8. Reasonable consider: a. Whether and resources are table for providing the att requires." policy titled C-585, reviewed March The regulations requires agencies to alert the changes that suggest a plan of care. If the home lovides fewer visits than lers, it has altered the the physician must be	<u> </u>	STREET A 3115 S	WEBSTER ST		(X5) COMPLETION DATE
maintain docume record indicating	me health agency must entation in the clinical that the physician was ware of the missed visit."					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	NG		11/19/	2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL				ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
G 0159 Bldg. 00	484.18(a) PLAN OF CARE The plan of care d with the agency st diagnoses, includi services and equiro of visits, prognosis functional limitatio nutritional requirer treatments, any sa against injury, inst discharge or referr appropriate items. Based on record interview, the ag durable medical by the patients w of care (POC) fo observations (#7 ensure all discipl physician upon r the start of care f records reviewed ensure interventi frequency for 1 of 11). Findings include 1. During home patient #7 on 11/ DME in the hom	eveloped in consultation aff covers all pertinent ng mental status, types of oment required, frequency s, rehabilitation potential, ns, activities permitted, ments, medications and afety measures to protect ructions for timely ral, and any other review, observation, and ency failed to ensure all equipment (DME) used ras included on the plan of 10 home visit (7, 8, and 9); failed to ines ordered by eferral were initiated at for 1 of 20 clinical (#10); and failed to onal orders contained a of 20 records reviewed (#12/15 at 10:30 AM, e included a walker.	G 0		G159 (N524) To assure compliance with 484.18(a) Plan of Care, the following interventions have be implemented: All clinical staff received education by 12/24/15 on the requirement to list all DME iter in the home on the 485. Education included the need to add any type of assistive or medical device on the POC. All clinical staff were educated by 12/24/15 on policic C-360 Coordination of Client services, C-660 Care Plans, C-145 Comprehensive Client Assessment, and C-635 Physicians orders. Education focused on adding all discipling as indicated at SOC, updating plan of care based on ongoing	ms o y es the	12/24/2015
		0/19-11/17/15 failed to			patient assessment, and include	ling	
	contain the walk	er.			detailed and clear physicians		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		157586	B. WI	NG		11/19/2015
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R				
CDEATI	AKES CADING				WEBSTER ST	
GREAT	AKES CARING			KUKUN	MO, IN 46902	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					orders.	
	2. During home	visit observation with				
	_	1/12/15 at 1:30 PM, DME			· All skilled nursing staff	
	in the home included a walker. The POC dated 10/30-12/28/15 failed to contain the walker. 3. During home visit observation with patient # 9 on 11/13/15 at 9:30 AM, DME in the home included a walker. The POC dated 11/8/15-1/6/16 failed to contain the walker.				received education on	
					documentation requirements f wound care, as well as hands	
					competency checks in a skills	
					for wound care, and infection	lab
					control with wound care, by ar	1
					RN preceptor by 12/24/15.	
					·	
					An audit will be performed by	
	Contain the wark	ici.			administrator/designee to assu compliance with G 159 of 100	
	4 771 1: 1	1.0			of all 485's to ensure that DME	
		record for patient # 10			listed until 100% compliance is	
	was reviewed or	n 11/17/15. The start of			met for 4 consecutive weeks.	
	care date was 9/	26/15. POC dated			After 4 weeks of 100%	
	9/26-11/24/15 c	ontained orders for SN 1			compliance the audit will	
	time a week for	1 week, 2 times a week			decrease to 10% quarterly and	t
		n 1 times a week for 7			will be completed through the	
	· ·	ded for falls, pain,			clinical record review process.	
	•				(Exhibit 10)	
		gastrourinary, respiratory,				
		d skin integrity, diabetes,			An audit will be performed by	the I
		ecline. Need for skilled			administrator/designee to assu	
	teaching and int	ervention related to			compliance with G 159 on 100	
	wound incision	cervical spine incision.			of all admissions to verify plan	of
	Keep clean and	dry. May leave open to			care includes all disciplines	_
	air if no drainag	-			ordered until 100% compliance	e is
					met for 4 consecutive weeks.	
	Δ The Clini	ical Coordination Note			After 4 weeks of 100% compliance, the audit will	
					decrease to 10% quarterly and	. l
	*	25/15 stated "Received			will be completed through the	-
		Cleveland Clinic			clinical record review process.	
		norrow 9/26/15. Patient			(Exhibit 8)	
	will need SN, P	Γ [Physical Therapy], OT				
	[Occupational T	herapyl due to				

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING B. WING	00	COMI	PLETED 9/2015
	PROVIDER OR SUPPLIEF	<u> </u>	3115 S	ADDRESS, CITY, STATE, ZIPS WEBSTER ST MO, IN 46902	P CODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	laminectomy, hy mellitus II, and of failed to evidence ordered on the PT was ordered to evidence OT. B. The Client Report dated 10/2 [spouse] called the doctor at Clevelar Physical Therapy that GLC would send a therapist. C. During in 3:30 PM, the Adapatient's spouse 10/12/15 to say ordered PT upor The Administrate any refusal by the OT services, and 5. The clinical rewas reviewed or care date was 12/10/5-12/3/15 contimes a week for for 1 week, 3 tin times a week for for 1 week, 4 tin times a week f	rpertension, diabetes depression." The record the PT and OT were OC; failed to evidence until 10/14/15; and failed		An audit will be perform administrator/designed compliance with G 18 of wound visits to ensurements q week detailed orders and of documentation of working provided until 100% of is met for 4 consecuted After 4 weeks of 100 compliance the audit decrease to 10% qualified will be completed through clinical record reviews (Exhibit 11)	ee to assure 59 of 100% sure ek, as well as complete und care compliance tive weeks. % will arterly and ough the	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			UILDING	00	COMPL 11/19/	ETED	
NAME OF	F PROVIDER OR SUPPLIEF		1		DDRESS, CITY, STATE, ZIP CODE	11/13/	2013
	LAKES CARING			1	WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	gastrointestinal/wound complicateaching and into heel, and poor slewith wound clear cover with foam lower extremities compression wrater A. The POC frequency of the B. During in 11:25 AM, the Ashould be a frequency of the should be a frequency. 6. The agency's Plans," # C-660, stated, "3. The Obut not be limited needs identified c. A list of speculars for implementation physician Plan of care plan if specularly identified address client callidana Addending of care will contain and appropriate	•					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUILDING B. WING			COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER		3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	C-360, reviewed After the initial a Registered Nurse communicate the visit with the Cli ensure: a. Claricare orders eservices and/or resources." 8. The agency's "Comprehensive C-145 reviewed addition to generassessment, GLC assessment tool v m. Equipmer 9. The agency's Orders," # C-635 stated, "1. When receives a verbal physician, he/she given and then rephysician verifying communication in the second communicate in the second com	March 2015 stated, "3. Assessment, the admitting be/Therapist shall be findings of the initial inical Supervisor to fication of the plan of the Plan of the Need for other deferral to community policy titled Client Assessment," # March 2015 stated, "Initial health status/system to comprehensive with OASIS will include: In management." policy titled "Physician to previewed March 2015 to the nurse or therapist order from the te shall write the order as the person the person the terror to correctly and the person the terror to correctly and the person the terror to correctly and the person the person the terror to correctly and the person the				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015	
NAME OF PROVIDER OR		3115 S	ADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST MO, IN 46902		
PREFIX (EACH	MARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
Bldg. 00 Agency prophysician need to all Based on the agency were not in needing State of the agency of th	CREVIEW OF PLAN OF CARE ofessional staff promptly alert the to any changes that suggest a ter the plan of care. record review, and interview, y failed to ensure physicians fied of patients no longer skilled Nursing (SN) services als met for 2 of 20 records (# 10 and 13), and failed to sysician to revise goals met and ding revised for pain for 1 of 20 eviewed (# 10). include: linical record for patient # 10 wed on 11/17/15. The start of was 9/26/15. POC dated (A/15 contained diagnosis of following Surgery, with orders time a week for 1 week, 2 times or 2 weeks, then 1 times a week ks, 3 as needed for falls, pain, estinal/gastrourinary, respiratory, mpaired skin integrity, diabetes, ional decline. Need for skilled and intervention related to cision cervical spine incision. In and dry. May leave open to drainage noted. SN for: tion and assessment of cardiac	G 0164	G164 To assure compliance with 484.18(b) Periodic Review of Plan of Care, the following interventions were implemente educated by 12/24/15 on polic C-360 Coordination of Client Services, and C-660 Care Pla Education focused on the nee revise goals as patient condition including when services are not longer needed, interventions of the match diagnosis and plan of compain interventions need to be detailed and address patient's pain, as patient goals are met they need to be discontinued, that wound care must be discontinued when wound healed. An audit will be performed by administrator/designee to assure compliance with G 164 on 100 of all admissions and recertification visits to assure patient interventions match diagnosis on the plan of care of 100% compliance, the audit decrease to 10% quarterly and	re re ry rs. d to on on ust are, and the ure o% until	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED	
		157586	B. W	ING		11/19/2015	
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					WEBSTER ST		
GREAT I	LAKES CARING			KOKOM	ЛО, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		1
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	will be completed through the	DATE	-
	1 -	y changes associated			clinical record review process.		
		n for early intervention			(Exhibit 12)		
	_	; observation/assessment					
	of gastrointestinal system to identify				An audit will be performed by t		
	changes associated with exacerbation of				administrator/designee to assuce compliance with G 164 on 50%		
	_	tion of complications;			all skilled nursing visits for	, 01	
		t and develop plan of			updated patient goals when		
		er signed by physician;			indicated, and physician	iamt	
		essment of respiratory			notification of updated and pat specific goals until 100%	ent	
	_	y changes associated			compliance is met for 4		
	with exacerbation for early intervention				consecutive weeks. After 4		
	of complications				consecutive weeks of 100%		
		ions related to discharge			compliance the audit will		
	1 .	arge summary for all			decrease to 10% quarterly and will be completed through the		
	_	able to physician upon			clinical record review process.		
	request;				(Exhibit 13)		
	<u>-</u>	and provide assistance to			A seconditivity has reconference and have	h	
	patient for under	•			An audit will be performed by t administrator/designee to assu		
	_	feelings. SN may			compliance with G 164 of 50%		
		on anxiety scale and/or			all skilled nursing visits for pair	1	
	mini mental exai	*			interventions and physician	.	
	-Provide assessn				notification when indicated unt 100% compliance is met for 4	"	
	_	cement of management of			consecutive weeks. After 4		
	_	ding disease process,			consecutive weeks of 100%		
		agement, coping skills			compliance the audit will		
	_	nges associated with			decrease to 10% quarterly and will be completed through the		
	depressive disord	-			clinical record review process.		
		may perform geriatric			(Exhibit 14)		
	depression scale	and/or mini mental					
	exam;				An audit will be performed by t administrator/designee to assu		
		g/reinforcement in			compliance with G 164 on 100		
	etiology of confi				of all patients discharged from		
	1 -	measures and home			skilled nursing services to ens		
	management; ob	servation and assessment			the physician was notified of the	e	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			l í	UILDING	onstruction 00	(X3) DATE : COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
TAG	of pain, effective management and teaching related to report increase physician for pro-Skilled teaching emergency care including self macardiovascular hrash to obtain pure measurement times shortness of breat intolerance; -SN for instructing astrointestinal structional	eness of pain I regimen and skilled to pain management, SN e in pain level to compt intervention; g and training of plan, disease process anagement of ypertension disease; le oximetry nes 3 as needed for oth, oxygen use, activity con/reinforcement of rystem related teaching, culitis and irritable (IBS); killed teaching regarding rol diarrhea/constipation nting related killed teaching and gency care plan, disease comy surgery including to of neurologic disease; ssessment and cement of management of ag disease process, agement, coping skills ages associated with y intervention. SN may lucose level as needed		TAG	discharge until 100% compliar is met for 4 consecutive week. After 4 weeks of 100% compliance, the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 19)	nce s.	DATE		
	0. 01. 400 1								

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W		<u> </u>	11/19/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
GREAT I	LAKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	diabetes mellitus	•		TAG	BETTELENCTY		DATE
	-SN observation	*					
	integumentary status to promote optimum						
	skin integrity;	attas to promote optimam					
		patient/caregiver on signs					
	1	f infection related to					
	cervical spine su						
	complications to	the wound;					
	-SN to establish	supports to minimize					
	risk of hospitalization patient/caregiver						
	will be instructed in emergency care plan,						
	and aspects of cervical spine surgery						
	disease management to reduce avoidable						
	hospitalization;						
		ion of medication					
	regimen to ident	-					
	changes/complic	cations for early					
	intervention;						
	•	nterventions to improve					
		ace the risk of falls;					
	_	patient/caregiver on					
	-	ures to reduce pressure					
	ulcer risk; and	ssional to report vital					
	_	side the following					
	"	meters: Temp < 96>					
	_	> 116, Respirations < 12					
	-	ood pressure, $80 > 170$,					
	1	pressure $< 50 > 90$,					
		gar < 60 > 300, oxygen					
	saturation < 88.	, , , ,					
	GOALS: Assoc	iated risks; Patient's					
		ction needs will be met,					
	discharge summ	ary for all disciplines					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUILDING B. WING 11/19/2015 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST	
NAME OF PROVIDER OR SUPPLIER 3115 S WEBSTER ST	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X	'ION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DAT	
TAG REGULATOR FOR ESCIDENTIL THROUGH ORMATION) TAG	
available to physician upon request; symptoms of anxiety are identified and	
interventions initiated to allow patient to	
manage feelings;	
-Patient/caregiver will	
verbalize/demonstrate understanding the	
management of depression by the end of	
the episode and symptoms are identified	
and managed to maintain patient safety in	
the home; Patient/caregiver will	
demonstrate understanding of etiology of	
confusion and maintain patient safety in	
the home;	
-Improvement in pain interfering with	
activity;	
-Pain controlled at level of 3 or less or at	
a level acceptable to the patient;	
-Patient/caregiver demonstrate	
understanding of pharmacological and	
nonpharmacologic pain control measures;	
-Patient will demonstrate ability to self	
manage cardiovascular hypertension	
disease process and reduce caregiver	
burden associated with disease process;	
pulse oximetry results obtained;	
-Patient/caregiver will demonstrate	
ability to self manage gastrointestinal	
disease process;	
-Patient/caregiver verbalize and	
demonstrate ability to manage altered	
bowel elimination. Patient will have	
bowel patency;	
-Demonstrated ability to self manage	
neurologic disease process and reduce	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIEF	.	•	1	DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		associated with disease		1110			DITTE
	_	ement in signs and					
	symptoms of nei	urologic disease;					
	-Patient/caregive	er will verbalize					
	demonstrate und	erstanding the					
	management of	diabetes by the end of the					
	episode and sym	ptoms are identified and					
	managed to main	ntain patient safely in the					
	home;						
	-Demonstrated improvement in existing						
	conditions and early identification and						
	intervention of additional compromises						
	in skin;						
	-Wound complic						
		entary status will					
	_	enced by a decrease in					
	1	f wound/decub by end					
	of cert period;						
		re appropriate agency					
		ent rehospitalization,					
	reduced;	alizations will be					
	· · · · · · · · · · · · · · · · · · ·	er will demonstrate					
	_	manage medications;					
	1 -	ble to perform activities					
		nd individual activities of					
		decreased risk for falls;					
		er will demonstrate					
	1	es of pressure ulcer					
	prevention.	1					
	"	ed to ensure the physician					
	_	goals being met and of					
	unobtainable goa	als needing to be changed					

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		157586	B. W		<u> </u>	11/19/	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
140	on the plan of ca	re; and failed to nursing staff to ensure education on goals met		TAG			DATE
	9/26/15. The Cl Report dated as stated "[Spouse of lowest patient's pain scale. Curr Claudia 2 millig The agency failed	I start of care was ient Coordination Note late entry for 9/26/15 of patient] states the pain ever gets is a # 8 on ently patient takes rams tablets for pain." d to ensure the goal of at level of 3 or less or at e to the patient" was					
	Assessment and assessment form "(M1018) Conditreatment regime stay within the p Intractable Pain. section stated "P Pain Scale Ratin make pain worse neck pain least? long does neck pineck pain be relititled "Endocrine" Indicate endocrassessment (mar	dated 9/26/15 stated tions prior to medical en change or inpatient ast 14 days 3- " The Pain assessment ain All of the time g: 9 What activities e: Movement. When is Always in Pain. How pain last? Constant. Can eved? No." The section e/Hematopoietic" stated ine/Hematopoietic					

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		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER		•	1	DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING			1	WEBSTER ST IO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		sulin? No Is the		IAG	,		DATE
		antidiabetic agent? Yes.					
		e blood sugars check?					
	Not checked ver	y often. What are the					
	patient's usual bl	ood sugar readings?					
	Below 130."						
	The section title	ed "Care Coordination"					
		if you communicated					
	_	lines involved in this					
		at discipline did you					
	communicate with? Physician,						
	Caregiver(s), Clinical Supervisor.						
	Indicate reason physician not contacted:						
		Contacted physician for					
		osed plan of care: No.					
		physician not contacted:					
		nds." The section titled					
		red: "3. Patient/caregiver					
		standing of basic					
		tion requirements." The					
		to evidence the SN					
	management of	g/reinforcement of					
	management of t	ilauctes.					
	C. The Visit	Note Report dated					
	10/2/15 stated "F	Pain: All of the time					
	Pain Scale Ratin	g 9 Wound: no					
	problems identif	ied Have the					
	patient's blood so	ugars remind stable for					
	the past two wee	k? Not Applicable-					
	_	not routinely checked."					
		ction stated "Pain never					
	_	a 6 Instructed on pain					
	management. Se	e interventions." The					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE COI JILDING		ľ í		
		157586	B. W			11/19	
AND PLAN	SUMMARY S' (EACH DEFICIEN REGULATORY OR section titled "In Observe and asse pain level. See p section." The Na generalized pain during SN visit r Just took pain m SN arrival." The record failed intervention othe provided; failed	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) terventions" stated, "3. ess pain intensity and physical assessment arrative note stated, "Has that is constant. Pain ated a 9 on 1-10 scale. and 30 minutes before If to evidence a pain er than instruction was to evidence the physician	A. BU	JILDING ING STREET A 3115 S V	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST O, IN 46902 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3	ETED
	was notified to c of "Pain controll at a level accepta failed to evidence teaching/reinforce diabetes. D. The Visit 10/2/15 Interven Instruct in cardio hypo/hypertensic Details/Comment Low Sodium/low Nutritional Reque "Diabetic." The evidence education diabetic diet, and	hange or revise the goal ed at level of 3 or less or able to the patient;" and e the SN provided ement of management of Note Report dated tions Provided stated, "6. evascular on disease process, ets: Dietary restrictions, ev fat." The POC irrements stated agency failed to on to the patient on I failed to clarify/verify					
	failed to notify the	an as to the eeds of the patient, and ne physician to remove and modify/revise the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
THIE TEAT	or condition	157586	B. W		00	11/19/	
		107000		CTDEET A	DDDEGG CITY CTATE ZID CODE	1 17 107	2010
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT I	AKES CARING			1	10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		Note Report dated					
		let section stated, "1.					
	Patient/caregiver						
	_	f instructions given					
	_	re ulcer relief and ulcer					
		Cardiac exacerbations are					
		tly and interventions					
		to minimize associated					
	risks 4. Pair	_					
	intervention completed this visit. 5.						
	Patient/caregiver demonstrate						
	understanding of pharmacological and						
	nonpharmacologic pain control measures						
	this visit. 6. Ins	truction in					
	cardiovascular h	ypo/hypertension disease					
	completed this e	pisode- patient/primary					
	caregiver indepe	ndent. 7. Changes in					
		s are identified and					
	reported to physi						
	intervention to n	ninimize associated risks.					
	8. Instruction re	garding self management					
	of gastrointestina	al disease completed this					
		/primary caregiver					
	independent. 9.	Instruction regarding					
	self management	t of altered bowel					
	elimination com	pleted this episode-					
	patient/primary of	caregiver independent.					
	10. Exacerbation	s of gastrointestinal					
	disease are prom	ptly identified and					
	interventions im	plemented to minimize					
	risks to patient.	Instruction regarding					
	_	t of meds that manage					
	depression comp	oleted this episode-					
		caregiver independent					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	l í	UILDING	nstruction 00	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	manage nutrition promote skin interpromote stated this episode patrial independent regarding wound this episode-patrial independent stated understand fall preventions in hazards." F. The Visit 10/6/15 stated, "and was rated at Endocrine/Hema "Have the patien remained stable Yes." The section stated, "2. Cardial identified promp	alleviate pressure pisode- patient/primary ndent. 20. Instructions and symptoms of n breakdown completed ient/primary caregiver 22. Instruction I management completed ent/caregiver . Instruction regarding complications completed ent/caregiver 29. Patient/caregiver ding of instructions of related to environmental Note Report dated Pain: All of the time," 9. The atopoietic section stated, t's blood sugars for the past two weeks? on titled "Goals Met" ac exacerbations are tly and interventions to minimize associated							

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	ľ í	UILDING	onstruction 00	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER LAKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	pain control mean Changes in respin identified and reprompt intervent associated risks. gastrointestinal control identified and in to minimize risk Instruction regard neurologic disease episode-patient independent. 9. patient ability to completed this we Patient/caregiver instructions of fargent environmental has a constantly," rated "Wounds" stated identified." The "Incision site cleewithout signs of left open to air, we without signs of left open to air, we have the patient/caregiver management and Instruct patient/caregiver m	and nonpharmacologic sures this visit. 6. ratory status are ported to physician for ion to minimize 7. Exacerbations of disease are promptly terventions implemented is to patient. 8. ding self management of se completed this primary caregiver. Assessment regarding self manage wound care isit 14. restated understanding of all preventions related to azards." Note Report dated "Pain, daily but not dat 9. The section titled dat 9. The section stated, an, dry and intact, infection or drainage, will continue to monitor." dat "Interventions", "4. Instruct							

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	l í	UILDING	onstruction 00	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE		
	patient/caregiver injury and improto prevent injury cardiovascular has process, 12. and complication constipation/diar patients ability to process, details/diabetic skin care care and inspection management wound treatment, details/comment treatment for eff progressing." H. The Visit 10/14/15 Goals I Patient/caregiver understanding of related to pressure prevention. 2. are identified proinitiated quickly risks 5. Patient demonstrate understanding completed this entities and pain control measure completed this entities.	rhea, 22. Assess of self manage disease comments: diabetic diet, et, proper skin care, foot on, medication 26. Assess current afor effectiveness weekly has: assess wound ectiveness and wound. Note Report dated Met section stated, "1. will verbalize affinity in the company of the compan							

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/19/2015	
	PROVIDER OR SUPPLIER _AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	completed this e independent. 8. cardiovascular h completed this e independent respiratory status reported to physicintervention to n 11. Instruction r management of a completed this e 12. Instruction r management of a completed this e independent. 13 gastrointestinal of identified and in to minimize risk Instruction regard anxiety completed patient/caregiver Instruction regard depression completed this regarding wound completed this e independent regarding wound this episode- pat	Instruction in ypo/hypertension disease pisode-patient/caregiver 10. Changes in are identified and ician for prompt inimize associated risks. egarding self gastrointestinal disease pisode-patient/caregiver. egarding self altered bowel elimination pisode- patient/caregiver. Exacerbations of disease are promptly terventions implements as to patient 15. ding self management of ed this episode-rindependent 19. ding self management of eleted this episode-rindependent 23. ding equipment to be completed this episode-rindependent. 25. ding sings and symptoms skin breakdown pisode-patient/caregiver 27. Instruction I management completed						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	00	COMPI		
	21 201422011011	157586	B. W			11/19	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-
NAME OF I	PROVIDER OR SUPPLIEF	₹		3115 S			
GREAT I	AKES CARING				1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
	this episode- pat	complications completed					
		31. Instruction in					
	•	pleted for this episode-					
		r independent 35.					
	^ ~	r stated understanding of					
	_	all preventions related to					
	environmental h	*					
		azarus.					
	I The Goals	Met previously on					
	10/6/15 were rep						
	_	and met again on					
		nd listed as #'s 1, 2, 5, 8,					
		8, and 35. The agency					
		he physician to remove					
	I	nd modify/revise the					
	POC.	Ž					
	J. The Visit	Note Report dated					
	10/21/15 stated,	"Indicate Patient Pain					
	Scale Rating: 8.	" The section titled					
	"Integumentary/	Wounds:" stated,					
		healing incision without					
		a." The Narrative section					
		an incision to posterior					
		tely 8 centimeters in					
		empletely healed without					
		a. Incision is left [open					
	to air] OTA."						
	K. The visit	note repeated					
		rventions identified on					
		isit Note Report dated					
		"Instructions Provided.					
	l ´		1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ľ í	JILDING	onstruction 00	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	changes/adaptive pressure deta in pressure relief for support, more prominences and least every 1-2 h patient/caregiver pharmacological pain control measigns and symptomonitor depressir routine basis instructed in avoid hazards includin poor lighting, insobstructed pathway L. The Visit 10/21/15 Goals Patient/caregiver understanding of related to pressure prevention. 2. are identified preinitiated quickly risks 5. Patients demonstrate understanding of the pressure prevention of the prevent	and nonpharmacologic asures 10. Assess for oms of depression and ion symptoms on a 18 Patient oidance of environmental g throw rugs, clutter, appropriate foot wear, ways, pets." Note Report dated Met section stated, "1. r will verbalize f instructions given re ulcer relief and ulcer Cardiac exacerbations comptly and interventions to minimize associated dient/caregiver derstanding of and nonpharmacologic asures this visit 7. aratory status are ported to physician for						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING	_	11/19	/2015
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROP		TE	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	DEFICIENCY)		DATE
	_	t of gastrointestinal					
	disease complete	*					
	patient/caregiver 18. Patient/caregiver stated understanding of instructions of fall preventions related to environmental						
	hazards." The a	assessment notes failed to					
	evidence any car	rdiac and respiratory					
	problems.						
	M. The Goa	als Met previously on					
	10/14/15 were re	epeated as being					
	re-instructed on	and met again on					
	10/21/15 visit ar	nd listed as #'s 1, 2, 5, 7,					
	8, and 18. The a	agency failed to notify the					
		nove the Met Goals and					
	modify/revise th						
	j						
	N. The Visi	t Note Report dated					
	10/30/15 stated,	"Pain all of the time.					
		ent Pain Scale Rating: 9."					
	The section title						
		'Wounds" stated, "No					
	_ ·	fied." The Narrative					
	1 *	Incision to posterior neck					
	healed."	meisten to posterior neek					
	neurea.						
	O. The visit	note repeated					
		rventions identified on					
		Visit Note Report dated					
		"Instructions Provided.					
	-	ent/caregiver in position					
		e equipment to elevate					
		ails/comments: instruct					
	-	f including using pillow					
	In bressure relie	i meruumg using pillow	1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
11.15 12.11	or condition.	157586	B. W		00	11/19/	
		******		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			WEBSTER ST		
GREAT I	AKES CARING			KOKOM	10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	11 /	itoring skin over bony					
	_	l position changes at ours 5. Instruct					
	patient/caregive						
	l ^	and nonpharmacologic					
	^ ~	sures 18. Skilled					
		ching and provision of					
		e as follows: signs and					
		ection to report such as					
	elevated temp, re	•					
	_	19. Instruct in nutritional					
		promote good skin					
		lling." The agency failed					
	to discontinue ui	nnecessary teaching					
	related to wound	l/decub instructions.					
		Met previously on					
	10/21/15 were re						
		and met again on					
		nd listed as #'s 1, 2, and 5.					
	"	ed to notify the physician					
	to remove the M						
	I -	e POC, and failed to					
		services once the cervical					
	incision was hea	ied.					
	Q. During te	lephone interview on					
		0 AM, patient #10's					
		e steri-strips fell off of					
		on by the first or second					
		ould be approximately					
	10/6/15]. The pa	atient's spouse stated the					
	nursing services	continued to be provided					
	after the steri str	ips fell off and the nurses					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	/2015
NAME OF D	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOTT EIEF			3115 S	WEBSTER ST		
GREAT L	AKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	were touching on teaching about depression and other self-care related topics for the patient.						
		nterview on 11/11/18/15					
	•	e Administrator stated if					
		nealed and no other SN					
	· · · · · · · · · · · · · · · · · · ·	t would be an indication					
	_	m SN services and let					
		e and close out the case.					
		tor stated the patient					
		discharged from SN on					
	11/4 or 11/10/15	5.					
	S. SN visits	s continued to be					
	provided on 11/4	4 and 11/11/15. The					
	Visit Note Repo	rt dated 11/4/15 stated,					
	"Pain all of	the time Indicate					
	Patient Pain Sca	le Rating: 8." The					
	section titled "In	ntegumentary/Wounds"					
	stated, "No prob	lems identified."					
	T. The visit	t note repeated					
	instructions/inte	rventions identified on					
	10/30/15. The V	Visit Note Report dated					
	11/4/15 stated, "	Interventions Provided.					
	1. Instruct patie	nt/caregiver in position					
	changes/adaptive	e equipment to elevate					
		• •					
	•						
	_						
	_	-					
	pressure deta in pressure relies for support, more prominences and	e equipment to elevate ails/comments: instruct f including using pillow nitoring skin over bony d position changes at nours 5. Instruct r regarding					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î í	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER		-		DDRESS, CITY, STATE, ZIP CODE		
GREAT I	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	pharmacological	and nonpharmacologic					
	pain control mea	sures 18. Skilled					
		thing and provision of					
		e as follows: signs and					
		ection to report such as					
	elevated temp, re						
	•	17. Instruct in nutritional					
		promote good skin					
		ling." The agency failed					
		nnecessary teaching					
	related to wound	/decub instructions.					
	U. The Goa	ls Met previously on					
	10/30/15 were re	epeated as being					
	re-instructed on	and met again on 11/4/15					
	visit and listed as	s: 1. Patient/caregiver					
	ill verbalized und	derstanding of					
	instructions give	n related to pressure					
	ulcer relief and u	lcer prevention. 2.					
	Cardiac exacerba	ations are identified					
		erventions initiate					
	quickly to minin	nize associated risks					
		aregiver demonstrate					
	_	pharmacological and					
		ic pain control measures					
		anges in respiratory					
		ied and reported to					
		ompt intervention and to					
	minimize associa						
		gastrointestinal disease					
		ntified and interventions					
	-	minimize risks to patient.					
		aregiver will demonstrate					
	ability to self ma	nage nutritional					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	E SURVEY PLETED 9/2015			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	integrity 19. understanding of preventions related hazards. The age physician to remmodify/revise the discontinue SN sincision was heated. V. The Vistandicate Patient. W. The vistandicate Patient. W. The vistandicate Patient. W. The Vistandicate Patient. 11/4/15. The Vistandicate Patient. 11/4/15. The Vistandicate Patient. Instruct patient changes/adaptive pressure detain pressure relief for support, mon prominences and least every 1-2 heatient/caregiver pharmacological pain control meanutritional requires skin integrity and Report Note dated the wound healed.	it Note Report dated "Pain all of the time. Pain Scale Rating: 8." It note repeated rventions identified on sit Note Report dated "Interventions Provided: nt/caregiver in position e equipment to elevate nils/comments: instruct f including using pillow nitoring skin over bony d position changes at ours 5. Instruct regarding and nonpharmacologic asures 17. Instruct in rements to promote good d healing." The Visit ed 10/30/15 evidenced						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586		UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	visit and listed a will verbalize uninstructions give ulcer relief and u Cardiac exacerbations promptly and integrity and integrity. A status are identify physician for prominimize associate Exacerbations of are promptly ide implemented to a status are identify to self material requirements to integrity. A status are identify ability to self material requirements to integrity. B understanding of preventions related hazards. The apphysician to remmodify/revise the discontinue SN status are identificant and in the self-material representation of the self-material re	and met again on 11/1/15 s: 1. Patient/caregiver aderstanding of an related to pressure alcer prevention. 2. ations are identified derventions initiate alcer associated risks caregiver demonstrate of pharmacological and gic pain control measures anges in respiratory fied and reported to compt intervention and to ated risks. 7. of gastrointestinal disease antified and interventions minimize risks to patient. caregiver will demonstrate anage nutritional promote good skin Patient/caregiver stated of instructions of fall ated to environmental gency failed to notify the alove the Met Goals and a POC, and failed to services once the cervical						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO UILDING	00	COMPL			
		157586	B. W	ING		11/19/	/2015	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
GREAT L	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWIDERIC DI AN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	_	orea. The POC dated ontained orders for SN						
		15, 1 time a week for 1						
		vo weeks for 4 weeks, 1						
		or 3 weeks, and 3 as						
	needed for cardi							
		strointestinal, endocrine,						
		n, wound status changes,						
	and falls. SN for	_						
	-Evaluate patien	t and develop plan of						
	-	n and assessment of pain,						
		pain management and						
	regimen and skil	led teaching related to						
	pain managemer	nt, report increase in pain						
	level to physicia	n;						
	-Observation/ass	sessment of cardiac						
	system to identif	Ty changes associated						
		n for early intervention						
	of complications							
	-	ximetry measurement						
	•	ion to confirm baseline						
		eeded shortness of						
		ise, activity intolerance;						
		sessment of respiratory						
		ry changes associated						
		n for early intervention						
	of complications	incontinence screening						
	_	; SN to provide skilled						
		to urinary incontinence						
	_	lay obtain urinalysis and						
	_	itivity times 3 if indicated						
		nptoms of urinary tract						
	infection or reter							
		-						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	-SN for observat gastrointestinal s changes associate or early intervent SN to provide sk measures to cont as well as prevent complications, Si saline enema time removal of fecal neededSN to evaluate a to improve balant fallsSN to instruct paper preventive measures to contain the saling saline enema time removal of fecal neededSN to evaluate a to improve balant fallsSN to instruct paper preventive measurements of hospitalization and as disease managent hospitalizationSN to provide in discharge planning for all disciplines upon requestSkilled instruction regiment to identification. GOALS; -Pulse oximetry in the same plan to identification.	ion/assessment of ystem to identify ed with exacerbation of tion of complications, illed teaching regarding rol diarrhea/constipation ating related N for administration of es 3 as needed, SN for impaction times 3 as and provide interventions ce and reduce the risk of atient/caregiver on ares to reduce pressure supports to minimize ation, patient/primary instructed in emergency pects of cardiovascular ment to reduce avoidable astructions related to ng. Discharge summary available to physician on of medication offy ations for early					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		r í	LDING	NSTRUCTION 00	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	prompt intervent associated risks; -Improvement in incontinence; -Exacerbations of will be promptly interventions imprisks to patientPatient/caregive demonstrate ability bowel eliminationPatient will have a patient will be a of daily living an daily living and adily living with and a prevention, -Patient will have supports to prevention, -Patient will have supports to prevention, -Patient's dischart disciplines available met. Dischart disciplines available met. Patient/caregive ability to safely to the safely of the safely	a urinary incontinence; a management of urinary of gastrointestinal disease identified and plemented to minimize or verbalize and ity to manage altered						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	î í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	breathing. Bilate Active bowel sor Reports BM [bornorning. No ed Denies chest pair No new skin issuremains intact. In meal time. Spastimes due to Hur Patient reports medication as probetter Discharges as ordered appointments with symptoms of hypotherical flushing. It the action of the a	escribed and feels much arge teaching: Continue Keep all follow up th physicians. Signs and pertension: chest pain, with, heart palpitations, Fall precautions. Med effect, dose, frequency, Patient voices Fall teaching completed Note Report dated itled "Interventions d, "1. Instruct in position equipment to elevate s/comments: instruct in cluding using pillows for ing skin over bony d position changes at						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		caregiver regarding pain		TAG	BEI ICE. (C.1)		DATE
	_	ement principles					
		t/caregiver regarding use					
	of pain scale						
	using 0-10 pain	scale. Instructed					
	regarding causes	of pain. Instructed					
		oles of pain management					
	_	or management of pain to					
	_	and ability to cope with					
		d patient/caregiver that					
	•	rolled before it reaches					
	_	e level. Instructed					
	patient/caregiver	f pain medication with					
		truct patient/caregiver					
	regarding pharm						
	• • •	ic pain control measures.					
		oximetry for shortness of					
	•	struct in nutritional					
	requirements to j	promote good skin					
	integrity and hea	ling."					
		Visit Note Report dated					
		itled "Goals Met," stated,					
	,	giver will verbalize					
	_	instructions given					
	-	re relief and ulcer Cardiac exacerbations are					
	•	tly and interventions					
		to minimize associated					
	risks 5. Pati						
	demonstrate und	_					
		and nonpharmacologic					
	-	sures this visit. 6. Pulse					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W		00	11/19/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	-
NAME OF F	PROVIDER OR SUPPLIER				WEBSTER ST		
GREAT L	AKES CARING				1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	oximetry comple						
	Changes in respi	-					
		ported to physician for					
	prompt intervent	8. Exacerbations of					
		lisease are promptly					
	_	terventions implemented					
	to minimize risks	•					
		will demonstrate ability					
	_	utritional requirements to					
	_	in integrity 12.					
	-	stated understanding of					
	_	ll preventions related to					
		azards." The assessment					
	section for Respi	ratory stated, "Was					
	_	m assessed? Yes.					
		ory assessment findings:					
	No problems ide	ntified." The assessment					
	section for Integr	umentary/Wounds stated,					
	"No problems id	entified." The					
	assessment section	on for Cardiovascular					
	stated, "Hyperter	nsion." The vital signs					
		temperature 98.7, pulse					
	_	8, and blood pressure					
	118/78.						
	D TL OU	Laid Mada Domont 1. 4 1					
		/isit Note Report dated					
		itled "Interventions					
	Provided," stated						
	patient/caregiver	_					
		e equipment to elevate s/comments: instruct in					
	*						
	_	cluding using pillows for ing skin over bony					
	support, illollitor	ing skin over bolly					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		JILDING	nstruction 00	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	every 1-2 hours. turning/positioni Instruct patient/c and pain manage instructed patient of pain scale usin Obtain pulse oxibreath 8. Instrequirements to provide a sexacerbations are interventions in the patient/caregiver to self manage manage managements and interventions in the promote good sk-The agency failed to remove the Managements of the section to Provided," stated patient/caregiver changes/adaptive changes/adaptive	aregiver regarding pain ament principles t/caregiver regarding use and 0-10 pain scale 5. metry for shortness of struct in nutritional promote good skin ling 12. Instruct allowing prescribed diet The assessment Met previously on seated as being and met again on 9/24/15 are identified promptly and chated quickly to atted risks. 4. will demonstrate ability autritional requirements to in integrity." ed to notify the physician et Goals and approach of the properties of the properties of the properties of the physician et Goals and approach of the physician et Goals and approach of the properties of the properties of the properties of the physician et Goals and approach of the physician et Goals				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED
	PROVIDER OR SUPPLIER _AKES CARING		•	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	support, monitor prominences and every 1-2 hours. turning/positioni Instruct patient/c and pain manage instructed patien of pain scale usin Instructed regard Instructed regard management of pand ability to coppatient/caregiver controlled before unmanageable lepatient/caregiver administration of activities. 5. Instructed patient/caregiver administration of activities. 5. Instruct pameasures to reduincontinence. 8. patient/caregiver assist in managir adult briefs, disp condom catheter. G. The SN V 10/6/15 section to previously on 9/2/2002.	aregiver regarding pain ment principles t/caregiver regarding use ag 0-10 pain scale. ing causes of pain. ing principles of pain uding need for pain to enhance healing the with illness. Instructed that pain is best to coordinate. The pain medication with the truct patient/caregiver accological and ic pain control measures. The tient/caregiver regarding to encidence of urinary. Instruct regarding measures to ag urinary incontinence-tosable underpads,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILE B. WING		<u>00</u>	COMPL 11/19/	ETED	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT I	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	10/6/15 visit and Patient/caregiver understanding of related to pressur prevention. 2. Consideratified prompt initiated quickly risks 5. Patied demonstrate under pharmacological pain control means and control means are prompt interventions in respiration of the prompt intervention associated risks. Patient/caregiver reduce incidence 8. Instruction regiment interventions improved interventions improved interventions improved in the proposition of the problems identified and reproblems identified and reproposition of the problems identified and reproblems	listed as: stated, "1. will verbalize instructions given re relief and ulcer fardiac exacerbations are thy and interventions to minimize associated rent/caregiver restanding of and nonpharmacologic sures this visit. 6. ratory status are reported to physician for ion to minimize 7. Instruct regarding measures to of urinary incontinence. regarding urinary repleted for this episode. regarding of gastrointestinal reply identified and relief and relief and relief of instructions of related to environmental ressessment section for d, "Was respiratory					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO JILDING	00	(X3) DATE COMPI		
THIOTETHY	or condition	157586	B. W.		00		/2015
		107000		OTD FET A	DDDEGG CITY OTATE ZID CODE		72010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	DROVIDERIC DI ANI OF CORRECTI	ONI	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO) BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ecertificaation Outcome					
	Assessment and						
	(OASIS)Visit No						
		titled "Interventions					
	Provided," stated						
	patient/caregiver	in position					
		e equipment to elevate					
	•	s/comments: instruct in					
	-	cluding using pillows for					
	support, monitor	ing skin over bony					
	prominences and	position changes at least					
	every 1-2 hours.	Instruct in					
	turning/positioni	ng schedule 4.					
	Instruct patient/c	aregiver regarding pain					
	and pain manage	ment principles					
	instructed patien	t/caregiver regarding use					
	of pain scale using	ng 0-10 pain scale.					
	Instructed regard	ing causes of pain.					
	Instructed regard	ing principles of pain					
	management incl	luding need for					
	management of p	pain to enhance healing					
	and ability to cop	be with illness. Instructed					
	patient/caregiver	that pain is best					
	controlled before	e it reaches an					
	unmanageable le	vel. Instructed					
	patient/caregiver	to coordinate					
	administration of	f pain medication with					
	activities. 5. Inst	truct patient/caregiver					
	regarding pharm	acological and					
	nonpharmacolog	ic pain control measures.					
	7. Perform as	sessment for urinary					
	incontinence	UA [Urinalysis] and C					
	& S [culture and	sensitivity] obtained. 8.					
			1				ı

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
					WEBSTER ST		
GREAT I	_AKES CARING			KOKOM	1O, IN 46902		
(X4) ID				ID PROVIDER'S PLAN OF COR			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	caregiver regarding					
	causes and comp						
	-	rhea 10. Instruct in					
	_	rement to promote good					
		d healing." The Visit					
	Note Report sect						
		Wound" stated, "No					
	problems identif	ied."					
		ecertification OASIS					
	Visit Note Repor	rt dated 10/26/15 section					
	titled "Goals Me	t," previously on 10/6/15					
	were repeated as	being re-instructed on					
	and met again or	1 10/26/15 visit and listed					
	as: stated, "1. Pa	atient/caregiver will					
	verbalize unders	tanding of instructions					
	given related to	pressure relief and ulcer					
	prevention. 2. (Cardiac exacerbations are					
	identified promp	tly and interventions					
	initiated quickly	to minimize associated					
	risks 5. Pati						
	demonstrate und	•					
		and nonpharmacologic					
		sures this visit. 6.					
	Changes in respi						
		ported to physician for					
	prompt intervent						
		9. Exacerbations of					
		disease are promptly					
	-	terventions implemented					
		s to patient." The					
		on for Respiratory stated,					
		y system assessed? Yes.					
		ory assessment findings:					
	mulcate respirate	ory assessment initings.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER	<u>. </u>	•		ADDRESS, CITY, STATE, ZIP CODE		
GREAT I	_AKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ntified." The assessment		TAG			DATE
		ovascular stated, "No					
		ied." The agency failed					
	to notify the phy	sician for a need to					
	remove met goal	s and update POC.					
	I The SN Re	ecertification OASIS					
		rt dated 10/26/15					
	narrative section						
		isit nursing not need at					
	this time patient	to continue with PT at					
	this time." The i	record failed to evidence					
	the patient was d	lischarged from SN					
	services.						
	3. The agency's	policy titled "Care					
		reviewed March 2015					
	stated, "1. Follo	wing the initial					
	assessment, a Ca	re Plan shall be					
	developed with t	he client and/or					
		nterventions shall					
	_	e problems identified,					
		and the client goals for					
		re. 2. The Care Plan					
		d, evaluated, and revised					
	1 '	y sixty (60) days and as					
		oon the client's health					
		rironment, ongoing client egiver support systems,					
		ness of the interventions					
		gress toward goals. All					
		communicated to the					
		members. 3. The Care					
		e, but not be limited to:					
	I		1				I

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT I	_AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
_		needs identified related		-			
	to diagnosis. b.	Reasonable, measurable,					
	_	ls as determined by the					
		elient expectations. c. A					
		terventions with plans					
	_	on. d. Indicators for achievement and					
		rames. 4. The physician					
		be used as a care plan if					
	specific interven	_					
	_	ne care staff to address					
	client care needs	."					
	4. The agency's	policy titled					
		Client Services," #					
	-	March 2015 stated,					
	_	ensure appropriate,					
		ing provided to clients.					
	_	e plan to reflect needs or					
		ed by members of the					
		duplication of services. s to modify the plan of					
	_	Instructions 2.					
	^	care conferences shall be					
		en as necessary to					
		ges in the client's needs,					
	services, care, or	goals. 3. After the					
	initial assessmen	t the admitting					
	Registered Nurse	-					
		e findings of the initial					
		nical Supervisor to					
		fication of the plan of					
		l. Client's need for					
	skilled nursing c	are. e. Need for other					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUII B. WIN	LDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION DATE
	services and/or reresources 7. Manager or Clinical assume responsibility updating/changing communicating of within 24 hours for changes. The contacted when he change is necessare physician to charmant. 9. GLC will is system to assure departments are in plan and/or need. 5. The agency's properties of Care and necessary services of Car	referral to community The Nurse Case cal Supervisor will collity for ag the Care Plan and changes to caregivers collowing the conference physician will be anis/her approval for that ary and to alert the ages in client condition. dentify a communication that all disciplines and anformed of changes to for modification." colicy titled "Skilled ad," # C-200, reviewed ad, "1. The Registered agularly reevaluates the coordinates the assary revisions and an of care and the care as services requiring ang skill e. Informs and other personnel of and observation to arse, physician and other					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	COMPLETED 11/19/2015		
	ROVIDER OR SUPPLIER		3115	FADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST DMO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
G 0166 Bldg. 00	include: observate teaching and train Management and plan and routine procedures." 484.18(c) CONFORMANCE ORDERS Verbal orders are and dated with the registered nurse of defined in section responsible for fur ordered services. Based on record the agency failed care (POC)contate wound care orderecords reviewed wound care (# 4 ensure the POC in drawing labs from Inserted Central 1 record review of lines. (# 3) Findings include	WITH PHYSICIAN Put in writing and signed date of receipt by the r qualified therapist (as 484.4 of this chapter) hishing or supervising the review, and interview, to ensure the plan of ined a frequency of rs for 2 of 2 clinical of patients receiving and 11), and failed to included orders for m the Peripherally Catheter (PICC) for 1 of of patients with PICC	G 0166	G166 To assure compliance with 484.18(c) Conformance with Physicians Orders, the following interventions were implemented: All LPN and RN staff received education by 12/24/1 that included hands on demonstration check offs in a skills lab by RN staff educators. The education included review PICC line procedures, physician otification of abnormal assessment, documentation review, as well as return demonstration of skills including measurement of PICC line.	ed: 5, s. v of an

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			WEBSTER ST		
CDEATI	_AKES CARING				MO, IN 46902		
				KOKOK			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		23/15, contained a plan of			All abiliand according to the ff		
	care (POC) date	d 10/23/-12/21/15 with			All skilled nursing staff received education on		
	orders for Skille	d Nursing (SN) 1 time a			documentation requirements for	or	
	week for 1 week	, 2 times a week for 8			wound care, as well as hands		
		ne a week for 1 week,			competency checks in a skills		
	· ·	l visits for cardiac,			for wound care, and infection		
	respiratory, gast	·			control with wound care, by ar	1	
	1 3,0	*			RN preceptor by 12/24/15.		
		eurologic, endocrine,			An audit will be performed by t	·h.o	
		n/wound status changes,			administrator or designee to	ille	
		r: Instruct on			assure compliance with G 166	of	
	lab/venipuncture	e procedure, obtain lab			100% of all patients with a PIC		
	results and repor	t to physician. SN to			line until 100% compliance is r		
	obtain Vancomy	cin trough week of			for 4 consecutive weeks. Afte	r 4	
	10/26/15 and BN	MP [basic metabolic			consecutive weeks of 100%		
	panel] twice wee	ekly until instructed			compliance the audit will	,	
	* -	N to change PICC			decrease to 10% quarterly and will be completed through the	¹	
		terile technique every			clinical record review process.		
	1 -	ded times 3 for soiled or			(Exhibit 6)	ord review process.	
	loose dressing.	ded times 5 for somed of					
	100se dressing.						
	A THE DOC	6.11.14			An audit will be performed by		
		failed to evidence the			administrator/designee to assu compliance with G 166 of 100		
	1 0 0	orders to draw labs via			of wound visits to ensure	70	
	the PICC line.				measurements g week, as wel	ll as	
					detailed orders and complete		
	B. During in	terview on 11/16/15 at			documentation of wound care		
	3:00 PM, the Ad	ministrator indicated the			provided until 100% compliand		
	orders for lab dr	aws via PICC line are on			is met for 4 consecutive weeks	3.	
	the infusion orde	ers for the Vancomycin.			After 4 weeks of 100% compliance the audit will		
		on orders for the vanconiyem.			decrease to 10% quarterly and	₁	
	C. The [Infusion Clinic] orders dated				will be completed through the		
					clinical record review process.		
	10/22/15-4/22/16 stated, "Physicians Orders: 2. Routine PICC Care." This				(Exhibit 11)		
		vidence the physician					
	ordered lab draw	s via the PICC line.					

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AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUILDING 00 B. WING		COMPLETED 11/19/2015			
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING			10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	reviewed on 11/1 date was 9/20/15 9/20-11/18/15 cottimes a week for for 1 week, 2 tim then 1 time a ween needed visits for respiratory/cardiacomplications, m SN for teaching a to wounds. Area cleanse with woubstadine and let right upper arm of cleanser, apply Slightly moistened gauze. Area to mound cleanser, lightly moistened dry gauze. -The wound cleanser, lightly moistened dry gauze. -The wound cleanser, lightly moistened dry gauze. 3. The clinical rewas reviewed on care date was 12, 10/5-12/3/15 contimes a week for for 1 week, 3 times a week for	-				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	IULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF F	PROVIDER OR SUPPLIER	3		STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		•			WEBSTER ST		
	AKES CARING			<u> </u>	IO, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	for 1 week, 4 tin	nes a week for 1 week, 3					
	times a week for	2 weeks, then 2 times a					
	week for 1 week	x, with 3 as needed visits					
		ardiac/respiratory,					
	•	gastrourinary, diabetic, or					
	_	tions. Need for skilled					
	_	ervention related to left					
		kin integrity. Cleanse					
		inser, apply collagen,					
	cover with foam dressing. Wrap bilateral						
	lower extremities with 2 layer compression wraps.						
	Compression wit	aps.					
	A. The POC	failed to contain a					
	frequency of the	wound care orders.					
	_	terview on 11/18/15 at					
	· · · · · · · · · · · · · · · · · · ·	Administrator stated there					
	1	uency on the wound care					
	orders.						
	4 The agency's	policy titled "Care					
		reviewed March 2015					
	·	Care Plan shall include,					
		ed to: a. Problems and					
	needs identified	related to diagnosis					
	c. A list of spec	ific interventions with					
	plans for implen	nentation 4. The					
		of Care may be used as a					
		ific interventions are					
	· ·	d for home care staff to					
		re needs State of					
		um: The nursing plan					
	of care will cont	ain: 1. A plan of care					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015		
	PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUIL B. WING ME OF PROVIDER OR SUPPLIER EAT LAKES CARING ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROPERTY OF THE PROPERTY		3115 S	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	information,					
	"Venipuncture for Collection," # I- stated, "Blood D Venous Access I 1. Review Physic	or Blood Specimen 140, revised 7/30/14 raw from Central Devices Procedure: ician order. 2. Use strict				
	"Coordination of C-360, reviewed After the initial a Registered Nurse communicate the visit with the Cli ensure: a. Clari care orders e	Client Services," # March 2015 stated, "3. assessment, the admitting				
G 0168 Bldg. 00	484.30 SKILLED NURSIN Based on record	IG SERVICES review, and interview,	G 0168	G 168	12/24/2015	
	the agency failed staff provided tre the plan of care f reviewed (See G	I to ensure the nursing eatments as ordered on For 1 of 20 records 170); failed to ensure e plans of care for 2 of		To assure compliance with 484.30 Skilled Nursing Service the following interventions wer implemented: G 170	es,	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	ì í	JILDING	onstruction <u>00</u>	(X3) DATE : COMPL 11/19/	ETED
	PROVIDER OR SUPPLIER		<u> </u>	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	physicians were longer needing S due to goals met reviewed, and fa to revise goals met revised for pain revised for pain reviewed (See G the admitting nut the plan of care, physician of the care pain goal for reviewed (See G the nursing staff Peripherally Inse (PICC) line for 1 patients receiving 174); failed to e the physician of for 1 of 1 patients receiving PICC measure wounds patients receiving 176); and failed Practical Nurse policies and product and changing PI record reviewed (See G 179). The cumulative oproblems resulted	wed, failed to ensure notified of patients no skilled Nursing services for 2 of 20 records iled to notify physician set and goals needing for 1 of 20 records 172); failed to ensure rese initiated revisions to and failed to notify the need to alter the plan of r 1 of 20 records 173); failed to ensure accurately measured the erted Central Catheter of 1 record reviewed of g PICC line care (See G nsure the nurses notified changes in PICC length a records reviewed ine care, and failed to weekly for 1 of 2 g wound care (See G to ensure the Licensed followed PICC Line cedures for measuring CC dressings 1 of 1 receiving PICC line care			All LPN and RN staff received education by 12/24/² that included hands on demonstration check offs in a skills lab by RN staff educator. The education included review PICC line procedures, physici notification of abnormal assessment, documentation review, as well as return demonstration of skills includi measurement of PICC line. An audit will be performed by administrator/ designee to asseompliance with G 170 of 100 of all patients with a PICC line until 100% compliance is met 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly an will be completed through the clinical record review process (Exhibit 6) G 172 (N541) G 173 (N541) G 174 (N541) G 175 (N541) G 175 (N541) G 176 (N541) G 177 (N541) G 177 (N541) G 178 (N541) G 179 (N541) G 170 (rs. v of an ng the sure % for d	

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING B. WING	00	COMPLETED 11/19/2015
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST	
GREAT L	AKES CARING			MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	environment.			administrator/designee to assict compliance with G 164 on 100 of all admissions and recertification visits to assure patient interventions match diagnosis on the plan of care of 100% compliance is met for 4 consecutive weeks. After 4 were of 100% compliance, the audit decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 12) An audit will be performed by administrator/designee to assict compliance with G 172 of 50% all skilled nursing visits for updated goals when indicated and physician notification of updated and patient specific goals until 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 13) An audit will be performed by administrator/designee to assic compliance with G 172 of 50% all skilled nursing visits for pair interventions and physician notification when indicated untal 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quarterly and compliance the audit will decrease to 10% quar	until eeks will d the ure of

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157586 B. WING	COMPLETED 11/19/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY	(X5) COMPLETION DATE
will be completed through the clinical record review process. (Exhibit 14)	
G173 (N542) • CICCION All RN's received education by 12/24/15 on Policy C-200 Skilled nursing services with a focus on the requirement of the RN to provide ongoing assessment and update of the plan of care. This includes physician notification of goals not met, uncontrolled pain, or other changes in patient condition. All interventions must be applicable to the plan of care. An audit will be performed by the administrator/designee to assure compliance with G 173 of 50% of all skilled nursing visits for updated goals when indicated and physician notification of updated and patient specific goals until 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 13) An audit will be performed by the administrator/designee to assure compliance with G 173 of 50% of all skilled nursing visits for pain interventions and physician notification when indicated until 100% compliance is interventions and physician notification when indicated until 100% compliance is met for 4 consecutive weth G 173 of 50% of all skilled nursing visits for pain interventions and physician notification when indicated until 100% compliance is met for 4	ot ee

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015
	ROVIDER OR SUPPLIER	3	3115 S	ADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
TAU	REGULATORI OR	ESC IDENTIFING INFORMATION)		consecutive weeks of 100% compliance the audit will decrease to 10% quarterly at will be completed through the clinical record review process (Exhibit 14) G 174 All LPN and RN staff received education by 12/24/2 that included hands on demonstration check offs in a skills lab by RN staff educated. The education included reviet PICC line procedures, physic notification of abnormal assessment, documentation review, as well as return demonstration of skills included measurement of PICC line. PICC measurement service code were created in the electronic measurement of PICC line. A PICC measurement at their will be performed by administrator or designee to assure compliance with G 17 100% of all patients with a Piline until 100% compliance is for 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly at will be completed through the clinical record review process (Exhibit 6)	nd e s /15, a ors. ew of cian ling vas dical to e a visits. v the /4 of ICC s met er 4
				G176	

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015
	ROVIDER OR SUPPLIEF		3115 S	ADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				HILPN and RN staff received education by 12/24/that included hands on demonstration check offs in a skills lab by RN staff educato. The education included revie PICC line procedures, physic notification of abnormal assessment, documentation review, as well as return demonstration of skills includ measurement of PICC line. A PICC measurement service code we created in the electronic med record software on 12/14/15 prompt clinicians to complete PICC measurement at their view. All skilled nursing staff received education on documentation requirements wound care, as well as hands competency checks in a skills for wound care, and infection control with wound care, by a RN preceptor by 12/24/15. An audit will be performed by administrator or designee to assure compliance with G 17 100% of all patients with a PI line until 100% compliance is for 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly ar will be completed through the clinical record review process (Exhibit 6)	rs. w of ian ing vas ical to a risits. for s on s lab an the for c on s lab an the do

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	T OF DEFICIENCIES OF CORRECTION	IN PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	A. BUILDING B. WING	00	COMPLETED 11/19/2015
	ROVIDER OR SUPPLIE	R	3115 S	ADDRESS, CITY, STATE, ZIP C S WEBSTER ST MO, IN 46902	ODE
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE COMPLETION APPROPRIATE DATE
				An audit will be perform administrator/designee compliance with G 176 of wound visits to ensure measurements q week detailed orders and condocumentation of wour provided until 100% cois met for 4 consecutive After 4 weeks of 100% compliance the audit will be completed through clinical record review processed to 10% quart will be completed through clinical record review processed education by that included hands on demonstration check of skills lab by RN staff end The education included PICC line procedures, notification of abnormatication of abnormatication of skills measurement of PICC measurement of PICC measurement of PICC measurement of PICC measurement at An audit will be performadministrator/ designer compliance with G 179 of words.	e to assure 3 of 100% ure 4, as well as mplete nd care compliance e weeks. vill terly and ugh the corocess. staff 12/24/15, uffs in a ducators. d review of physician al ttation rn including line. code was ic medical 14/15 to mplete a their visits. med by the e to assure

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	2015
	ROVIDER OR SUPPLIER			3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE
		9		-	of all patients with a PICC line until 100% compliance is met 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 6)	for	
G 0170	484.30	IC SERVICES					
Bldg. 00	in accordance with Based on record the agency failed staff provided tree the plan of care (reviewed. (# 3) Findings include 1. The clinical reof care date 10/2 care (POC) dated orders for Skilled week for 1 week weeks, then 1 tim with 3 as needed respiratory, gastre gastrourinary, nemental, pain, skin and falls. SN for lab/venipuncture results and report	s skilled nursing services in the plan of care. review, and interview, it to ensure the nursing eatments as ordered on it. POC) for 1 of 20 records cecord of patient # 3, start 3/15, contained a plan of it 10/23/-12/21/15 with it. It Nursing (SN) 1 time a it., 2 times a week for 8 ine a week for 1 week, visits for cardiac, cointestinal, surologic, endocrine, in/wound status changes,	G 0	170	G 170 To assure compliance with 484.30, Skilled Nursing Service the following interventions were implemented: All LPN and RN staff received education by 12/24/1 that included hands on demonstration check offs in a skills lab by RN staff educators. The education included review PICC line procedures, physician otification of abnormal assessment, documentation review, as well as return demonstration of skills including measurement of PICC line. An audit will be performed by administrator/ designee to assecompliance with G 170 of 100 of all patients with a PICC line until 100% compliance is met 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the	s. v of an	12/24/2015

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO UILDING	00	COMPL		
11112 12111	or condition,	157586	B. W		00	11/19/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			WEBSTER ST		
GREAT L	AKES CARING				1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	clinical record review process		DATE
	10/26/15 and BMP [basic metabolic profile] twice weekly until instructed				(Exhibit 6)		
		N to change PICC			,		
		terile technique every					
		ded times 3 for soiled or					
İ	loose dressing.	ded times 5 for somed of					
	A. The start	of care assessment form					
	dated 10/23/15 b	y employee G,					
	Registered Nurse	e (RN) stated, "Indicate					
	length of exposed PICC catheter from insertion site to catheter hub in						
	centimeters: 10.	0."					
		isit Note Report dated					
		ployee U, Licensed					
		(LPN) stated, "PICC line					
		ed. PICC line dressing					
		septic technique Lab ia PICC line using					
		e." The record failed to					
		N measured the PICC					
		o evidence the nurse used					
	, , , , , , , , , , , , , , , , , , ,	for the dressing change.					
	1	<i>Q Q</i>					
	C. The SN V	isit Report dated					
	10/30/15 by emp	ployee G stated, "Indicate					
	•	ed PICC catheter from					
	insertion site to						
		0." The record failed to					
		sician was notified of					
		longer measurement of					
	the PICC line.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	IULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		157586	B. W		00	11/19/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	WEBSTER ST		
GREAT I	AKES CARING			KOKOM	IO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		Visit Note dated 11/3/15					
		LPN stated, "Skilled					
	_	nent completed for Vanco					
		eak draw from PICC line					
	using clean tech	•					
		ote Report dated 11/3/15					
	1 2 1 2	stated, "Patient requesting					
		ng changed during visit nent. PICC line dressing					
		terile technique." The					
		•					
	record failed to evidence the PICC line was measured during the dressing						
	change.	uring the dressing					
	change.						
	E The SN V	isit Note Report dated					
		oyee G stated, "Indicate					
		Site Assessment: Red					
		of exposed PICC catheter					
		ite to catheter hub in					
	centimeters: 11	.0." The record failed to					
	evidence the phy	ysician was notified of					
		e PICC catheter site.					
	F. The SN V	isit Note Report dated					
	11/13/15 by emp	oloyee V, LPN stated,					
	"Indicate length	of exposed PICC					
	catheter from in	sertion site to catheter					
	hub in centimete	ers: 3.0." The record					
		ce the physician was					
	notified of the 3	centimeter PICC					
	measurement.						
		11/1/17 (2.22					
	_	view on 11/16/15 at 3:00					
	PM, the Admini	strator stated PICC					

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	î ´	ILDING	<u>00</u>	COMPL 11/19/	ETED
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	3. During intervental AM, the Administration to the nurse that at 3 centimeters are said she measured showing under not that the PICC linux. 4. The agency's "Responding to Cartain types of a susceptible to cartain types of a susceptible to cartain types of a susceptible to cartain types. Measuremental length of dressing changes detection. Period verification by a performed on all placed catheters. 5. The agency's "PICC Line Dress stated, "PICC linus Strict Aseptic Procedure 9. catheter exposed	eath the dressing, and e is sutured in place. undated policy titled Complications of PICC tated, "Catheter Tip possible for any type of atheter to migrate to while in the body. clients are more theter tip migration very active ure and document the f the catheter with each This will assist in early dic catheter tip -ray study should be long-term, centrally " undated policy titled ssing Change," # I-240 e dressing changes will					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETS B. WING 11/19/20			
		157586	B. W	ING		11/19/2015	
	ROVIDER OR SUPPLIER AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	Document in the	clinical record: d.					
	Length of cathete	er visible at exit site. e.					
	Any physician no	otification."					
	31 3						
G 0172	484.30(a) DUTIES OF THE I	REGISTERED NURSE					
Bldg. 00		se regularly re-evaluates					
	•	review, and interview,	G 0	172	G 172	12/24/2015	
		to ensure nurses revised			To assure compliance with		
		for 2 of 20 records			484.30 (a), Duties of the		
	•	to ensure physicians			Registered Nurse, the followin interventions were implemented		
		patients no longer			• • • • All clinical staff we		
		Nursing (SN) services			educated by 12/24/15 on police		
	_	• , ,			C-360 Coordination of Client		
	_	for 2 of 20 records			services, C-660 Care Plans, a		
	,	nd 13), and failed to			C200 Skilled Nursing Services	š.	
		to revise goals met and			Education focus included the		
		vised for pain for 1 of 20			need to provide all disciplines indicated, detailed and timely		
	records reviewed	l (# 10).			physician orders, and updating	a l	
					the care plan and patient goal		
	Findings include	:			change, physician notification		
					changes in patient status and		
	1. The clinical re	ecord for patient # 10			discharge when goals met.		
		11/17/15. The start of			An audit will be performed by	the	
		26/15. POC dated			administrator/designee to assi		
		ontained diagnosis of			compliance with G 164 on 100		
		ing Surgery, with orders			of all admissions and		
		week for 1 week, 2 times			recertification visits to assure		
					patient interventions match	until	
		eks, then 1 times a week			diagnosis on the plan of care of 100% compliance is met for 4		
		needed for falls, pain,			consecutive weeks. After 4 we		
	_	gastrourinary, respiratory,			of 100% compliance, the audit		
		d skin integrity, diabetes,			decrease to 10% quarterly and		
		ecline. Need for skilled			will be completed through the		
	teaching and inte	ervention related to			clinical record review process.	,	

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MUL A. BUIL B. WINC	DING	nstruction 00	(X3) DATE S COMPL 11/19/	ETED
wound incision of Keep clean and of air if no drainage -Observation and system to identify with exacerbation of complications of gastrointesting changes associated or early intervention -Evaluate patientic care to be counted -Observation/assistem to identify with exacerbation of complications of complications -Provide instruct planning. Dischaused in the patient for under management of the perform Hamilton minimental examples and identify change assessing teaching/reinforce depression inclumed in the perform than and identify change depressive disordintervention, SN	ratement of deficiencies CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) cervical spine incision. dry. May leave open to e noted. SN for: d assessment of cardiac fy changes associated in for early intervention fy cobservation/assessment al system to identify ed with exacerbation of tion of complications; and develop plan of for signed by physician; fy changes associated in for early intervention fy changes associated for early intervention fy changes f	PF	3115 S \	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) (Exhibit 12) An audit will be performed by the administrator/designee to assume compliance with G 172 of 50% all skilled nursing visits for updated goals when indicated and physician notification of updated and patient specific goals until 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 13) An audit will be performed by the administrator/designee to assume compliance with G 172 of 50% all skilled nursing visits for pair interventions and physician notification when indicated unt 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 14)	he ire of he ire of h	(X5) COMPLETION DATE

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	l í	JILDING	<u>00</u>	COMPL 11/19/	ETED
NAME OF F	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	(X5) COMPLETION DATE
	-Provide teaching etiology of confucognition, safety management; obe of pain, effective management and teaching related to report increase physician for prospection of pain, effective management and teaching related to report increase physician for prospective of physician for instruction gastrointestinal sincluding divertion of physician physician provides and physician provides of provides and physician phys	g/reinforcement in asion or altered measures and home servation and assessment mess of pain regimen and skilled to pain management, SN in pain level to mpt intervention; and training of plan, disease process magement of green and see a servation disease; le oximetry mes 3 as needed for th, oxygen use, activity on/reinforcement of gystem related teaching, culitis and irritable (IBS); killed teaching regarding rol diarrhea/constipation ting related called teaching and gency care plan, disease omy surgery including of neurologic disease;					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
		`			WEBSTER ST		
	AKES CARING			<u> </u>	1O, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	perform blood g	lucose level as needed					
	for signs and syr						
		emia or for baseline					
		feet and reinforce					
	diabetes mellitus						
	-SN observation	and reaching					
	integumentary st	tatus to promote optimum					
	skin integrity;	- •					
	-SN to instruct p	atient/caregiver on signs					
	and symptoms o	f infection related to					
	cervical spine su	tures to reduce					
	complications to	the wound;					
	-SN to establish	supports to minimize					
	risk of hospitaliz	cation patient/caregiver					
	will be instructed	d in emergency care plan,					
	and aspects of co	ervical spine surgery					
	disease manager	ment to reduce avoidable					
	hospitalization;						
	-Skilled instructi	ion of medication					
	regimen to ident	ify					
	changes/complic	eations for early					
	intervention;						
		nterventions to improve					
		ice the risk of falls;					
	•	atient/caregiver on					
	_	ures to reduce pressure					
	ulcer risk; and						
		ssional to report vital					
		side the following					
		meters: Temp < 96>					
		> 116, Respirations < 12					
		ood pressure, $80 > 170$,					
		pressure $< 50 > 90$,					
	tasting blood sug	gar < 60 > 300, oxygen					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
NAME OF F	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING			WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	discharge instruct discharge summa available to phys symptoms of anx interventions init manage feelings; -Patient/caregive verbalize/demonsmanagement of of the episode and sand managed to the home; Patien demonstrate undeconfusion and matthe home; -Improvement in activity; -Pain controlled a level acceptable -Patient/caregive understanding of nonpharmacolog -Patient will demmanage cardioval disease process a burden associated pulse oximetry re-Patient/caregive ability to self madisease process; -Patient/caregive	r will strate understanding the depression by the end of symptoms are identified maintain patient safety in t/caregiver will erstanding of etiology of aintain patient safety in pain interfering with at level of 3 or less or at the to the patient; r demonstrate Tharmacological and tic pain control measures; tonstrate ability to self scular hypertension and reduce caregiver d with disease process; tesults obtained; r will demonstrate mage gastrointestinal				

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILI B. WING	DING	<u>00</u>	COMPL 11/19/	ETED
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION DATE
	bowel elimination bowel patency; -Demonstrated al neurologic disease caregiver burden process, improve symptoms of neurologic disease caregiver burden process, improve symptoms of neurologic demonstrate undemonstrate undemonstrate undemonstrate undemonstrate undemonstrate undemonstrate undemonstrate undemonstrate undemonstrated in conditions and earlier vention of action skin; -Demonstrated in conditions and earlier vention of action skin; -Wound complicing patient integrated size or healing of cert period; -Patient will have supports to prevent avoidable hospitated reduced; -Patient/caregive ability to safely repatient will be about daily living and daily living with patient/caregive	bility to self manage se process and reduce associated with disease ement in signs and prologic disease; r will verbalize erstanding the diabetes by the end of the ptoms are identified and patain patient safely in the emprovement in existing parly identification and dditional compromises ations avoided; entary status will enced by a decrease in f wound/decub by end e appropriate agency ent rehospitalization,					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	l í	JILDING	nstruction 00	(X3) DATE COMPL 11/19	ETED
	PROVIDER OR SUPPLIER		•	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	physician was not and of unobtainal changed on the property coordinate with a instructions and was not being coordinate with a instructions and was not being coordinate with a instructions and was not being coordinate with a state of the coordinate with a state of the coordinate was a stated "[Spouse of lowest patient's pain scale. Curre Dilaudid 2 milling The agency faile "Pain controlled a level acceptable revised. B. The start of dated 9/26/15 stated 9/26/15 stat	I start of care was ient Coordination Note late entry for 9/26/15 of patient] states the pain ever gets is a # 8 on ently patient takes grams tablets for pain." d to ensure the goal of at level of 3 or less or at e to the patient" was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GREAT I	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
_		rine/Hematopoietic		_			
	assessment (mar	k all that apply):					
	Diabetes, thyroic	d problems Is the					
	patient taking in	sulin? No Is the					
	patient taking an	antidiabetic agent? Yes.					
	How frequent ar	e blood sugars check?					
	Not checked ver	y often. What are the					
	patient's usual bl	lood sugar readings?					
	Below 130."						
	The section title	ed "Care Coordination"					
	stated "Indicate	if you communicated					
	with other discip	olines involved in this					
	case: YES. Wh	at discipline did you					
	communicate wi	th? Physician,					
	Caregiver(s), Cli	inical Supervisor.					
	Indicate reason	physician not contacted:					
	Was Contacted.	Contacted physician for					
	approval of prop	osed plan of care: No.					
	Indicate reason p	physician not contacted:					
	Not in on weeke	nds." The section titled					
	"Goals Met" stat	ted: "3. Patient/caregiver					
	verbalizes under	standing of basic					
	nutritional/hydra	ation requirements." The					
	visit note failed	to evidence the SN					
	provided teaching	g/reinforcement of					
	management of	diabetes.					
		Mark Danier day 1					
		Note Report dated					
		Pain: All of the time					
		g 9 Wound: no					
	1 ^	ied Have the					
	_	ugars remind stable for					
		k? Not Applicable-					
	blood sugars are	not routinely checked."					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	ľ í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	gets lower than a management. Se section titled "In Observe and assipain level. See pasection." The Nageneralized pain during SN visit in Just took pain in SN arrival." The record failed intervention other provided; failed was notified to coof "Pain controll at a level accepta failed to evidence teaching/reinford diabetes. D. The Visit 10/2/15 Intervention cardion hypo/hypertension Details/Commert Low Sodium/low Nutritional Required The evidence education diabetic diet, and with the physicial diet/nutritional in section 1 in the section of the section o	on disease process, ats: Dietary restrictions, at fat." The POC airements stated agency failed to on to the patient on I failed to clarify/verify						

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	OF CORRECTION	IDENTIFICATION NUMBER:	l í	ULTIPLE CO UILDING	00	(X3) DATE COMPI	
		157586	B. W		00	11/19	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				WEBSTER ST		
GREAT L	AKES CARING			KOKON	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	POC.	nd modify/revise the					
	roc.						
	E. The Visit	Note Report dated					
		let section stated, "1.					
	Patient/caregiver	· ·					
	_	f instructions given					
		re ulcer relief and ulcer					
	*	Cardiac exacerbations are					
	identified promp	tly and interventions					
	initiated quickly	to minimize associated					
	risks 4. Paiı	n management					
	intervention com	pleted this visit. 5.					
	Patient/caregiver	demonstrate					
	understanding of	f pharmacological and					
	nonpharmacolog	gic pain control measures					
	this visit. 6. Ins						
		ypo/hypertension disease					
	•	pisode- patient/primary					
		ndent. 7. Changes in					
		s are identified and					
	reported to phys						
		ninimize associated risks.					
		garding self management					
	_	al disease completed this					
		/primary caregiver					
	_	Instruction regarding					
	_	t of altered bowel					
		pleted this episode- caregiver independent.					
		raregiver independent.					
		ptly identified and					
	_	plemented to minimize					
		Instruction regarding					
	risks to patient.	instruction regarding					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	<u>00</u>	COMPLETED 11/19/2015			
	PROVIDER OR SUPPLIER LAKES CARING	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	self management of meds that manage depression completed this episode-patient/primary caregiver independent 18. Instructions regarding ability to self manage nutritional requirements to promote skin integrity completed this episode- patient/primary caregiver independent. 19. Instructions regarding ability to self manage nutritional requirements to alleviate pressure completed this episode- patient/primary caregiver independent. 20. Instructions regarding signs and symptoms of infection and skin breakdown completed this episode- patient/primary caregiver independent 22. Instruction regarding wound management completed this episode-patient/caregiver independent. 23. Instruction regarding avoiding wound complications completed this episode-patient/caregiver independent 29. Patient/caregiver stated understanding of instructions of fall preventions related to environmental hazards." F. The Visit Note Report dated 10/6/15 stated, "Pain: All of the time," and was rated at 9. The Endocrine/Hematopoietic section stated, "Have the patient's blood sugars remained stable for the past two weeks? Yes." The section titled "Goals Met" stated, "2. Cardiac exacerbations are						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
THINDTERNI	or condition	157586	B. W		00	11/19/	
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	1 ., 10,	
NAME OF F	PROVIDER OR SUPPLIER				WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		tly and interventions					
		to minimize associated					
	risks 5. Pati	_					
	demonstrate und	_					
	_	and nonpharmacologic					
	•	sures this visit. 6.					
	Changes in respi	•					
		ported to physician for					
	prompt intervent						
		7. Exacerbations of					
	_	lisease are promptly					
		terventions implemented					
	to minimize risk	-					
	_	ding self management of					
	_	se completed this					
		primary caregiver					
	-	Assessment regarding					
	1 *	self manage wound care					
	completed this v						
	_	stated understanding of					
		all preventions related to					
	environmental h	azards."					
	G. The Visit	Note Report dated					
		"Pain, daily but not					
	•	d at 9. The section titled					
	"Wounds" stated						
		Narrative section stated,					
		an, dry and intact,					
		infection or drainage,					
	_	vill continue to monitor."					
	The section title						
	Provided" stated						
	patient/caregiver						
	r	0 a0 ka					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ľ	ULTIPLE CO UILDING	NSTRUCTION 00	COMPI		
ANDILAN	or connection	157586	B. W		00	11/19		
		107000			DDDEGG CITY CELEB ZID COSS	11/19/	2010	
NAME OF PROVIDER OR SUPPLIER				1	ADDRESS, CITY, STATE, ZIP CODE			
GREAT L	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE	
	management and	l principles, 5.						
	Instruct patient/c	earegiver regarding						
	pharmacological	and nonpharmacologic						
	pain control mea	sures, 6. Instruct						
	patient/caregiver	in reduction of risk for						
	injury and impro	vement in environment						
	to prevent injury	, 8. Instruct in						
	cardiovascular h	ypo/hypertension disease						
	process, 12.	Instruct regarding causes						
	and complication	n of						
	constipation/diar	rhea, 22. Assess						
	patients ability to	o self manage disease						
	process, details/o	comments: diabetic diet,						
	diabetic skin car	e, proper skin care, foot						
	care and inspecti	on, medication						
	management	26. Assess current						
	wound treatment	for effectiveness weekly						
	, details/commer	nts: assess wound						
	treatment for eff	ectiveness and wound						
	progressing."							
		Note Report dated						
		Met section stated, "1.						
	Patient/caregiver							
		finstructions given						
	_	re ulcer relief and ulcer						
	*	Cardiac exacerbations						
	are identified pro	omptly and interventions						
		to minimize associated						
	risks 5. Pati	ent/caregiver						
	demonstrate und	_						
	pharmacological	and nonpharmacologic						
	•	sures this visit. 6.						
	Instruction regar	ding injury prevention						
			•					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
ANDILAN	or connection	157586	B. W		00	11/19/	
		107000			DDDDGG CITIL CTATE TID CODE	11/10/	2010
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING			1	10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		pisode- patient/caregiver					
	-	Instruction regarding					
	managing chang	•					
		pisode- patient/caregiver					
	independent. 8.						
	· '	ypo/hypertension disease					
	•	pisode-patient/caregiver					
	independent						
		s are identified and					
	reported to physi						
	intervention to m	ninimize associated risks.					
	11. Instruction r	egarding self					
	management of §	gastrointestinal disease					
	completed this e	pisode- patient/caregiver.					
	12. Instruction r	egarding self					
	management of a	altered bowel elimination					
	- '	pisode- patient/caregiver					
	independent. 13	. Exacerbations of					
	gastrointestinal o	lisease are promptly					
	identified and in	terventions implements					
	to minimize risk	s to patient 15.					
	Instruction regar	ding self management of					
	anxiety complete	ed this episode-					
	patient/caregiver	independent 19.					
	Instruction regar	ding self management of					
	depression comp	leted this episode-					
	patient/caregiver	independent 23.					
	Instruction regar	ding equipment to					
	alleviate pressur	e completed this episode-					
	patient/caregiver	independent. 25.					
	Instruction regar	ding sings and symptoms					
	of infection and	skin breakdown					
	completed this e	pisode- patient/caregiver					
	independent						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586		ILDING	NSTRUCTION 00	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE	
	this episode- pat independent. 28 avoiding wound this episode- pat independent wound care compatient/caregiver Patient/caregiver instructions of far environmental had a substitution of the environmenta	complications completed ient/caregiver 31. Instruction in pleted for this episoderindependent 35. Instructions related to a stated understanding of all preventions related to a stated as being and met again on a disted as #'s 1, 2, 5, 8, 8, and 35. The agency he physician to remove and modify/revise the Note Report dated "Indicate Patient Pain" " The section titled Wounds:" stated, healing incision without a." The Narrative section an incision to posterior ely 8 centimeters in mpletely healed without a. Incision is left [open						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO UILDING	00	(X3) DATE COMPI				
ANDILAN	or connection	157586	B. W		00	11/19			
		137300	J. ,,			11/19	72013		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE				
GRFATI	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902						
		FATEMENT OF DEFICIENCIES		<u> </u>			(VE)		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F		(X5) COMPLETION		
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE		
	instructions/inter	ventions identified on							
	10/14/15. The V	isit Note Report dated							
		"Instructions Provided.							
		nt/caregiver in position							
	•	e equipment to elevate							
		ills/comments: instruct							
	•	including using pillow							
	•	itoring skin over bony							
		l position changes at							
	_	ours 5. Instruct							
	patient/caregiver								
		and nonpharmacologic							
		sures 10. Assess for							
	signs and sympto	oms of depression and							
		on symptoms on a							
	routine basis								
	instructed in avo	idance of environmental							
	hazards includin	g throw rugs, clutter,							
	poor lighting, in	appropriate foot wear,							
	obstructed pathw	vays, pets."							
	-	_							
	L. The Visit	Note Report dated							
	10/21/15 Goals I	Met section stated, "1.							
	Patient/caregiver	will verbalize							
	understanding of	instructions given							
	related to pressu	re ulcer relief and ulcer							
	prevention. 2.	Cardiac exacerbations							
	are identified pro	omptly and interventions							
		to minimize associated							
	risks 5. Pat	ient/caregiver							
	demonstrate und	erstanding of							
	pharmacological	and nonpharmacologic							
	pain control mea	sures this visit 7.							
	Changes in respi	ratory status are							
			1				<u>. </u>		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586		ILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	prompt intervent associated risks. self management disease complete patient/caregiver stated understand fall preventions in hazards." The aevidence any car problems. M. The Goal 10/14/15 were represented on a 10/21/15 visit and 8, and 18. The aphysician to remmodify/revise the N. The Visit 10/30/15 stated, Indicate paties The section titled "Integumentary/problems identification stated," Inhealed." O. The visit instructions/intervise.	8. Instruction regarding to of gastrointestinal and this episode- 2 18. Patient/caregiver ding of instructions of related to environmental ssessment notes failed to diac and respiratory s Met previously on epeated as being and met again on disted as #'s 1, 2, 5, 7, gency failed to notify the ove the Met Goals and the POC. Note Report dated "Pain all of the time. Int Pain Scale Rating: 9." If Wounds" stated, "No ited." The Narrative incision to posterior neck the other repeated eventions identified on							
	10/30/15 stated,	Tisit Note Report dated "Instructions Provided. nt/caregiver in position							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF PROVIDER OR SUPPLIER			•		DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		e equipment to elevate					
	_	nils/comments: instruct					
	-	f including using pillow nitoring skin over bony					
		d position changes at					
	_	ours 5. Instruct					
	patient/caregiver	r regarding					
	pharmacological	and nonpharmacologic					
	•	sures 18. Skilled					
		ching and provision of					
		e as follows: signs and					
	elevated temp, re	ection to report such as					
	* '	19. Instruct in nutritional					
	•	promote good skin					
		aling." The agency failed					
		nnecessary teaching					
		d/decub instructions.					
	P The Goal	Met previously on					
	10/21/15 were re	• •					
		and met again on					
		nd listed as #'s 1, 2, and 5.					
	The agency faile	ed to notify the physician					
	to remove the M						
	<u> </u>	e POC, and failed to					
		services once the cervical					
	incision was hea	lled.					
	Q. During te	lephone interview on					
		0 AM, patient #10's					
		e steri-strips fell off of					
	the wound incisi	on by the first or second					
	nursing visit [wo	ould be approximately					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157586	B. W		<u>oo </u>	11/19/		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GREAT I	_AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE	
IAG		atient's spouse stated the		mo	·		DAIL	
		continued to be provided						
	after the steri str	ips fell off and the nurses						
	were touching of	n teaching about						
	depression and o	other self-care related						
	topics for the pa	tient.						
	R. During in	terview on 11/11/18/15						
	at 10:30 AM, the	e Administrator stated if						
	the wound was h	nealed and no other SN						
	was needed, that	would be an indication						
	1	n SN services and let						
	1 2	e and close out the case.						
		or stated the patient						
		discharged from SN on						
	11/4 or 11/10/15	i.						
	S. SN visits	continued to be provided						
		1/15. The Visit Note						
	_	4/15 stated, "Pain all						
		dicate Patient Pain Scale						
	Rating: 8." The							
		Wounds" stated, "No						
	problems identif	ied."						
	T. The visit	_						
	instructions/inte	rventions identified on						
		isit Note Report dated						
	· · · · · · · · · · · · · · · · · · ·	Interventions Provided.						
	-	nt/caregiver in position						
		e equipment to elevate						
	-	nils/comments: instruct						
	_	f including using pillow						
	for support, mor	nitoring skin over bony						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W		00	11/19/	
		.0.000		CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF PROVIDER OR SUPPLIER					WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	l position changes at					
	_	ours 5. Instruct					
	patient/caregiver	•					
	-	and nonpharmacologic					
		sures 18. Skilled					
		ching and provision of					
		e as follows: signs and					
		ection to report such as					
	elevated temp, re						
	_	17. Instruct in nutritional					
		promote good skin					
		lling." The agency failed					
		nnecessary teaching					
	related to wound	/decub instructions.					
		s Met previously on					
	10/30/15 were re	-					
		and met again on 11/4/15					
		s: 1. Patient/caregiver					
	ill verbalized un	•					
	_	n related to pressure					
		alcer prevention. 2.					
		ations are identified					
		erventions initiate					
		nize associated risks					
		aregiver demonstrate					
	_	f pharmacological and					
	nonpharmacolog	ic pain control measures					
	this visit. 6. Ch	anges in respiratory					
	status are identif	ied and reported to					
	physician for pro	ompt intervention and to					
	minimize associa	ated risks. 7.					
	Exacerbations of	gastrointestinal disease					
	are promptly ide	ntified and interventions					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLE	
	157586	B. W	ING		11/19/2	2015
NAME OF PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP CODE		
THE OF THE TELENOTE ELECT				WEBSTER ST		
GREAT LAKES CARING			KOKOM	1O, IN 46902		
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
, ,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
-	minimize risks to patient.					
	aregiver will demonstrate					
ability to self ma	•					
^ *	promote good skin					
integrity 19.	Patient/caregiver stated					
understanding of	instructions of fall					
preventions relat	ed to environmental					
hazards. The age	ency failed to notify the					
physician to rem	ove the Met Goals and					
modify/revise the	e POC, and failed to					
discontinue SN s	services once the cervical					
incision was hea	led.					
V. The Visit	Note Report dated					
11/11/15 stated,	"Pain all of the time.					
Indicate Patient J	Pain Scale Rating: 8."					
W. The visit i	note repeated					
instructions/inter	ventions identified on					
11/4/15. The Vi	sit Note Report dated					
11/11/15 stated,	"Interventions Provided:					
1. Instruct paties	nt/caregiver in position					
•	e equipment to elevate					
0 1	ils/comments: instruct					
_ ^	including using pillow					
-	itoring skin over bony					
	l position changes at					
_	ours 5. Instruct					
patient/caregiver						
^ -	and nonpharmacologic					
_	sures 17. Instruct in					
•	rements to promote good					
_	d healing." The Visit					
	ed 10/30/15 evidenced					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	lì í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) d.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	re-instructed on visit and listed a will verbalize un instructions give ulcer relief and u Cardiac exacerbations of promptly and integrity and integrity are identified implemented to a listed as a cardiac exacerbations of are promptly ide implemented to a listed integrity. If a listed integrity are identified integrity are identified integrity are identified integrity are identified integrity as a listed integrity and integrity are identified integrity and integrity are identified integrity and integrity are identified integrity. If a listed in a listed integrity are identified integrity and integrity are identified integrity. If a listed integrity are identified integrity are identified integrity and integrity are identified integrity. If a listed in	and met again on 11/1/15 s: 1. Patient/caregiver derstanding of n related to pressure alcer prevention. 2. ations are identified derventions initiate nize associated risks daregiver demonstrate of pharmacological and dic pain control measures anges in respiratory fied and reported to compt intervention and to dated risks. 7. of gastrointestinal disease ntified and interventions minimize risks to patient. daregiver will demonstrate darage nutritional promote good skin Patient/caregiver stated of instructions of fall ded to environmental degency failed to notify the deleve the Met Goals and de POC, and failed to dervices once the cervical						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì	ULTIPLE CO UILDING	NSTRUCTION 00	COMPL				
		157586	B. W	ING			11/19/2015		
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
			3115 S WEBSTER ST						
	AKES CARING			<u> </u>	1O, IN 46902				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE		
	2. The clinical r	ecord for patient # 13							
		11/19/15. The start of							
	care date was 5/2	2/15. Diagnosis of							
		orea. The POC dated							
		ontained orders for SN							
	the week of 9/6/	15, 1 time a week for 1							
		vo weeks for 4 weeks, 1							
	every 3 weeks fo	or 3 weeks, and 3 as							
	needed for cardi								
		strointestinal, endocrine,							
	-	n, wound status changes,							
	and falls. SN for	_							
	-Evaluate patien	t and develop plan of							
	_	and assessment of pain,							
		pain management and							
	regimen and skil	led teaching related to							
	pain managemer	nt, report increase in pain							
	level to physicia	n;							
	-Observation/ass	sessment of cardiac							
	system to identif	y changes associated							
	with exacerbatio	n for early intervention							
	of complications	;							
	- Obtain pulse or	ximetry measurement							
	upon recertificat	ion to confirm baseline							
	and times 3 as no	eeded shortness of							
	breath, oxygen u	se, activity intolerance;							
	-Observation/ass	sessment of respiratory							
	system to identif	y changes associated							
		n for early intervention							
	of complications								
	-SN for urinary i	ncontinence screening							
	and intervention	; SN to provide skilled							
	teaching related	to urinary incontinence							
	management. M	lay obtain urinalysis and							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015			
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
GREAT L	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE	
	for signs and syninfection or reter-SN for observat gastrointestinal schanges associate or early intervent SN to provide sk measures to contas well as prevent complications, Schanges associated or early intervent SN to provide sk measures to contas well as prevent complications, Schange enema times removal of fecal needed. -SN to evaluate a to improve balant falls. -SN to instruct propreventive measurable ulcer risk. -SN to establish the risk of hospitalize caregiver will be care plan, and as disease managent hospitalization. -SN to provide in discharge planning the second	ion/assessment of ystem to identify ed with exacerbation of tion of complications, illed teaching regarding rol diarrhea/constipation ating related N for administration of es 3 as needed, SN for impaction times 3 as and provide interventions ce and reduce the risk of atient/caregiver on ares to reduce pressure supports to minimize ation, patient/primary instructed in emergency pects of cardiovascular ment to reduce avoidable astructions related to ng. Discharge summary is available to physician on of medication on of medication						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ľ í	JILDING	nstruction 00	(X3) DATE COMPL 11/19/	ETED		
NAME OF	PROVIDER OR SUPPLIEI	R	•		ADDRESS, CITY, STATE, ZIP CODE	•		
GREAT	LAKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	GOALS;							
	1	results obtained.						
		piratory status will be						
		eported to physician for						
		tion to minimize						
	associated risks;							
	_	n urinary incontinence;						
	1 ^	n management of urinary						
	incontinence;	0						
		of gastrointestinal disease						
	will be promptly							
		plemented to minimize						
	risks to patient.	1 1 1						
	-Patient/caregive							
		lity to manage altered						
	bowel elimination							
		ve bowel patency;						
		able to perform activities						
	1	nd individual activities of						
	1 -	decreased risk for falls;						
	1	er will demonstrate						
		es of pressure ulcer						
	prevention,							
		ve appropriate agency						
		ent rehospitalization,						
	reduced;	talizations will be						
	·	man imatemation manda vvill						
		rge instruction needs will						
		ge summary for all						
	_	able to physician upon						
	request;	or will domonstrate						
	_	er will demonstrate manage medications.						
	ability to safely	manage medications.						
	I		1				1	

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Event ID:

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Facility ID: 011284

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	UILDING	nstruction 00	(X3) DATE COMPL 11/19	ETED			
	PROVIDER OR SUPPLIER _AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE		
	Narrative section "Patient seen for supervisory visit breathing. Bilate Active bowel so Reports BM [bo morning. No ed Denies chest pai No new skin issuremains intact. I meal time. Spastimes due to Hur Patient reports medication as probetter Disch meds as ordered appointments wis symptoms of hys shortness of breafacial flushing. teaching: Ziac: side effects understanding of today." B. The Visit 9/10/15 section to Provided," stated patient/caregiver changes/adaptive pressure. Detail pressure relief in	rescribed and feels much arge teaching: Continue . Keep all follow up th physicians. Signs and pertension: chest pain, ath, heart palpitations, Fall precautions. Med reffect, dose, frequency, Patient voices f all teaching completed Note Report dated titled "Interventions d, "1. Instruct							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
THINDTERM	or condition	157586	B. W		00	11/19/	
		107000		CTD FFT A	DDDEGG CITY CTATE ZID CODE	1 17 107	2010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	l position changes at					
	least every 1-2 h						
	• •	ng schedule 4.					
	•	aregiver regarding pain					
		ement principles					
	instructed patien	_					
		pain scale using 0-10					
	•	acted regarding causes of					
	•	regarding principles of					
		t including need for					
	-	pain to enhance healing					
	and ability to cop	be with illness. Instructed					
	patient/caregiver	that pain is best					
	controlled before	e it reaches an					
	unmanageable le	vel. Instructed					
	patient/caregiver	to coordinate					
	administration of	f pain medication with					
	activities. 5. Inst	truct patient/caregiver					
	regarding pharm	acological and					
	nonpharmacolog	ic pain control measures.					
	6. Obtain pulse	oximetry for shortness of					
	breath 9. In:	struct in nutritional					
	requirements to p	promote good skin					
	integrity and hea	ling."					
	C. The SN V	isit Note Report dated					
	9/10/15 section t	itled "Goals Met," stated,					
	"1. Patient/careg	giver will verbalize					
	understanding of	instructions given					
	related to pressur	re relief and ulcer					
	_	Cardiac exacerbations are					
	•	tly and interventions					
		to minimize associated					
	risks 5. Pati						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	<u>00</u>	COMPL 11/19/	ETED		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
GREAT L	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	pain control mean oximetry comple Changes in respirit identified and reprompt intervention associated risks. gastrointestinal didentified and into minimize risks Patient/caregiver to self manage nupromote food ski Patient/caregiver instructions of farenvironmental has section for Respirespiratory system. No problems identified assessment section for Integration fo	and nonpharmacologic sures this visit. 6. Pulse ted this visit. 7. ratory status are ported to physician for ion to minimize 8. Exacerbations of isease are promptly erventions implemented at to patient. 9. will demonstrate ability attritional requirements to inintegrity 12. stated understanding of 11 preventions related to initegrity 12. stated understanding of 12 preventions related to initegrity 14 preventions related to initegrity. The assessment initified. The assessment findings: initified. The assessment initified. The infor Cardiovascular initified. The infor Cardiovascular initified. The vital signs temperature 98.7, pulse 8, and blood pressure						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157586	B. W	ING		11/19/	/2015	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
GREAT I	AKES CARING				IO, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID DEELY	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
	_ <u>_</u>	s/comments: instruct in						
	_	cluding using pillows for						
		ing skin over bony I position changes at least						
	every 1-2 hours.	-						
	1	ng schedule 4.						
	Instruct patient/c	aregiver regarding pain						
		ement principles						
		t/caregiver regarding use						
	_	ng 0-10 pain scale 5.						
		metry for shortness of struct in nutritional						
		oromote good skin						
		ling 12. Instruct						
	"	llowing prescribed diet						
	after discharge."							
		M 1						
	E. The Goals 9/10/15 were rep	Met previously on						
	_	and met again on 9/24/15						
	visit and listed as	•						
		e identified promptly and						
	interventions init							
	minimize associa	ated risks. 4.						
	_	will demonstrate ability						
		utritional requirements to						
	promote good sk	0 0						
	"	ed to notify the physician						
	to remove the M	et Goals and e POC on 9/10/15.						
	mounty/revise in	C 1 OC 011 7/10/13.						
	F. The SN V	isit Note Report dated						
	10/6/15 section t	itled "Interventions						
	Provided," stated	l, "1. Instruct						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		r í	UILDING	nstruction 00	(X3) DATE COMPL 11/19/	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	pressure. Details pressure relief in support, monitor prominences and every 1-2 hours. turning/positioni Instruct patient/c and pain manage instructed patient of pain scale usin Instructed regard Instructed regard management included management of pain ability to copatient/caregiver controlled before unmanageable le patient/caregiver administration of activities. 5. Instruct patient/caregiver administration of activities. 5. Instruct patient/caregiver administration of activities. 5. Instruct patient/caregiver assist in managir adult briefs, disp condom catheter	e equipment to elevate s/comments: instruct in cluding using pillows for ing skin over bony position changes at least Instruct in ing schedule 4. aregiver regarding pain ment principles t/caregiver regarding use ing 0-10 pain scale. ing causes of pain. ing principles of pain auding need for pain to enhance healing be with illness. Instructed that pain is best it reaches an invel. Instructed to coordinate a pain medication with the ruct patient/caregiver regarding ce incidence of urinary Instruct regarding measures to a gurinary incontinence-osable underpads,							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED		
		157586	B. W	ING		11/19/	2015	
NAME OF I	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
		•	3115 S WEBSTER ST					
GREAT I	_AKES CARING			KOKOM	1O, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG	-	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	10/6/15 section titled "Goals Met," previously on 9/24/15 were repeated as							
		•						
	_	ed on and met again on						
		l listed as: stated, "1.						
	Patient/caregiver							
	_	f instructions given						
	•	re relief and ulcer						
	^	Cardiac exacerbations are						
		otly and interventions						
		to minimize associated						
	risks 5. Pati	_						
	demonstrate und	· ·						
	-	and nonpharmacologic						
	pain control mea	sures this visit. 6.						
	Changes in respi	ratory status are						
	identified and re	ported to physician for						
	prompt intervent	tion to minimize						
	associated risks.	7. Instruct						
	patient/caregiver	regarding measures to						
	reduce incidence	e of urinary incontinence.						
	8. Instruction re	garding urinary						
	incontinence cor	mpleted for this episode.						
	9. Exacerbation	s of gastrointestinal						
	disease are prom	ptly identified and						
	interventions im	plemented to minimize						
	risks to patient.	19. Patient/caregiver						
	stated understand	ding of instructions of						
	fall preventions	related to environmental						
	hazards." The assessment section for							
	Respiratory state	ed, "Was respiratory						
	system assessed							
	respiratory asses	sment findings: No						
		ied." The assessment						
	_	iovascular stated, "No						
	I.							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL				
		157586	B. W	ING		11/19/	2015		
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE				
			3115 S WEBSTER ST						
	AKES CARING			<u> </u>	1O, IN 46902				
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE		
	problems identifi	ied." The agency failed							
	to notify the phy	sician for a need to							
	remove met goal	s and update POC.							
		ecertificaation Outcome							
	Assessment and								
	(OASIS)Visit No	•							
		titled "Interventions							
	Provided," stated								
	patient/caregiver	•							
		e equipment to elevate							
	•	s/comments: instruct in							
	•	cluding using pillows for							
		ing skin over bony							
	-	position changes at least							
	every 1-2 hours.	ng schedule 4.							
	• •	aregiver regarding pain							
	•	ment principles							
		t/caregiver regarding use							
	•	ng 0-10 pain scale.							
	_	ling causes of pain.							
	_	ing principles of pain							
		luding need for							
		pain to enhance healing							
	-	be with illness. Instructed							
	patient/caregiver	that pain is best							
	controlled before	e it reaches an							
	unmanageable le	vel. Instructed							
	patient/caregiver	to coordinate							
	administration of	f pain medication with							
	activities. 5. Inst	truct patient/caregiver							
	regarding pharm	_							
	nonpharmacolog	ic pain control measures.							

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	ľ í	UILDING	onstruction 00	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER LAKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	incontinence & S [culture and Instruct patient/c causes and comp constipation/diar nutritional requires skin integrity and Note Report sect "Integumentary/problems identified. I. The SN Revisit Note Report titled "Goals Mewere repeated as and met again on as: stated, "1. Paverbalize underst given related to prevention. 2. Cidentified prompinitiated quickly risks 5. Patidemonstrate under pharmacological pain control mea Changes in respindentified and reprompt intervent associated risks. gastrointestinal dispersions.	rhea 10. Instruct in rement to promote good defined." The Visit ion titled Wound" stated, "No ied." eccertification OASIS at dated 10/26/15 section to the control of							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	IULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W		<u> </u>	11/19/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R	3115 S WEBSTER ST				
GREAT I	LAKES CARING			KOKON	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
	- The assessme						
	system assessed	ed, "Was respiratory					
	1 *	sment findings: No					
		ied." The assessment					
	•	ovascular stated, "No					
		ied." The agency failed					
	^	sician for a need to					
		sicial for a fieed to					
	Temove met gour	is and apaute 1 oc.					
	J. The SN Re	ecertification OASIS					
	Visit Note Repor	rt dated 10/26/15					
	narrative section	stated, "Patient					
	recertified this v	isit nursing not need at					
	this time patient	to continue with PT at					
	this time." The	record failed to evidence					
	the patient was d	lischarged from SN					
	services.						
	3. The agency's	policy titled "Care					
		reviewed March 2015					
	stated, "1. Follo	wing the initial					
	assessment, a Ca	re Plan shall be					
	developed with t	the client and/or					
	caregiver. The i	nterventions shall					
	correspond to the	e problems identified,					
	services needed	and the client goals for					
	the episode of ca	are. 2. The Care Plan					
		d, evaluated, and revised					
	(minimally every	y sixty (60) days and as					
		oon the client's health					
		vironment, ongoing client					
		egiver support systems,					
	and the effective	eness of the interventions					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO UILDING	NSTRUCTION 00	COMPL			
		157586	B. W	ING		11/19/	2015	
NAME OF I	PROVIDER OR SUPPLIER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
GREAT I	AKES CARING				10, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	changes will be dappropriate staff Plan shall includ a. Problems and to diagnosis. b. and realistic goal assessment and colist of specific in for implementating measuring goals identified time find Plan of Care may specific interventidentified for hor client care needs. 4. The agency's "Coordination of C-360, reviewed "Purpose To quality care is be To modify the changed identified ream and avoid to the care Special Interdisciplinary conducted as offer respond to change services, care, or initial assessment Registered Nurse	policy titled Client Services," # March 2015 stated, ensure appropriate, sing provided to clients. e plan to reflect needs or ed by members of the duplication of services. s to modify the plan of Instructions 2. care conferences shall be en as necessary to ges in the client's needs, a goals. 3. After the t the admitting						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		Ĺ	JILDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
GREAT I	AKES CARING				WEBSTER ST 1O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	ensure: a. Clarificare orders diskilled nursing caservices and/or resources 7. Manager or Clinicassume responsibility updating/changing communicating of within 24 hours for changes. The contacted when he change is necessare physician to charman. 9. GLC will insystem to assure departments are in plan and/or need. 5. The agency's provided to the plan and plan and plan and plan and plan. d. Provided specialized nursing the physician and changes in the clinical services. The Licensis in the clinical services and necessary services and necessary services of Care and necessary s	cal Supervisor will polity for ag the Care Plan and changes to caregivers collowing the conference physician will be ais/her approval for that ary and to alert the ages in client condition. dentify a communication that all disciplines and anformed of changes to for modification." colicy titled "Skilled a," # C-200, reviewed ad, "1. The Registered egularly reevaluates the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		i '	ILDING	instruction 00	(X3) DATE : COMPL 11/19/	ETED	
	ROVIDER OR SUPPLIER			3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	(X5) COMPLETION DATE
G 0173 Bldg. 00	members of the trecoordination and changes or needs activities in the hinclude: observate teaching and train Management and plan and routine procedures." 484.30(a) DUTIES OF THE IT The registered nurcare and necessar Based on record to ensure the admirevisions to the protify the physic the plan of care precords reviewed. Findings include 1. The clinical rewas reviewed on care date was 9/2	timely response to client 3. Skilled nursing ome care setting may tion and assessment, ning activities. I evaluation of the care and complex skilled REGISTERED NURSE rese initiates the plan of ry revisions. review, the agency failed nitting nurse initiated plan of care, and failed to ian of the need to alter pain goal for 1 of 20 l. (# 10)	G 01	173	G173 To assure compliance with 484.30(a), Duties of the Registered Nurse, the following interventions were implemented education by 12/24/15 on Polic C-200 Skilled nursing services with a focus on the requirement of the RN to provide ongoing assessment and update of the plan of care. This includes physician notification of goals are the uncontrolled pain, or other changes in patient condition. A interventions must be applicable.	ed: cy nt not er	12/24/2015

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILI B. WING	DING	00	(X3) DATE COMPL 11/19/	ETED
AND PLAN	SUMMARY ST. (EACH DEFICIENCY AFTER THE PROVIDER OR SUPPLIER AKES CARING SUMMARY ST. (EACH DEFICIENCY OR Aftercare follow for SN 1 time a variety a week for 2 week for 7 weeks, 3 as gastrointestinal/g cardiac, impaired and functional deteaching and intervolution wound incision of Keep clean and or air if no drainage -Observation and system to identify with exacerbation of complications of gastrointestinal changes associated or early intervent -Evaluate patient care to be counted -Observation/assisty system to identify with exacerbation of complications -Provide instruction planning. Dischalation of complications -Provide instruction -Provide -Prov	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Ing Surgery, with orders week for 1 week, 2 times eks, then 1 times a week needed for falls, pain, gastrourinary, respiratory, diskin integrity, diabetes, ecline. Need for skilled ervention related to ervical spine incision. Iry. May leave open to enoted. SN for: diassessment of cardiac ey changes associated in for early intervention gobservation/assessment all system to identify ed with exacerbation of tion of complications; and develop plan of er signed by physician; essment of respiratory ey changes associated in for early intervention going related to discharge arge summary for all able to physician upon and provide assistance to estanding and elelings. SN may	A. BUILI B. WING	DING STREET A		the ure to of the til	ETED
		n anxiety scale and/or n;					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	00	COMPL			
		157586	B. W	ING		11/19	/2015	
NAME OF E	PROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
			3115 S WEBSTER ST					
	AKES CARING			<u> </u>	1O, IN 46902			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
		cement of management of						
	_	ding disease process,						
	-	agement, coping skills						
		nges associated with						
	depressive disord	_						
	•	may perform geriatric						
		and/or mini mental						
	exam;							
	-Provide teachin	g/reinforcement in						
	etiology of confu							
	cognition, safety	measures and home						
	_	servation and assessment						
	of pain, effective	eness of pain						
	_	l regimen and skilled						
	_	to pain management, SN						
	to report increase	e in pain level to						
	physician for pro	ompt intervention;						
	-Skilled teaching	g and training of						
	emergency care	plan, disease process						
	including self ma	anagement of						
	cardiovascular h	ypertension disease;						
	-SN to obtain pu	le oximetry						
	measurement tin	nes 3 as needed for						
	shortness of brea	th, oxygen use, activity						
	intolerance;							
	-SN for instruction	on/reinforcement of						
	gastrointestinal s	system related teaching,						
	including diverti	culitis and irritable						
	bowel syndrome	(IBS);						
	-SN to provide s	killed teaching regarding						
	measures to cont	rol diarrhea/constipation						
	as well as prever	nting related						
	complications; sl	killed teaching and						
	training of emerg	gency care plan, disease						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ſ ′	JILDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST 1O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	self management -SN to provide as teaching/reinforce diabetes includin medication mana and identify char diabetes for early perform blood gl for signs and syn hyper/hypoglyce testing. SN ass f diabetes mellitus -SN observation integumentary st skin integrity; -SN to instruct pa and symptoms of cervical spine su complications to -SN to establish s risk of hospitaliz will be instructed and aspects of ce disease managen hospitalization; -Skilled instructi regimen to identi changes/complic intervention; -SN to provide in balance and redu -SN to instruct po	g disease process, agement, coping skills ages associated with a intervention. SN may ucose level as needed aptoms of mia or for baseline are and reinforce foot care; and reaching atus to promote optimum atient/caregiver on signs at infection related to tures to reduce the wound; supports to minimize ation patient/caregiver din emergency care plan, arvical spine surgery ment to reduce avoidable on of medication afy					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF F	PROVIDER OR SUPPLIER				NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	signs falling outs established parar 101, Pulse < 50 2 > 29, Systolic blood p fasting blood sug- saturation < 88. GOALS: Assoc discharge instruc- discharge summa available to phys symptoms of any interventions ini- manage feelings -Patient/caregive						
	the episode and	depression by the end of symptoms are identified maintain patient safety in					
	the home; Patien	•					
	confusion and m the home;	aintain patient safety in					
	activity; -Pain controlled a level acceptabl -Patient/caregive understanding of nonpharmacolog						
	manage cardiova	scular hypertension					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF F	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	burden associated pulse oximetry re-Patient/caregiver ability to self madisease process; -Patient/caregiver demonstrate ability bowel elimination bowel patency; -Demonstrated all neurologic disease caregiver burden process, improves symptoms of neurologic disease	r will demonstrate nage gastrointestinal r verbalize and ity to manage altered n. Patient will have bility to self manage se process and reduce associated with disease ment in signs and prologic disease; r will verbalize erstanding the diabetes by the end of the ptoms are identified and attain patient safely in the mprovement in existing arly identification and dditional compromises ations avoided; entary status will enced by a decrease in f wound/decub by end e appropriate agency ent rehospitalization,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE (A. BUILDING B. WING	OONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 11/19/2015				
	PROVIDER OR SUPPLIEF _AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	ability to safely patient will be all of daily living and daily living with -Patient/caregive proper technique prevention.	er will demonstrate manage medications; ble to perform activities and individual activities of decreased risk for falls; er will demonstrate es of pressure ulcer						
	Report dated as stated "[Spouse lowest patient's pain scale. Curr Dilaudid 2 millig The agency failed "Pain controlled a level acceptable revised; failed to was notified of gunobtainable goon the plan of ca coordinate with	ient Coordination Note late entry for 9/26/15 of patient] states the pain ever gets is a # 8 on ently patient takes grams tablets for pain." ed to ensure the goal of at level of 3 or less or at lee to the patient" was o ensure the physician goals being met and of als needing to be changed are; and failed to nursing staff to ensure education on goals met						
	B. The start of dated 9/26/15 start of Conditions prior regimen change the past 14 days. The Pain assessing	of care assessment form						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			UILDING	onstruction 00	(X3) DATE COMPL 11/19	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	Movement. Whe Always in Pain. pain last? Const relieved? No." "Endocrine/Hem" "Indicate endocr assessment (mar Diabetes, thyroid patient taking in patient taking and How frequent ar Not checked very patient's usual ble Below 130." C. The section Coordination structure of the communicated with involved in this ediscipline did you Physician, Carege Supervisor. Indicontacted: Was physician for application of care: No. Indicontacted: No. Indicontact	I problems Is the sulin? No Is the antidiabetic agent? Yes. e blood sugars check? y often. What are the ood sugar readings? In titled "Care ated "Indicate if you with other disciplines case: YES. What u communicate with? giver(s), Clinical cate reason physician not Contacted. Contacted proval of proposed plan icate reason physician lot in on weekends." In d'Goals Met" stated: "3. It verbalizes basic stion requirements." The to evidence the SN g/reinforcement of						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			ILDING	<u>00</u>	COMPL 11/19/	ETED		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
GREAT L	AKES CARING				1O, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	Nursing Services March 2015 state Nurse: b. Re client needs, and necessary service of Care and nece updates to the pla plan. d. Provide specialized nursi the physician and changes in the cl 2. The Licens d. Reports findir the registered nur members of the t coordination and client changes or nursing activities may include: ob assessment, teach activities. Manage	es. c. Initiates the Plan ssary revisions and an of care and the care es services requiring ng skill e. Informs d other personnel of ient condition and needs. sed Practical Nurse: ngs and observation to rse, physician and other eam to assure timely response to rneeds 3. Skilled in the home care setting servation and ning and training gement and evaluation of a routine and complex						
G 0174		REGISTERED NURSE						
Bldg. 00	services requiring specialized nursing							
		review, and interview,	G 0	174	G 174 To assure compliance with		12/24/2015	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		157586	B. W	ING		11/19/	2015
		l .		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
GREAT I	_AKES CARING				//O, IN 46902		
		TATEMENT OF DEFICIENCIES	<u> </u>		I	1	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	TE	DATE
IAG		· · · · · · · · · · · · · · · · · · ·		IAG	484.30(a), Duties of the		DATE
		d to ensure the nursing			Registered Nurse, the followin	a l	
	<u>-</u>	measured the Peripherally			interventions were implemente	•	
		Catheter (PICC) line for			All LPN and RN staff		
	1 of 1 record rev	viewed of patients			received education by 12/24/1	5,	
	receiving PICC	line care. (# 3)			that included hands on		
					demonstration check offs in a	_	
	Findings include	: :			skills lab by RN staff educators The education included review		
	_				PICC line procedures, physicia		
	1. The clinical r	record of patient # 3, start			notification of abnormal		
		23/15, contained a plan of			assessment, documentation		
		d 10/23/-12/21/15 with			review, as well as return		
	` ′				demonstration of skills includir	ng	
		d Nursing (SN) 1 time a			measurement of PICC line.		
		z, 2 times a week for 8			•====== A PICC		
	· ·	ne a week for 1 week,			measurement service code wa	as I	
		l visits for cardiac,			created in the electronic medic		
	respiratory, gast				record software on 12/14/15 to		
	gastrourinary, no	eurologic, endocrine,			prompt clinicians to complete		
	mental, pain, ski	in/wound status changes,			PICC measurement at their vis	sits.	
	and falls. SN fo	r: Instruct on			An audit will be performed by t	he	
	lab/venipuncture	e procedure, obtain lab			administrator or designee to		
	results and repor	rt to physician. SN to			assure compliance with G 174	of	
	obtain Vancomy	cin trough week of			100% of all patients with a PIC		
		MP [basic metabolic			line until 100% compliance is r		
		eekly until instructed			for 4 consecutive weeks. Afte	r 4	
	_	N to change PICC			consecutive weeks of 100% compliance the audit will		
		terile technique every			decrease to 10% quarterly and	₃	
		ded times 3 for soiled or			will be completed through the		
		ded times 3 for softed of			clinical record review process.		
	loose dressing.				(Exhibit 6)		
	A TEST A						
		of care assessment form					
	dated 10/23/15 b	3 1 3					
	_	e (RN) stated, "Indicate					
		ed PICC catheter from					
	insertion site to	catheter hub in					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT I	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	centimeters: 10.	0."					
	B. The SN V 10/26/15 by emp Practical Nurse (dressing dislodg changed using as draw obtained via aseptic technique evidence the LPI line and failed to changed the drestechnique. C. The SN V 10/30/15 by emplength of expose insertion site to occur imeters: 11. evidence the phythe 1 centimeter the PICC line. D. The SN V by employee E, Nursing assessming assessming peak draw from technique." A C Report dated 11/stated, "Patient right dressing changed dislodgement. P	risit Note Report dated bloyee U, Licensed (LPN) stated, "PICC line ed. PICC line dressing septic technique Lab and PICC line using e." The record failed to N measured the PICC of evidence the nurse ssing using sterile. Tisit Report dated bloyee G stated, "Indicate dd PICC catheter from					
		evidence the PICC line					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	ILDING	nstruction 00	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		•	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	was measured du change.	uring the dressing					
	11/6/15 by employer PICC Catheter Solution Indicate length of from insertion sincentimeters: 11. evidence the physical three redness at the F. The SN V 11/13/15 by employer Indicate length catheter from insolution in centimeter failed to evidence notified of the 3 measurement. 2. During interve PM, the Administration of the Administration of the Administration of the nurse that at 3 centimeters said she measures showing under in that the PICC limits and the second of the PICC limits and the second of the PICC limits and the piccolor of	fisit Note Report dated oyee G stated, "Indicate dite Assessment: Red of exposed PICC catheter te to catheter hub in 0." The record failed to visician was notified of the PICC catheter site. This is the Note Report dated bloyee V, LPN stated, of exposed PICC sertion site to catheter the physician was centimeter PICC the sertion was centimeter PICC. The record the physician was centimeter PICC the should be sterile. The won 11/16/15 at 3:00 strator stated PICC is should be sterile. The won 11/17/15 at 10:05 strator stated she talked measured the PICC line on 11/13 and the nurse and only what was the strate in place.					
	4. The agency's	undated policy titled					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTI A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPL 11/19/	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
G 0176	Lines," # I-230 s Migration: It is possible to cate another location Certain types of susceptible to cate Clients who are response: Mease external length of dressing change detection. Period verification by a performed on all placed catheters. 5. The agency's "PICC Line Dress stated, "PICC line use Strict Aseptimasses of the procedure in the placed gloves Document in the central procedure in the procedure	theter tip migration very active ure and document the f the catheter with each This will assist in early dic catheter tip -ray study should be long-term, centrally " undated policy titled ssing Change," # I-240 e dressing changes will c Technique Note length of 11. Don sterile mentation Guidelines 1. clinical record: d. er visible at exit site. e.					
Bldg. 00	DUTIES OF THE I The registered nui progress notes, co informs the physic	REGISTERED NURSE rese prepares clinical and coordinates services, ian and other personnel of tient's condition and					
		review, and interview,	G 0176		G176 To assure compliance with		12/24/2015

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Event ID:

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Facility ID: 011284

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		157586	B. W	ING		11/19/2015
NAME OF F	AND CAMPED ON CAMPAGE		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF F	PROVIDER OR SUPPLIE	· ·		3115 S	WEBSTER ST	
GREAT L	AKES CARING			KOKON	ЛО, IN 46902	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	"	d to ensure the nurses			484.30(a), Duties of the Registered Nurse, the followin	g .
	notified the physician of changes in				interventions were implemented	•
	Peripherally Inso	erted Central Catheter			· All LPN and RN staff	
	(PICC) length for	or 1 of 1 patient records			received education by 12/24/1	5,
	reviewed receiv	ing PICC line care (# 3),			that included hands on	
	and failed to me	asure wounds weekly for			demonstration check offs in a	
		eceiving wound care (#			skills lab by RN staff educator	
	4).	secrying wound care ("			The education included review PICC line procedures, physicial	
	T).				notification of abnormal	an
	Din din an in alard				assessment, documentation	
	Findings include	ð.			review, as well as return	
					demonstration of skills includir	ng
		record of patient # 3, start			measurement of PICC line.	
	of care date 10/2	23/15, contained a plan of				
	care (POC) date	d 10/23/-12/21/15 with			•aaaaaa A PICC	
	orders for Skille	d Nursing (SN) 1 time a			measurement service code wa	
	week for 1 week	z, 2 times a week for 8			created in the electronic medic record software on 12/14/15 to	
		ne a week for 1 week,			prompt clinicians to complete	
		l visits for cardiac,			PICC measurement at their vis	
	respiratory, gast	·				
	1 2.0	· ·			• and an All skilled nursing	
	-	eurologic, endocrine,			staff received education on	
	-	in/wound status changes,			documentation requirements f	
		r: Instruct on			wound care, as well as hands	
		e procedure, obtain lab			competency checks in a skills for wound care, and infection	lab
	results and report	rt to physician. SN to			control with wound care, by ar	1
	obtain Vancomy	cin trough week of			RN preceptor by 12/24/15.	
	10/26/15 and BN	MP [basic metabolic				
		eekly until instructed				
		N to change PICC			An audit will be performed by	the
		terile technique every			administrator or designee to	of
	1	eded times 3 for soiled or			assure compliance with G 176 100% of all patients with a PIC	
		aca tillies 5 for solica of			line until 100% compliance is	
	loose dressing.				for 4 consecutive weeks. Afte	
					consecutive weeks of 100%	
		of care assessment form			compliance the audit will	. [
	dated 10/23/15 b	by employee G,			decrease to 10% quarterly and	d

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			COMPLETED
		157586	B. W	ING		11/19/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8			WEBSTER ST	
GREAT I	_AKES CARING				ло, IN 46902	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	DEFICIENCIES ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	_	e (RN) stated, "Indicate			will be completed through the	
	length of expose	ed PICC catheter from			clinical record review process. (Exhibit 6)	
	insertion site to	catheter hub in			(EXHIBIT 0)	
	centimeters: 10	.0."				
					An audit will be performed by	
	B. The SN V	isit Report dated			administrator/designee to assu	
		ployee G stated, "Indicate			compliance with G 176 of 100	%
		ed PICC catheter from			of wound visits to ensure measurements q week, as we	ll ac
	insertion site to				detailed orders and complete	11 43
		.0." The record failed to			documentation of wound care	
					provided until 100% compliand	ce
		ysician was notified of			is met for 4 consecutive weeks	S.
		longer measurement of			After 4 weeks of 100%	
	the PICC line.				compliance the audit will	.
					decrease to 10% quarterly and will be completed through the	1
	2. During interv	view on 11/17/15 at 10:05			clinical record review process.	
	AM, the Admini	strator stated she talked			(Exhibit 11)	
	to the nurse that	measured the PICC line				
	at 3 centimeters	on 11/13 and the nurse				
	said she measure	ed only what was				
		neath the dressing, and				
	_	ne is sutured in place.				
		ie is sutured in place.				
	3. The clinical r	record for patient # 4 was				
	reviewed on 11/	17/15. The start of care				
	date was 9/20/15	5. The POC dated				
		ontained orders for SN 6				
		1 week, 7 times a week				
		nes a week for 1 week,				
		eek for 6 weeks, with 3 as				
	needed visits for	-				
	respiratory/cardi					
	_	nental status changes.				
		and intervention related				
	to wounds. Area	a to ball of left foot				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 11/19		
	OF PROVIDER OR SUPPLIED	3	3115 S	ADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST MO, IN 46902	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	betadine and let right upper arm cleanser, apply so lightly moistened gauze. Area to a wound cleanser, lightly moistened dry gauze. A. The Wound Report dated 9/2 evidence the Uphip, and Left Barmeasured the word 10/4-10/10, and 4. During interval, AM, the Admin see any docume measurements do 5. The agency's "Responding to Lines," # I-230 so Migration: It is central venous of another location Certain types of susceptible to care Clients who are Response: Mea external length of the word of the susceptible to care the susceptible	view on 11/17/15 at 11:45 istrator stated she did not intation of wound uring those weeks. undated policy titled Complications of PICC stated, "Catheter Tip possible for any type of atheter to migrate to while in the body. I clients are more utheter tip migration				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	_	ray study should be long-term, centrally					
	"PICC Line Dresstated, "PICC linuse Strict Asepti Procedure 9. catheter exposed gloves Docu Document in the	Note length of 11. Don sterile 1. dinical record: d. er visible at exit site. e.					
	revised 12/18/14 present measure	policy titled Skin Integrity," # G-095, stated, "If a wound is ments will occur at least ne patient is being seen					
G 0179 Bldg. 00	NURSE The licensed practices in accord Based on record the agency failed Practical Nurse (Peripherally Inse (PICC) Line political	tical nurse furnishes ance with agency policy. review and interview, I to ensure the Licensed (LPN) followed erted Central Catheter icies and procedures for hanging PICC dressings	G 0179	G 179 To assure compliance with 484.30(b), Duties of the Registered Nurse, the following interventions were implement. All LPN and RN staff	red:		
	(PICC) Line polimeasuring and c	icies and procedures for		interventions were implement	red:		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		157586	B. W	NG		11/19/2015	
				CTD FFT A	ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
ODEATI	AKEO OADINO				WEBSTER ST		
GREAT	AKES CARING			KOKON	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	line care. (# 3)				demonstration check offs in a		
	,				skills lab by RN staff educators		
	Eindings include				The education included review		
	Findings include:				PICC line procedures, physicia	an	
					notification of abnormal		
		record of patient #3, start			assessment, documentation		
	of care date 10/2	23/15, contained a plan of			review, as well as return demonstration of skills includir	ng	
	care (POC) date	d 10/23/-12/21/15 with			measurement of PICC line.	'Y	
	` ,	d Nursing (SN) 1 time a			measurement of Fioo line.		
		x, 2 times a week for 8			•===== A PICC		
		me a week for 1 week,			measurement service code wa	as I	
	*	· · · · · · · · · · · · · · · · · · ·			created in the electronic medic		
		l visits for cardiac,			record software on 12/14/15 to		
	respiratory, gasti	rointestinal,			prompt clinicians to complete	a	
	gastrourinary, ne	eurologic, endocrine,			PICC measurement at their vis	sits.	
	mental, pain, ski	in/wound status changes,					
	and falls SN fo	r: Instruct on			An audit will be performed by t		
		e procedure, obtain lab			administrator/ designee to ass		
	•				compliance with G 179 of 100		
	_	rt to physician. SN to			of all patients with a PICC line until 100% compliance is met		
	_	cin trough week of			4 consecutive weeks. After 4	ioi	
	10/26/15 and BN	MP [basic metabolic			consecutive weeks of 100%		
	profile] twice we	eekly until instructed			compliance the audit will		
	otherwise Si	N to change PICC			decrease to 10% quarterly and	t l	
		terile technique every			will be completed through the		
		ded times 3 for soiled or			clinical record review process.		
		ded times 3 for solice of			(Exhibit 6)		
	loose dressing.						
		of care assessment form					
	dated 10/23/15 b	by employee G,					
	Registered Nurs	e (RN) stated, "Indicate					
	_	ed PICC catheter from					
	insertion site to						
	centimeters: 10.						
	cenumeters: 10.	.U.					
	B. The SN V	isit Note Report dated					
	10/26/15 by emp	ployee U, Licensed					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	CON	TE SURVEY MPLETED 19/2015
	PROVIDER OR SUPPLIEF	2	3115 S	ADDRESS, CITY, STATE, ZIP CO WEBSTER ST MO, IN 46902	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	dressing dislodg changed using as draw obtained vaseptic technique evidence the LP line and failed to changed the drestechnique. C. The SN Vaseption by the property of the change of the technique. C. The SN Vaseption of the change of the technique of the change D. The SN Vaseption of the change of the cha	(LPN) stated, "PICC line ed. PICC line dressing septic technique Lab ia PICC line using e." The record failed to N measured the PICC of evidence the nurse ssing using sterile Visit Note dated 11/3/15 LPN stated, "Skilled ment completed for Vanco PICC line using clean care Coordination Note (3/15 by employee E requesting PICC line during visit due to PICC line dressing terile technique." The evidence the PICC line uring the dressing Visit Note Report dated ployee V, LPN stated, of exposed PICC sertion site to catheter ers: 3.0." The record see the physician was centimeter PICC				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	IULTIPLE CO. UILDING	NSTRUCTION	COMPL		
ANDILAN	OF CORRECTION	157586	B. W		00	11/19	
		137300	J. ,,			11/19/	72013
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
GREATI	_AKES CARING				WEBSTER ST 10, IN 46902		
	1	TATEMENT OF DEFICIENCIES		<u> </u>			(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
		strator stated PICC					
	· ·	s should be sterile.					
		s should be sterne.					
	3 During interv	view on 11/17/15 at 10:05					
	_	istrator stated she talked					
		measured the PICC line					
		on 11/13 and the nurse					
		ed only what was					
		neath the dressing, and					
	_	ne is sutured in place.					
	that the Tree in	ie is sutured in place.					
	4 The agency's	undated policy titled					
		Complications of PICC					
		stated, "Catheter Tip					
	· ·	possible for any type of					
	1	atheter to migrate to					
		while in the body.					
	Certain types of	-					
	. –	theter tip migration					
	Clients who are						
		sure and document the					
	_	of the catheter with each					
		. This will assist in early					
	detection. Perio	_					
		a-ray study should be					
	1	l long-term, centrally					
	placed catheters.						
	placea cumeters.	•					
	5. The agency's	undated policy titled					
		ssing Change," # I-240					
		ne dressing changes will					
	use Strict Asepti						
	_	Note length of					
		l 11. Don sterile					
	cameter exposed	i II. Don steine					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUILDING B. WING		JILDING	00 COMPLETED 11/19/2015		ETED		
	ROVIDER OR SUPPLIER			3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENCE REGULATORY OR gloves Docu	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) mentation Guidelines 1. clinical record: d.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
		er visible at exit site. e.					
G 0202	484.36 HOME HEALTH A	IDE SERVICES					
Bldg. 00	the agency failed aide (HHA)skills included bathing Health Aide files ensure the filed sincluded transfer 2 of 5 files review an arrangement of the acquired agenservices to 1 of 7 services listed or census (See G 21 skills competence Aides included hith the skills bathing motion for 3 of failed to ensure the acquired agenoragreement to provide the acquired agenoragreement to provide a files review the acquired agenoragreement to provide a files for 4 of 73 patier on the South Ber	review and interview, to ensure home health competency checks patients for 4 of 5 Home reviewed; failed to kills competencies and range of motion for wed; and failed to ensure or agreement existed for ney to provide HHA 3 patients with HHA the South Bend branch 2); failed to ensure the y of the Home Health ands-on supervision of g, transfers, and range of 5 HHA files reviewed; the field skills 2 of 5 Home Health ed; and failed to ensure ney had an arrangement provide HHA services ats HHA services, listed and branch census (See G sure the home health	G 0.	202	G 202 To assure compliance with 484.36, Home Health Aide Services, the following interventions have been implemented: G 212 G 212 G 215 G 216 G 217 G 217 G 217 G 218 G 218 G 218 G 219 G 219 G 2016 G 219 G 2017 G 2017 G 2018 G 2018 G 2019 G 2018 G 2019 G 20	ent ncy ne C uch d	12/24/2015
	, ·	aide plan of care and			checks included bathing patier	nt,	

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPLI 11/19/3	ETED
	OF PROVIDER OR SUPPLIE	R	•	3115 S \	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) II PREFI TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	reported vital signs for 2 of 9 record HHA services (from the Health for 3 of 9 record HHA services where the Home Health for 3 of 9 record HHA services where the parent or brasupervision ever records reviewed from the acquired The cumulative problems resulted.	gns to the registered nurse ds reviewed receiving See G 225); and failed to stered Nurse supervised h Aides every two weeks ds reviewed receiving with a skilled service for eeks, and failed to ensure each provided HHA ry 2 weeks for 1 of 1 d receiving HHA services ed agency (See G 229). effect of these systemic ed in the home health by to ensure the provision		TAG	transfer and range of motion a well as all other required skills b. On December 22, 2015 of Competency Based Skills Checklist for home health aide was revised to include how an where the skill was performed that the skill was performed or patient, the employee who observed these skills as well at the signature of home health aide. The revised Competency Based Skills Checklist will be used for all Home Health Aide hired on or after December 21 2015. An audit will be performed by administrator/designee to assic compliance with G 212 of 100 of all new home health aides hired on or after December 21 2015 to ensure Competency Based Skills Checklist is completed prior to home health aide seeing patient independently. Audit will contiuntil 100% compliance is maintained for 4 consecutive weeks. After 4 weeks of 100% compliance audit will decrease 10% quarterly and will be completed by Human Resource (Exhibit 5) G 218 G 218 G 218 G 218 G 218 G 218	the es d as / s , the ere % , the inue % et to ees.	DATE

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015		
	ROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
				requirements in compliance of 484.36(b)(3)(iii): c. Beginning September 2015 the skills competency checks included bathing patiet transfer and range of motion well as all other required skills. d. On December 22, 2015 Competency Based Skills. Checklist for home health aid was revised to include how a where the skill was performed that the signature of home health aide. The revised Competence Based Skills Checklist will be used for all Home Health Aid hired on or after December 2 2015. An audit will be performed by administrator/designee to assocompliance with G 218 of 100 of all new home health aides hired on or after December 2 2015 to ensure Competency Based Skills Checklist is completed prior to home heal aide seeing patient independently. Audit will con until 100% compliance is maintained for 4 consecutive weeks. After 4 weeks of 100 compliance audit will decreas 10% quarterly and will be completed by Human Resour (Exhibit 5) G 225	21, ent, as s. the les es es end don a les es e		

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING STREET ADDRESS CITY STATE ZIP CODE		COMPLETED 11/19/2015	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING			MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				• • • • • • • • • • • • • • • • • • •	wital the sure % is d the nt ncy ne	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		(X3) DATE SURVEY COMPLETED	
		157586	B. WING		11/19/2015
	ROVIDER OR SUPPLIER		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEPICIENCY)	(X5) COMPLETION DATE
				provide the agency services so as PT, OT, SLP, SN, MSW an HHA	
				training by 12/24/15 on Home Health Aide Supervisory visits with review of policy C-340 Ho Health Aide Supervision.	
				An audit will be performed by administrator/ designee to ass compliance with G 229 of 100 of patients receiving HHA services to ensure HHA supervisory visits are complete as outlined in policy C-340 unt 100% compliance is maintaine for 4 consecutive weeks. Afte weeks of 100% compliance the audit will decrease to 10% quarterly and will be complete through the clinical record reviprocess. (Exhibit 18)	ure % ed cill ed r 4 e
G 0212 Bldg. 00	individuals who fu services on its bel				
	the agency failed aide (HHA) skill included bathing	review, and interview, It to ensure home health Its competency checks Its patients for 4 of 5 Home Its patients for 4 of 5 Home Its patients for 4 of 5 Home	G 0212	G 212 To assure compliance with 484.36(b)(1), the following interventions have been implemented:	12/22/2015
	N, and P); failed	to ensure the filed skills cluded transfer and range		• 2015, a contractual arrangement was secured between the age	ent

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			WEBSTER ST		
CDEATI	_AKES CARING				10, IN 46902		
					10, 111 40902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	of motion (ROM				referred to as Community Hon Health Network of Indiana, LL		
	reviewed (I and	N); and failed to ensure			dba Great Lakes Caring CCN	,	
	an arrangement or agreement existed for				157586 (agency) and the		
	the acquired agency to provide HHA				acquired agency of AC and		
	services to 1 of '	73 patients with HHA			Associates dba Great Lakes		
	services listed or	n the South Bend branch			Caring(acquired agency) to		
	census (# 16).				provide the agency services si		
					as PT, OT, SLP, SN, MSW an HHA	a	
	Findings include	••					
	1 manigs merade	··			•□□□□□□□ To ensure the		
	1 Domin a intam	.i 11/10/15 at 1.25			individuals who furnish home		
	_	riew on 11/19/15 at 1:35			health aide services on its beh	alf	
		, the Registered Nurse			meet the competency evaluati		
	. ,	stated the agency does			requirements in compliance wi	th	
		for the HHAs on site at			484.36(b)(1):		
	the parent office	using a mannequin for			a. Beginning September 2	1	
	on-boarding, and	d includes performing a			2015 the skills competency	• ,	
	bed bath and a d	iscussion of shower and			checks included bathing patier	nt,	
	sponge bathing,	and the next day is spent			transfer and range of motion a		
	in the field with	a RN for the HHA to be			well as all other required skills		
	checked off. En	nployee T stated the RN			b. On December 22, 2015 t	·ho	
		copy of the check list to			Competency Based Skills	.110	
		to go over with the aides.			Checklist for home health aide	s	
	00 1110 1110 11010	and the second s			was revised to include how an	d	
	2 During interv	riew on 11/19/15 at 2:00			where the skill was performed		
	1	stated the agency does			that the skill was performed or	ı a	
					patient, the employee who observed these skills as well a	e	
		npetency check off sheets			the signature of home health	.5	
	_	s-on in the field for			aide. The revised Competency	,	
		N and P due to a process			Based Skills Checklist will be		
	change of assess	ing skills out in the field.			used for all Home Health Aide		
					hired on or after December 21	,	
	3. During interview on 11/19/15 at 12:20				2015.		
	PM, employee L, Human Resources,						
	stated the agency	y does not keep track of			An audit will be performed by t	he l	
		ent care dates, as the			administrator/designee to assu		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE (COMPL		
THAD TEAM	or condition	157586	B. W		00	11/19/	
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	,	
NAME OF F	PROVIDER OR SUPPLIER				WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		sually in the office for	+	TAG	compliance with G 212 of 100°	%	DATE
	orientation and s	-			of all new home health aides		
		week, so they just say			hired on or after December 21	,	
		act date is 5 days after			2015 to ensure Competency Based Skills Checklist is		
	date of hire.	y			completed prior to home healt	h	
					aide seeing patient		
	4. During interv	iew on 11/19/15 at 2:30			independently. Audit will conti until 100% compliance is	riue	
	PM, the Adminis	strator stated the annual			maintained for 4 consecutive		
	skills competence	ies for the HHAs are			weeks. After 4 weeks of 100%		
		with the mannequin for			compliance audit will decrease 10% quarterly and will be	e to	
all Great Lakes HHAs.				completed by Human Resource	es.		
					(Exhibit 5)		
	5. Employee file						
		19/15. Date of hire					
	_	ent contact date 4/7/12.					
	The file containe	ed a "Summary for Skills Demonstration					
		e 4/4/12. The section					
		oserved" stated "Lab					
	1A Temperature						
	^	ed Bath, 3 Sponge, Tub,					
		4A Shampoo in Bed, 4B					
		c or in Tub, 5A Nail					
	*	are, 5C Backrub, 6 Oral					
	Hygiene, 7A Uri	nal, 7B Bedpan, 8A					
	Transfer Technic	ques, 8B Ambulation, 9A					
	Range of Motior	Exercises, 9B					
		Make Occupied Bed."					
		led to evidence any of					
		ssessed being performed					
	on a patient.						
	(E1	. I . IIII A !					
		e I, a HHA, was reviewed					
	on 11/19/15. Da	te of hire 10/15/12, first					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì	ULTIPLE CO UILDING	00	(X3) DATE COMPI		
ANDILAN	or connection	157586	B. W		00	11/19	
		107000			DDDEGG CITY CTATE ZID CODE	11713	2010
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	ate 10/20/12. The file					
		nmary Documentation					
		nstration Checklists,"					
		The section titled "Where					
	Observed" stated						
		Pulse and Respiration, 2					
		nge, Tub, or Shower					
		oo in Bed, 4B Shampoo					
		o, 5A Nail Care, 5B Skin					
	·	b, 6 Oral Hygiene, 7A					
	Urinal, 7B Bedp	·					
	Techniques, 8B Ambulation, 9A Range						
		ises, 9B Positioning, 10					
	•	Bed." The checklist					
		e any of the skills were					
	assessed being p	erformed on a patient.					
		ment titled "Competency					
		entation Checklist for					
		de (CHC)," stated "Day					
	4 Will be spent i						
		National Home Care					
		on Program" and the					
		emonstrate/Observe" was					
	dated 11/7/12 an						
	Washing, Cleani	•					
	•	usage, Bag Technique,					
		itions Kit Use, Vital					
		ssure, pulse, respiration,					
	1,,	ft, Meals Preparation,					
		pplication of TED hose,					
		Skills, Observation,					
		cumentation of patient					
	status and the ca	re or service furnished,					
			_				-

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED
	PROVIDER OR SUPPLIER AKES CARING		3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E NATE	(X5) COMPLETION DATE
	changes in body reported to a RN safe and healthy Recognizing emotional and depatients, and Resprivacy and propfailed to evidence range of motion 7. Employee filterviewed on 11/5/12/14, first patter The document tis Skills Orientation Health Aide (CHealth Aide (CHealth Aide) Program" and the "Demonstrate/O'5/13/14 and state Cleaning of equiusage, Bag Tech Precautions Kit pressure, pulse, and Lift, Special Die hose, Communic Observation, repdocumentation of care or service for body function	ergencies and knowledge ocedures, Physical, evelopmental needs of spect for the patient, berty." This checklist e bathing, transfer, and (ROM). e N, a HHA, was 19/15. Date of hire ient contact date 5/17/14. tled "Competency Based in Checklist for Home IC)," stated "Day 4 Will with RN completing the: Care Aide Certification e section titled beserve" was dated ed, "Hand Washing, pment between patient inique, Universal Use, Vital Signs (blood respiration, temp), Hoyer its, Application of TED cation Skills,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			ILDING	nstruction 00	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		•	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	environment, Re and knowledge of Physical, emotion needs of patients patient, privacy a checklist failed to transfer, and RO 8. Employee fill reviewed on 11/25/27/15, first pat The document to Assignment Deta "MET" for "Assist to Walker, Assist to Walker, Assist to Walker, Assist to Walker, Assist was Bed Bath, Bedpa Pressure, Check Technique, Hoye Bed, Nail Care, Or Temperature, Por Respiration, Ran Hose, Transfer Pransport, Urinal and Shaving- Safailed to evidence in the field, and or T's signature. 9. The clinical rewas reviewed on was chosen from the service of the service was reviewed on was chosen from the service was reviewed on was revi						

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	PROVIDER OR SUPPLIEF		3115 S	ADDRESS, CITY, STATE, ZIP CO S WEBSTER ST MO, IN 46902	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	South Bend brar the territory serv	had been a patient of the ach. Patient # 16 lived in riced by the acquired ient was discharged to 5.				
	Administrator st maintains the ch they provided se	A15 at 11:35 AM, the ated the acquired agency arts for all the patients ervices for and patient # a services by the acquired				
	12:05 PM, the A patient # 16 is m	dministrator stated anaged by the acquired South Bend branch had in the care.				
	3/23/15, contain Health Aide (HI	of care dated th start of care date ed orders for Home HA) 2 times a week for 1 es a week for 2 weeks.				
	was provided HI acquired agency 4/6, 4/8, 4/10, 4/	rd evidenced patient # 16 HA services from the on 3/25, 3/27, 3/30, 4/1, 115, 4/17, 4/21, 4/24, 8/15 by employee WW; oyee LL.				
	1	s job description titled .ide," revised 6/6/14				

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-	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BU	A. BUILDING 00 B. WING		COMPLETED 11/19/2015	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT I	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	stated, "Job Qual Must provide of successful cor State-established Aide training pro requirements of a competency eval Otherwise, must Home health Aid competency eval providing direct 11. The agency's Health Aide Serv reviewed March individuals provi services will be a and/or competen Purpose To abid guidelines and of staff, physicians, appropriate utiliz Aide Services. S Home Health Aid a. Providing per including bathing weighing. back r shampoos as direct licensed professi client transfers, a protecting the cli Making observat condition and rep	ifications: Education: a satisfactory evidence inpletion of: 1. a or other Hoe Health ogram that meets the 42 CFR 484.36(a) and a uation program successfully complete a le training and uation program prior to patient care." s policy titled "Home vices," # C-220, 2015 stated, "All ing home health aide qualified through training cy evaluations be by state/federal ffer guidelines to GLC and community for the station of Home Health special Instructions 1. de services may include: sonal care services g, dressing, feeding, ubs, skin care and bet by the care plan and onal. b. Assisting with					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	<u>00</u>	COMPLETED 11/19/2015	
	ROVIDER OR SUPPLIER AKES CARING		3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	Nursing Services March 2015 state nurse: h. Sup other nursing per aides as appropri	s policy titled "Skilled s," # C-200, reviewed ed, "1. The registered pervises and teaches rsonnel and home health			
G 0218 Bldg. 00	(iii), (ix), (x), and (x) evaluated after observation of the other subject areas this section may be written examination after observation of a patient. Based on record the agency failed competency of the (HHAs) included the skills bathing motion (ROM) for		G 0218	G 218 To assure compliance with 484.36(b)(3)(iii), the following interventions have been implemented: • • • • • • • • • • • • • • • • • • •	12/22/2015
		2 of 5 Home Health		health aide services on its beh meet the competency evaluation	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/19/2015	
PROVIDER OR SUPPLIEI	3		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
AKES CARING SUMMARY S (EACH DEFICIENT REGULATORY OF Aide (HHA) file ensure the acquiral arrangement or a HHA services for services, listed of census. Findings included 1. During intervery PM, employee Taylor (RN) Educator, skill check offs the parent office on-boarding, and bed bath and a disponge bathing, in the field with checked off. En preceptor gets a go over with the 2. During intervery PM, employee Taylor and home health aid.	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ILSC IDENTIFYING INFORMATION) The serviewed; and failed to red agency had an agreement to provide for 4 of 73 patients HHA for the South Bend branch The Registered Nurse stated the agency does for the HHAs on site at the using a mannequin for dincludes performing a discussion of shower and and the next day is spent a RN for the HHA to be apployee T stated the RN copy of the check list to		3115 S	WEBSTER ST	ith 1, nt, sthe es d n a as y s, the h	(X5) COMPLETION DATE
PM, employee I stated the agenc	riew on 11/19/15 at 12:20 L, Human Resources, y does not keep track of ent care dates, as the			weeks. After 4 weeks of 100% compliance audit will decrease 10% quarterly and will be completed by Human Resource (Exhibit 5)	e to	

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	OF CORRECTION	IDENTIFICATION NUMBER:	lì í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL	
		157586	B. W		<u>oo </u>	11/19/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	{		3115 S	WEBSTER ST		
GREAT I	LAKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
		sually in the office for		-			
	orientation and s						
	approximately a week, so they just say						
	first patient cont	act date is 5 days after					
	date of hire.						
	_	view on 11/19/15 at 2:30					
	·	strator stated the annual					
		cies for the HHAs are					
done in the lab with the mannequin.							
	5. Employee file C, a HHA, was						
		19/15. Date of hire					
		ent contact date 4/7/12.					
	The file contains						
		for Skills Demonstration					
		$e \frac{4}{4}$. The section					
	titled "Where Ol	bserved" stated "Lab					
	1A Temperature	, 1B Pulse and					
	Respiration, 2 B	ed Bath, 3 Sponge, Tub,					
	or Shower Bath,	4A Shampoo in Bed, 4B					
		k or in Tub, 5A Nail					
	· ·	are, 5C Backrub, 6 Oral					
	'	inal, 7B Bedpan, 8A					
		ques, 8B Ambulation, 9A					
	Range of Motion						
		Make Occupied Bed."					
		iled to evidence any of					
		ssessed being provided					
	on a patient.						
	6. Employee fil	e I, a HHA, was reviewed					
		ate of hire 10/15/12, first					
		late 10/20/12. The file					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	for Skills Demondate 10/16/12. Tobserved" stated Temperature, 1E Bed Bath, 3 Spo Bath, 4A Shamp at Sink or in Tub Care, 5C Backru Urinal, 7B Bedp Techniques, 8B of Motion Exerce Make Occupied failed to evidence assessed being part of the A. The document of the A. The A. The document of the A. The	a Pulse and Respiration, 2 nge, Tub, or Shower oo in Bed, 4B Shampoo o, 5A Nail Care, 5B Skin b, 6 Oral Hygiene, 7A an, 8A Transfer Ambulation, 9A Range ises, 9B Positioning, 10 Bed." The checklist e any of the skills were rovided on a patient. ment titled "Competency entation Checklist for de (CHC)," stated "Day n field with RN National Home Care on Program" and the emonstrate/Observe" was						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF F	PROVIDER OR SUPPLIEF			STREET A	DDRESS, CITY, STATE, ZIP CODE		
		•		1	WEBSTER ST		
	_AKES CARING			<u> </u>	IO, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	changes in body	function that must be					
	reported to a RN	I, Maintenance of a clean,					
	safe and healthy						
	"	ergencies and knowledge					
	1 2 2 1	ocedures, Physical,					
		evelopmental needs of					
		spect for the patient,					
		perty." This checklist be bathing, transfer, and					
	ROM.	e balling, transfer, and					
	KOWI.						
	7. Employee fi	le N, a HHA, was					
	reviewed on 11/	19/15. Date of hire					
	5/12/14, first pat	tient contact date 5/17/14.					
		ment titled "Competency					
		entation Checklist for					
		de (CHC)," stated "Day					
	4 Will be spent i	National Home Care					
		on Program" and the					
		emonstrate/Observe" was					
	dated 5/13/14 ar						
		ing of equipment					
	between patient	usage, Bag Technique,					
	Universal Preca	utions Kit Use, Vital					
		essure, pulse, respiration,					
		ft, Special Diets,					
	Application of T						
		Skills, Observation,					
		cumentation of patient					
		re or service furnished,					
		of body functioning and					
	changes in body	function that must be					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
111,12112111	or condition	157586	B. W		00	11/19/	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE	
	safe and healthy Recognizing em of emergency pr emotional and de patients, and Res privacy and prop failed to evidence ROM. 8. Employee fit reviewed on 11/ 5/27/15, first pat The document ti Assignment Det to evidence skill field and only ex signature. 9. The agency's "Home Health A stated, "Job Qua Must provide of successful cor State-established Aide training pro requirements of competency eva Otherwise, must Home health Aid competency eva providing direct	ergencies and knowledge rocedures, Physical, evelopmental needs of spect for the patient, perty." This checklist be bathing, transfer, and le P, a HHA, was 19/15. Date of hire tient contact date 5/31/15. tled "Skills Checklist ail" dated 5/26/15 failed s were performed in the videnced employee T's job description titled aide," revised 6/6/14 lifications: Education: a satisfactory evidence empletion of: 1. a d or other Hoe Health togram that meets the 42 CFR 484.36(a) and a luation program a successfully complete a de training and luation program prior to					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586		UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902						
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	individuals proviservices will be and/or competen Purpose To abid guidelines and of staff, physicians, appropriate utiliz Aide Services. S Home Health Aida. Providing per including bathing weighing, back r shampoos as directlicensed professicient transfers, a protecting the cli Making observate condition and representation and representations.	2015 stated, "All ing home health aide qualified through training cy evaluations le by state/federal ffer guidelines to GLC and community for the ration of Home Health special Instructions 1. de services may include: sonal care services g, dressing, feeding, ubs, skin care and eet by the care plan and onal. b. Assisting with ambulation and ent from falls g. ions of the client's porting the results to the extrapist, h. Assisting							
G 0225 Bldg. 00	HEALTH AIDE The home health a	DUTIES OF HOME aide provides services that physician in the plan of							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. Wl	ING		11/19/	2015
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
CDEATI	AKES CARING				MO, IN 46902		
GREAT	ARES CARING			KOKOK			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		aide is permitted to					
	perform under sta			225	G 225		12/24/2015
		review, and interview,	G 0	225	To assure compliance with		12/24/2015
	"	d to ensure the home			484.36(c)(2), the following		
	`	A) followed the aide plan			interventions have been		
		rted vital signs to the			implemented:		
	registered nurse	for 2 of 9 records					
	reviewed receiving	ing HHA services. (# 2			• All Home Health		
	and 12)				Aides attended training by	of	
	,				12/24/15 that included: review policies C-800 Home Health A		
	Findings include	à·			Documentation and C-751 Ho		
	i mamga meraak				Health Aide Care Plan, and		
	1 The eliminal r	report for notions # 2 was			documentation requirements		
		record for patient # 2 was			including notification to the		
		16/15. The start of care			RN/Clinical supervisor of any	vital	
		15. The record contained			signs outside of the ordered		
		OC) dated 10/10-12/8/15			parameters for the patient. An audit will be performed by	tho	
	with orders for	HHA effective 10/11/15			administrator /designee to ass		
	2 visits a week f	for 3 weeks.			compliance with G 225 of 100		
					of HHA visits to ensure		
	A. The Aide	Care Plan Report dated			compliance with reporting as		
		tated, "Vital Signs that			outlined in Policies C-800 and		
		an Notification by SN:			C-200 until 100% compliance	is	
	1 1	Upper 170/90, Lower			met for 4 consecutive weeks. After 4 weeks of 100%		
		Opper 170/30, Lower			compliance the audit will		
	80/50."				decrease to 10% quarterly and	d	
	D 001 177 1	M. D. William			will be completed through the		
		Note Report dated			clinical record review process.		
	' '	ployee C, HHA, stated,			(Exhibit 7)		
	"Blood Pressure	174/82 Physician					
	Contacted: No.	Comments: [patient]					
	said feeling f	ine." The visit note					
	1	ce the HHA notified the					
	nurse of the vita						
		- 5					
	C The Wigit	Note Report dated					
	C. THE VISIT	Note Report dated					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTII A. BUILDII B. WING		NSTRUCTION 00	(X3) DATE : COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		31	15 S \	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	"Blood Pressure Contacted: No. over 91 DIAS ." evidence the HH the vital signs. D. During in	oloyee W, HHA, stated, 173/91 Physician Comments: SYS: 173 The visit note failed to A notified the nurse of terview on 11/16/15 at					
	1:45 PM, the Administrator stated the agency could not find any notes saying the HHAs called the nurses on 10/14 or 10/17/15 to notify of vital signs being high.						
	was reviewed on care date was 7/1	ecord for patient # 12 11/18/15. The start of 19/15. The POC dated ontained orders for HHA r 3 weeks.					
	9/17-11/15/15 st Require Physicia	Care Plan Report dated ated, "Vital Signs that an Notification by SN: Upper 170/90, Lower					
	10/28/15 by emp "Blood Pressure Contacted: No. dizziness from p	Note Report dated sloyee X, HHA, stated, 147/95 Physician Comments: DIAS: No atient." The visit note e the HHA notified the signs.					

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i '		(X2) MULTIPLE C	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		157586	B. WING		11/19/2015	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
ODEATI	ALCEO CARINO			S WEBSTER ST		
GREAT	AKES CARING		KOKO	MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		policy titled "Home				
		ocumentation," # C-800,				
		2015 stated, "2. The				
		de shall be responsible				
		changes in the client's				
		er pertinent observations				
	to the Clinical Si	upervisor."				
	1 The aganasila	policy titled "Home				
		e Plan," # C-751,				
		2015 stated, "Policy				
		aide staff will follow the				
		aide stair will follow the				
	identified plan."					
	5 The agency's	policy titled "Home				
	Health Aide Serv					
		2015 stated, "Special Home Health Aide				
	_	lude: g. Making				
		he client's condition and				
		ults to the Registered				
	Nurse/Therapist.					
G 0229	484.36(d)(2)					
	SUPERVISION					
Bldg. 00	The registered nur					
		ribed in paragraph (d)(1) of				
		make an on-site visit to no less frequently than				
	every 2 weeks.	The least requertity triali				
	-	review, the agency failed	G 0229	G 229	12/24/2015	
		gistered Nurse (RN)		To ensure compliance with		
				484.36(d)(2) Supervision, the		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		157586	B. W	ING		11/19/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹			WEBSTER ST	
GREATI	AKES CARING				MO, IN 46902	
	,				10, 114 40002	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE
		Iome Health Aides			following interventions were initiated:	
	(HHA) every tw	o weeks for 3 of 9			• □ □ □ □ □ □ As of November 6t	.h
	records reviewed	d receiving HHA services			2015, a contractual arrangement	
	with a skilled service for longer than 2				was secured between the age	
	weeks (# 12, 14	and 16), and failed to			referred to as Community Hon	
		t or branch provided			Health Network of Indiana, LL	
	_	n every 2 weeks for 1 of			dba Great Lakes Caring CCN	
	•	red receiving HHA			157586 (agency) and the	
		e acquired agency (# 16).			acquired agency of AC and Associates dba Great Lakes	
	services from the	e acquired agency (# 16).			Caring(acquired agency) to	
	Dia dia an in da da				provide the agency services s	uch
	Findings include:				as PT, OT, SLP, SN, MSW an	
					ННА	
		record for patient # 12				
	was reviewed on	11/18/15. The start of			•□□□□□□□□ All RNs attended	
	care date was 7/	19/15. The POC dated			training by 12/24/15 on Home	
	9/17-11/15/15 co	ontained orders for HHA			Health Aide Supervisory visits	
	1 visit a week fo	or 3 weeks, and Skilled			with review of policy C-340 Ho Health Aide Supervision.	ome
		ime a week for 2 weeks,			Ticaltif Aluc Supervision.	
		for 6 weeks, and 3 as			An audit will be performed by	the
	needed visits for				administrator/ designee to ass	
	liceded visits for	lans, etectera.			compliance with G 229 of 100	%
	A (TE)	1 1 1 1 1			of patients receiving HHA	
		d evidenced a HHA			services to ensure HHA	ad
		t was conducted on			supervisory visits are complete as outlined in policy C-340 unt	
		again until 10/15/15,			100% compliance is maintaine	
	then not again u	ntil 10/30/15. The record			for 4 consecutive weeks. Afte	
	failed to evidence	ee the supervisory visits			weeks of 100% compliance the	
	were conducted	every 2 weeks and within			audit will decrease to 10%	
	the appropriate d	•			quarterly and will be complete	•
		upervisory visit, the next			through the clinical record revi	ew
		e been conducted on			process. (Exhibit 18)	
	10/6/15, 10/20/1					
	10/0/13, 10/20/1	J, and 11/3/13.				
	2 771 1:	1.6				
		record for patient # 14,				
	start of care date	e 6/29/15 was reviewed				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W			11/19/	
	PROVIDER OR SUPPLIEF	2	<u> </u>	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902	<u> </u>	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING DEFORMATIONS		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
TAG	on 1119/15 and 10/27-12/25/15 a week for 1 weeks for 8 week for labs, safety, and HHA 1 time two times a week. A. The record supervisory visit 10/22/15, and not The record failed supervisory visit weeks and within After the 10/22/15. B. During in 11:10 AM, the Anext supervisory conducted around 3. The clinical rewas reviewed or was chosen from Deteriorating Welisted as having South Bend branthe territory serverse.	d evidenced a HHA was conducted on of again until 11/12/15. d to evidence the es were conducted every 2 in the appropriate dates. 15 supervisory visit, the have been conducted on terview on 11/19/15 at Administrator stated the evisit should have been ed 11/3/15. record for patient # 16 in 11/9 and 11/16/15 and in the OASIS list for ound Status and was had been a patient of the each. Patient # 16 lived in riced by the acquired eient was discharged to 5.		TAG	DEFICIENCY		DATE
	A. The plan	of care dated					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO JILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIEF	1			DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT I	_AKES CARING				10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
	3/23-5/21/15 wit 3/23/15, contains nursing (SN) 1 trand 3 as needed respiratory/carding astrointestinal/gintegumentary continues a week for week for 2 week. B. The record was provided HI acquired agency 4/6, 4/8, 4/10, 4/4/28, 5/5, and 5/1 by employed. The record supervisory visit 4/7/15 by employed until 4/24/15 by record failed to esupervisory visit parent agency or failed to evidence were conducted the appropriate of supervisory visit have been conducted. D. On 11/16 Administrator st maintains the children and some conducted that the children appropriate of supervisory visit have been conducted.	ch start of care date ed orders for skilled time a week for 9 weeks visits for pain, falls, ac, diabetic, gastrourinary, and complications; HHA 2 1 week then 3 times a s. rd evidenced patient # 16 HA services from the on 3/25, 3/27, 3/30, 4/1, 15, 4/17, 4/21, 4/24, 8/15 by employee WW; coyee LL. d evidenced a HHA was conducted on yee NN, and not again employee NN. The evidence the HHA s were conducted by the r South Bend branch, and the the supervisory visits every 2 weeks and within lates. After the 4/7/15 to, the next one should					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	<u>00</u>	COMPLETED 11/19/2015	
NAME OF P	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE	
GREAT L	AKES CARING			S WEBSTER ST OMO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	16 was provided agency.	services by the acquired			
	E. During into 1:40 PM, the Ad some of the curre were serviced by that had been acc Lakes Corporation listed on the Sou patient list and al agency's active pacquired agency insurance plans. stated that the ac own provider number. During im 10:15 AM, the A was not a contract the acquired agent the South Bend pacquired agent the South Bend pacquired acquired acquired acquired acquired agent the South Bend pacquired acquired	terview on 11/6/15 at dministrator stated there et or an agreement for ney to provide services to patients. The atted when the ired the agency provider the Bend branch provided			
	by the acquired a				
	11:12 AM, the A the acquired ager organizational ch Clinical Supervis	terview on 11/6/15 at dministrator indicated ney had their own eart, Administrator, and sor, but she was also the istrator for the acquired			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î í	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
					WEBSTER ST		
	AKES CARING			<u> </u>	1O, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	agency. The Ad	ministrator stated the					
	•	South Bend branch is					
	_	he day to day scheduling					
		seeing care provided for					
	the patients.						
	1 The aganavia	policy titled "Home					
		ervision," # C-340,					
	reviewed March						
		ts of Home Health Aides					
	-	ng to the following					
		hen skilled nursing					
	services are bein	g provided to a client, a					
	Registered Nurse	e must make a					
	supervisory visit	to the client's residence					
	_	days (either when the					
		de is present to observe					
		lelivery, or when the					
		de is absent) to assess					
		and determine whether					
		net 8. If Home vices are provided by an					
		s not directly employed					
		er arrangement, GLC					
	_	sibility to ensure overall					
	-	provide supervision					
		ulations, and ensure that					
	training and com	petency requirements are					
	met. 9. The aid	e visit record is reviewed					
	by the Clinical S	upervisor or designee to					
		re being provided					
	according to the	plan of care."					
	5 The aganavia	policy titled "Skilled					
	5. The agency s	poncy fined Skilled					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	Nursing Services March 2015 state nurse: h. Sup other nursing per aides as appropria 6. The agency's "Supervision of the March 2015 state receiving skilled addition to person the Nurse will make client's residence weeks." 7. The agency's Supervision," # 0 2015 stated, "Poother therapeutic under the supervision," the Reg Manager will be ongoing supervision of GLC. It will the administ responsibilities to organization. Pur requirement of s	s," # C-200, reviewed ed, "1. The registered pervises and teaches rsonnel and home health late."			CROSS-REFERENCED TO THE APPROPRIA	ATE	
	all staff delivering services. To asseque performance is a that care is direct	ng home health care ure employee ppropriately supervised, ted toward the					
	achievement of g	goals, and that services					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		Ĺ	ILDING	nstruction <u>00</u>	(X3) DATE (COMPL 11/19/	ETED		
	ROVIDER OR SUPPLIER AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Ē	(X5) COMPLETION DATE	
G 0235 Bldg. 00	are provided base accordance with Care Special Regional Director be responsible for provided and surproviding therapy contract staff. He responsible for of GLC's ongoing for Regional Director coordinate the dathe organization Administrator. 3 Supervisor will provided activities relevant services furnished development of cassignment of personal Director activities.	ed on client need and in the physician's Plan of I Instructions 1. The or/Clinical Manager shall or the quality of care pervision of all staff eutic services, including te/she will also be organizing and directing functions. 2. The or/Clinical Manager shall any-to-day operation of and work with the B. The Clinical participate with the or/Clinical Manager in all at to the professional of the content of the professional of the professional of the content of the professional	G 02		G 235 To ensure compliance with		12/24/2015	
	of clinical inform reviewed (See G ensure the confic records by allow to provide servic patients listed on branch active pat	nation for 7 of 20 records 236); and failed to dentiality of medical ing an acquired agency es to 26 of 73 active a both the South Bend tient list and the acquired patient list, for 1 of 1			484.48 Clinical Records, the following interventions have be implemented: G236 All LPN and RN staff received education by 12/24/1s that included hands on demonstration check offs in a skills lab by RN staff educators. The education included review	5, s.		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED				
ANDILAN	OI CORRECTION	157586	B. WING	00	11/19/2015			
		1.0.000	_	ADDRESS CITY STATE STROOPS	11/10/2010			
NAME OF P	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST				
GREAT L	AKES CARING		KOKOMO, IN 46902					
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION				
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE			
TAG		LSC IDENTIFYING INFORMATION)	TAG	PICC line procedures, phys	DATE			
		chosen from the parent		notification of abnormal	lciaii			
	"	ne Assessment and		assessment, documentation	1			
		(OASIS) report; and		review, as well as return				
		an arrangement or		demonstration of skills inclu	ding			
	agreement was in place for the corporate			measurement of PICC line.				
office in Michigan to submit OASIS data				A PICC measuremen	t			
		icy for 1 of 1 agency (See		service code was created in				
	G 239).			electronic medical record				
				software on 12/14/15 to pro	•			
The cumulative effect of these systemic				clinicians to complete a PIC measurement at their visits.				
	problems resulte	ed in the home health		incasurement at their visits.				
	agency's inability to ensure the provision			· All clinical staff were				
	of quality health	care in a safe		educated by 12/24/15 on po				
	environment.			C-360 Coordination of Clien				
				services, C-660 Care Plans C-155 Client	,			
				recertification/Follow-up/Re	sumpti			
				on of care, C-200 skilled nu	•			
				services and C-145				
				Comprehensive client				
				assessment.				
				All clinical staff educations	ited			
				on policy C-145 comprehen	sive			
				client assessment and C-15	55			
				Client Recortification/Follow up/an	,d			
				Recertification/Follow-up/an Resumption of Care. Educa				
				included the requirement to				
				recertify within the five day				
				window.				
				· All skilled nursing sta	ff			
				received education on	"			
				documentation requirement	s for			
				wound care, as well as hand				
				competency checks in a ski				
				for wound care, and infection	n			

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING		COMPLETED 11/19/2015			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GREAT L	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
				control with wound care, by ar RN preceptor by 12/24/15.	1			
				An audit will be performed by administrator/ designee to ass compliance with G236 of 100% all patients with a PICC line ur 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 6) An audit will be performed by the administrator/designee to assicompliance with G 236 of 50% all skilled nursing visits for pair interventions and physician notification when indicated unt 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process (Exhibit 14) An audit will be performed by administrator/designee to assicompliance with G 236 of 100% of wound care visits to ensure measurements q week, as weldetailed orders and complete documentation of wound care provided until 100% compliance is met for 4 consecutive weeks After 4 weeks of 100% compliance the audit will	ure 6 of httil d ure 6 of n ure 7 of n ure 8 of n ure 8 of n ure			
				decrease to 10% quarterly and	۱			

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
THE TEAM	or conduction	157586	B. WING	00	11/19/2015
			STREET	ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF P	ROVIDER OR SUPPLIER	8		WEBSTER ST	
GREAT L	AKES CARING			MO, IN 46902	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION DATE
IAG	REGULATORT OR	ESC IDENTIF TING INFORMATION)	IAG		
				will be completed through the clinical record review proces	
				(Exhibit 11)	
				An audit will be performed by	y the
				administrator/designee of 10	
				of all recertification visits to vertex that they were completed	/егіту
				between day 56 and 60 until	
				100% compliance is met for	4
				weeks. After 100% complianmet for 4 weeks the audit will	
				decrease to 10% quarterly a	
				will be completed through the	
				clinical record review proces	S.
				(Exhibit 16) An audit will be performed by	ny the
				administrator/designee to as	
				compliance with G236 of 100	
				all recertification plans of car	re to
				ensure that all goals and interventions have been upd	ated
				from previous certification pe	
				until 100% compliance is me	
				4 consecutive weeks. After consecutive weeks of 100%	4
				compliance, the audit will	
				decrease to 10% quarterly a	
				will be completed through the	
				clinical record review proces (Exhibit 15)	s.
				An audit will be performed by	v the
				administrator/designee to as	· · · · · · · · · · · · · · · · · · ·
				compliance with G236 of 50°	
				all skilled nursing visits for	, d
				updated goals when indicate and physician notification of	tu
				updated and patient specific	
				goals until 100% compliance	
				met for 4 consecutive weeks After 4 consecutive weeks or	
				Alter 4 consecutive weeks of	l

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING B. WING	00	COMPLETED 11/19/2015			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GREAT L	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				100% compliance the audit wi decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 13)	d			
				G 239 • • • • • As of November 6t 2015, a contractual arrangeme was secured between the age referred to as Community Hon Health Network of Indiana, LL dba Great Lakes Caring CCN 157586 (agency) and the acquired agency of AC and Associates dba Great Lakes Caring(acquired agency) to provide the agency services si as PT, OT, SLP, SN, MSW an HHA. • • • • The OASIS review and lock process was revised 12/13/15 to have the specific provider number Clinical	ent ncy ne C			
				Supervisors or RNs review and lock their responsible areas OASIS. • • • • • • • • • • • • • • • • • • •	ch ent at SIS			

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	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 11/19/2015		
	ROVIDER OR SUPPLIER	·	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE		
				the correct South Bend RN Clinical Supervisor. • • • • • • • • • • • • • • • • • • •			
				15th, 2015 – no new patients were accepted to service for agency that would normally admitted to the acquired age provider number.	the pe		
				• acquired agency's' patients discharged from the agency.	were		
				• 12/23/15 The Electronic Med Record access of all employing the state of Indiana was thoroughly reviewed and upon to assure employees only has access to the locations they assigned or contracted through the employee transfers will need go through an HR process to assure computer access integrity.	ees dated live are ligh. ernal to		
				An audit will be performed w by the administrator/designe assure 100% compliance wit 239 with the applicable provinumber Clinical Supervisors/reviewing and locking the Offor a period of 4 weeks. Afte consecutive weeks of 100% compliance, the audit will decrease to 50% of all OASI another 4 weeks. After that weeks of 100% compliance i obtained the audit will decrease	e to th G der //RNs ASIS er 4 S for 4		

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING B. WING	00	COMPLETED 11/19/2015		
	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				10% quarterly and will be completed through the clinica record review process. (Exhib			
				An audit to assure compliance with G 239 will be performed the administrator/designee or 100% of all new South Bend admissions with a SOC date or after November 15th for a period of 8 weeks. After 8 consecutive weeks of 100% compliance, the audit will decrease to 10% quarterly an will be completed through the clinical record review process (Exhibit 1)	by n on d		
				An audit will be completed by administrator/designee on 20 all employees in regards to the medical record access to assempliance with protection of records until 100% compliance has been obtained for 4 consecutive weeks. After 4 weeks of 100% compliance a will decrease to 10% quarterly and will be completed by Hun Resources. (Exhibit 17)	% of eir ure e udit		
G 0236 Bldg. 00	and current findin accepted professi maintained for ev health services. I care, the record of identifying informating, dietary, trea	containing pertinent past gs in accordance with					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			ETED
		157586	B. WING 11/19/20			2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			WEBSTER ST		
GREAT I	LAKES CARING				MO, IN 46902		
(X4) ID	SHIMMARYS	TATEMENT OF DEFICIENCIES	1	ID	<u>,</u>		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	notes; copies of summary reports sent to the		1				
	attending physician; and a discharge summary. Based on record review and interview,						
			G 0	236	G236		12/24/2015
		d to ensure the accuracy			To assure compliance with		
		nation for 7 of 20 records			484.48, Clinical Records, the		
		4, 10, 11, 12, 13, and 16)			following interventions have been		
	10 γ10 wed. (π 3, 2	i, 10, 11, 12, 13, and 10)			implemented:		
	Findings include	: :	. re		· All LPN and RN staff received education by 12/24/15,		
	1. The clinical record of patient # 3, start of care date 10/23/15, contained a plan of care (POC) dated 10/23/-12/21/15 with				that included hands on	- 7	
					demonstration check offs in a		
					skills lab by RN staff educator		
					The education included review		
	orders for Skille	d Nursing (SN) 1 time a			PICC line procedures, physicia	an	
		z, 2 times a week for 8			notification of abnormal assessment, documentation		
		ne a week for 1 week,			review, as well as return		
	· ·	l visits for cardiac,			demonstration of skills including	ng	
					measurement of PICC line.		
	respiratory, gast	·					
		eurologic, endocrine,			A PICC measurement	_	
	_	n/wound status changes,			service code was created in the electronic medical record	ie	
		r: Instruct on			software on 12/14/15 to promp	ot	
	lab/venipuncture	e procedure, obtain lab			clinicians to complete a PICC		
	results and repor	t to physician. SN to			measurement at their visits.		
	obtain Vancomy	cin trough week of					
	10/26/15 and BN	MP [basic metabolic			· All clinical staff were		
		eekly until instructed			educated by 12/24/15 on police C-360 Coordination of Client	:y	
		N to change PICC			services, C-660 Care Plans,		
		terile technique every			C-155 Client		
		ded times 3 for soiled or			recertification/Follow-up/Resu	mpti	
		aca miles 5 for solice of			on of care, C-200 skilled nursi		
	loose dressing.				services and C-145		
					Comprehensive client		
		of care assessment form			assessment.		
	dated 10/23/15 b				All clinical staff educate	d	
	Registered Nurs	e (RN) stated, "Indicate			on policy C-145 comprehensiv	_	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMP		ETED		
		157586	B. WI	NG		11/19/2015	
		l .		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
GREATI	AKES CARING				10, IN 46902		
			1		10, 114 +0302		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG			DATE
	length of exposed PICC catheter from insertion site to catheter hub in				client assessment and C-155 Client		
					Recertification/Follow-up/and		
	centimeters: 10.	.0."			Resumption of Care. Educatio	n	
	B. The SN Visit Note Report dated				included the requirement to		
					recertify within the five day		
		oloyee U, Licensed			window.		
	Practical Nurse (LPN) stated, "PICC line dressing dislodged. PICC line dressing changed using aseptic technique Lab						
					. All okilled pursing staff		
					All skilled nursing staff received education on		
					documentation requirements for	or	
	draw obtained via PICC line using				wound care, as well as hands		
	aseptic technique." The record failed to				competency checks in a skills		
		N measured the PICC			for wound care, and infection		
	line and failed to	evidence the nurse			control with wound care, by an	l	
	changed the dres	ssing using sterile			RN preceptor by 12/24/15.		
	technique.				An audit will be performed by t	ho	
	•				administrator/ designee to ass		
	C. The SN V	visit Note dated 11/3/15			compliance with G236 of 100%		
		LPN stated, "Skilled			all patients with a PICC line ur		
		nent completed for Vanco			100% compliance is met for 4		
	_	_			consecutive weeks. After 4		
	_	PICC line using clean			consecutive weeks of 100%		
	_	Care Coordination Note			compliance the audit will decrease to 10% quarterly and	1	
	1 ^	/3/15 by employee E			will be completed through the	4	
		requesting PICC line			clinical record review process.		
	dressing change	d during visit due to			(Exhibit 6) An audit will be		
	dislodgement. P	PICC line dressing			performed by the		
	changed using st	terile technique." The			administrator/designee to assu		
	record failed to	evidence the PICC line			compliance with G 236 of 50%		
		uring the dressing			all skilled nursing visits for pair interventions and physician	I	
	change.	6			notification when indicated unt	il	
	Change.				100% compliance is met for 4		
	D. T. CNIV. AND D. A. L. L.				consecutive weeks. After 4		
		Visit Note Report dated			consecutive weeks of 100%		
		oloyee V, LPN stated,			compliance the audit will		
		of exposed PICC			decrease to 10% quarterly and	t	
	catheter from ins	sertion site to catheter			will be completed through the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 CO			ETED
		157586	B. Wl	ING	_	11/19/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			3115 S	WEBSTER ST		
GREAT LAKES CARING			KOKOM	//O, IN 46902	<u>.</u>		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADE DEFICIENCY)		TE	COMPLETION
TAG		<u> </u>	-	TAG	clinical record review process		DATE
		ers: 3.0." The record			(Exhibit 14)		
	failed to evidence the physician was				(Exhibit 11)		
	notified of the 3 centimeter PICC measurement.				An audit will be performed by		
					administrator/designee to assu		
					compliance with G 236 of 100		
	E. During in	terview on 11/16/15 at			of wound care visits to ensure measurements q week, as well		
	3:00 PM, the Administrator stated PICC dressing changes should be sterile. F. During interview on 11/17/15 at 10:05 AM, the Administrator stated she				detailed orders and complete	ıı as	
					documentation of wound care		
					provided until 100% compliand		
					is met for 4 consecutive weeks	S	
					After 4 weeks of 100%		
	talked to the LPN that measured the				compliance the audit will decrease to 10% quarterly and	,	
	PICC line at 3 centimeters on 11/13 and				will be completed through the	_	
		e measured only what			clinical record review process.		
		der neath the dressing,			(Exhibit 11)		
	_	C line is sutured in place.			An audit will be performed by	tha	
	and that the rice	e fille is sutured in place.			An audit will be performed by talent administrator/designee of 100°		
	2 The clinical r	record for patient # 4 was			of all recertification visits to ve		
		17/15. The start of care			that they were completed	, I	
		5. The POC dated			between day 56 and 60 until		
					100% compliance is met for 4		
		ontained orders for SN 6			weeks. After 100% compliand met for 4 weeks the audit will	E 18	
		1 week, 7 times a week			decrease to 10% quarterly and	l t	
		nes a week for 1 week,			will be completed through the		
		eek for 6 weeks, with 3 as			clinical record review process.		
	needed visits for	•			(Exhibit 16)	41	
	respiratory/cardi	-			An audit will be performed by administrator/designee to assu		
		nental status changes.			compliance with G236 of 100%		
	_	and intervention related			all recertification plans of care		
	to wounds. Area	a to ball of left foot			ensure that all goals and		
	cleanse with wound cleanser, apply betadine and let dry, every day. Area to				interventions have been updat		
					from previous certification peri until 100% compliance is met		
	right upper arm	cleanse with wound			4 consecutive weeks. After 4	101	
		Santyl and cover with			consecutive weeks of 100%		
		d gauze and dry and dry			compliance, the audit will		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W.	JILDING ING	00	COMPL	
		157586	D. W.			11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
CDEATI	LAKES CARING				WEBSTER ST 10, IN 46902		
	1				10, 111 40902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	+	right hip cleanse with			decrease to 10% quarterly an	d	
		apply Santyl cover with		will be completed through the			
	lightly moistened gauze and cover with dry gauze.				clinical record review process		
					(Exhibit 15)		
	dry gauze.				An audit will be performed by	the	
	A The wour	nd care orders for the			administrator/designee to ass	ure	
		and the right hip failed to			compliance with G236 of 50%	of	
	contain frequencies for the wound care. 3. The clinical record for patient # 10 was reviewed on 11/17/15. The start of care date was 9/26/15. POC dated 9/26-11/24/15 contained diagnosis of				all skilled nursing visits for updated goals when indicated		
					and physician notification of		
					updated and patient specific		
					goals until 100% compliance i	S	
					met for 4 consecutive weeks.		
					After 4 consecutive weeks of 100% compliance the audit w	Ш	
		ring Surgery, with orders			decrease to 10% quarterly an		
		week for 1 week, 2 times			will be completed through the		
		eks, then 1 times a week			clinical record review process.		
		s needed for falls, pain,			(Exhibit 13)		
	· ·	gastrourinary, respiratory,					
	,	d skin integrity, diabetes,					
		ecline. Need for skilled					
		ervention related to					
	_	cervical spine incision.					
		•					
	_	dry. May leave open to e noted. SN for:					
		d assessment of cardiac					
	_	fy changes associated					
		on for early intervention					
	_	s; observation/assessment					
	_	al system to identify					
	_	ted with exacerbation of					
		t and dayslan plan of					
	^	t and develop plan of					
		er signed by physician;					
	-Observation/ass	sessment of respiratory					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ľ	JILDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST 1O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	with exacerbation of complications -Provide instruct planning. Dischardisciplines availar request; =Assess anxiety patient for unders management of figure perform Hamilton mini mental exart-Provide assessment teaching/reinforce depression including medication management and identify charding depressive disordintervention, SN depression scale exam; -Provide teaching etiology of confuction, safety management; obsort of pain, effective management and teaching related to report increases physician for proskilled teaching emergency care princluding self materials.	ions related to discharge arge summary for all able to physician upon and provide assistance to standing and feelings. SN may an anxiety scale and/or m; and the ement of management of ding disease process, agement, coping skills ages associated with ders for early may perform geriatric and/or mini mental and/or mini mental ag/reinforcement in asion or altered measures and home servation and assessment aregimen and skilled to pain management, SN as in pain level to ampt intervention; and training of tolan, disease process					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO UILDING	00	(X3) DATE COMPL		
THINDTERM	or condition	157586	B. W		00	11/19/	
		107000		CTREET	DDDEGG OFFI GTATE ZID CODE	11710	2010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-SN to obtain pu	-					
		nes 3 as needed for					
		th, oxygen use, activity					
	intolerance;						
		on/reinforcement of					
	_	system related teaching,					
	_	culitis and irritable					
	bowel syndrome	* 7					
		killed teaching regarding					
		rol diarrhea/constipation					
	as well as prever	•					
	-	killed teaching and					
	,	gency care plan, disease					
	•	omy surgery including					
	_	t of neurologic disease;					
	-SN to provide a						
	_	cement of management of					
		ng disease process,					
		agement, coping skills					
		nges associated with					
	-	y intervention. SN may					
	_	lucose level as needed					
	for signs and syr	•					
		mia or for baseline					
	_	feet and reinforce					
	diabetes mellitus	, , , , , , , , , , , , , , , , , , ,					
	-SN observation	_					
		atus to promote optimum					
	skin integrity;						
	_	atient/caregiver on signs					
		f infection related to					
	cervical spine su						
	complications to						
	-SN to establish	supports to minimize					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ration patient/caregiver					
		d in emergency care plan,					
	_	ervical spine surgery					
	hospitalization;	ment to reduce avoidable					
		on of medication					
	regimen to ident						
	changes/complic	•					
	intervention;						
	· · · · · · · · · · · · · · · · · · ·	nterventions to improve					
	_	ice the risk of falls;					
		atient/caregiver on					
	_	ures to reduce pressure					
	ulcer risk; and	•					
	-Licensed profes	sional to report vital					
	signs falling outs	side the following					
	established paraı	meters: Temp < 96>					
	101, Pulse < 50	> 116, Respirations < 12					
	> 29, Systolic bl	ood pressure, $80 > 170$,					
	Diastolic blood p	pressure $< 50 > 90$,					
	, ,	gar < 60 > 300, oxygen					
	saturation < 88.						
		iated risks; Patient's					
	_	ction needs will be met,					
	_	ary for all disciplines					
		sician upon request;					
		xiety are identified and					
		tiated to allow patient to					
	manage feelings						
	-Patient/caregive						
		strate understanding the					
	_	depression by the end of symptoms are identified					
	and managed to	maintain patient safety in					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	the home; Patient demonstrate under confusion and matthe home; -Improvement in activity; -Pain controlled a level acceptable -Patient/caregive understanding of nonpharmacolog -Patient will dem manage cardioval disease process a burden associated pulse oximetry respective ability to self matthe disease process; -Patient/caregive ability to self matthe disease process; -Patient/caregive demonstrate ability bowel elimination bowel patency; -Demonstrated at neurologic disease caregiver burden process, improve symptoms of neurologic disease caregiver burden process disease caregi	t/caregiver will erstanding of etiology of aintain patient safety in pain interfering with at level of 3 or less or at e to the patient; r demonstrate pharmacological and ic pain control measures; nonstrate ability to self scular hypertension and reduce caregiver d with disease process; esults obtained; r will demonstrate nage gastrointestinal r verbalize and ity to manage altered n. Patient will have bility to self manage se process and reduce associated with disease ement in signs and prologic disease; r will verbalize					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 COMB. WING 11/			COMPL 11/19/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	-Demonstrated in conditions and earlier conditions are vided size or healing of of cert period; -Patient will have supports to prevea voidable hospitared conditions and cally living and daily living and daily living and daily living with and prevention. The agency faile was notified of gunobtainable goal on the plan of call coordinate with a coordin	mprovement in existing arly identification and dditional compromises ations avoided; entary status will enced by a decrease in f wound/decub by end e appropriate agency ent rehospitalization, alizations will be er will demonstrate manage medications; ole to perform activities ad individual activities of decreased risk for falls; er will demonstrate s of pressure ulcer d to ensure the physician coals being met and of als needing to be changed re; and failed to nursing staff to ensure education on goals met					
	stated [Spouse (or patienty states the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIES	2	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
	AKES CARING		1	<u> </u>	10, IN 40902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
IAU	lowest patient's pain scale. Curr Dilaudid 2 millig The agency faile "Pain controlled a level acceptable revised. B. The start Assessment and assessment form "(M1018) Condit treatment regime stay within the pIntractable Pain. section stated "PPain Scale Ratin make pain worse neck pain least? long does neck pinck pain be relittled "Endocrine "Indicate endocrassessment (mar Diabetes, thyroic patient taking and How frequent ar Not checked ver patient's usual be Below 130." The section titl stated "Indicate	pain ever gets is a # 8 on ently patient takes grams tablets for pain." ed to ensure the goal of at level of 3 or less or at le to the patient" was of care Outcome Information Set a dated 9/26/15 stated itions prior to medical en change or inpatient east 14 days 3- " The Pain assessment eain All of the time ag: 9 What activities end have in Pain. How beain last? Constant. Can deved? No." The section end Hematopoietic stated end have have in last? It is the salidation of the sulin? No Is the salidation and sugar scheck? The section of the sulin in		IAU	DEFICIENCE!		DATE	
	with other discip	olines involved in this						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			UILDING	onstruction 00	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	communicate with Caregiver(s), Cli Indicate reason proportion of proportion of proportion of the communicate reason proportion of the communicate reason proportion of the communication of the commun	contacted physician for osed plan of care: No. obysician not contacted: nds." The section titled ed: "3. Patient/caregiver standing of basic tion requirements." The to evidence the SN g/reinforcement of diabetes. The POC dated ntained orders for SN 3 1 week, 4 times a week nes a week for 1 week, 4 1 week, 3 times a week nes a week for 1 week, 3 2 weeks, then 2 times a with 3 as needed visits ardiac/respiratory, gastrourinary, diabetic, or tions. Need for skilled ervention related to left cin integrity. Cleanse nser, apply collagen, dressing. Wrap bilateral is with 2 layer						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMP	E SURVEY PLETED 9/2015	
	PROVIDER OR SUPPLIEF		3115 S	ADDRESS, CITY, STATE, ZIP COE WEBSTER ST MO, IN 46902	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	B. During in 11:25 AM, the A	failed to contain a wound care orders. terview on 11/18/15 at administrator stated there uency on the wound care				
	5. The clinical r was reviewed or care date was 7/ dated 9/17-11/15 for recertificatio	ecord for patient # 12 a 11/18/15. The start of 19/15. The POC was 5/15. The 5 day window in was 9/12-9/16/15.				
	B. The Physis 9/16/15 stated, "today for recerting today."	ician Verbal Order dated Patient refused visit fication. Intervention: sed visit for Friday				
	Report dated 9/1 called to set up a for recert and wa was staying with primary CG [car visit. Could be a Tuesday. Patien new Glucometer	t Coordination Note 7/15 stated, "This nurse appointment with patient as informed that patient a other son to give regiver] respite and to done Monday or apparently received a from Dr. and DIL] would like instructions				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO. UILDING	00	COMPL		
		157586		ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT I	AKES CARING				10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
		Will notify PCP ysician] of delay along ervisor."					
	dated 9/18/15 sta for visit on 9/18/	ician Verbal Order form ated, "Patient unavailable 15 Reschedule Medicare week."					
	9/22/15 stated, " Supervisory" Timing: 1-Early	_					
	1:50 PM, the Ad patient should hat the agency found	derview on 11/18/15 at ministrator stated the ave been discharged once dout they would not be the recertification visit window.					
	was reviewed on care date was 5/2 Huntington's Ch 8/30-10/28/15 co the week of 9/6/ week, 1 every tw every 3 weeks fo needed for cardia	ecord for patient # 13 a 11/19/15. The start of 2/15. Diagnosis of orea. The POC dated ontained orders for SN 15, 1 time a week for 1 yo weeks for 4 weeks, 1 or 3 weeks, and 3 as ac/respiratory, strointestinal, endocrine,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO JILDING	00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF F	PROVIDER OR SUPPLIER	<u>. </u>	•		ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and falls. SN for	n, wound status changes,					
		t and develop plan of					
		and assessment of pain,					
		pain management and					
		led teaching related to					
	~	nt, report increase in pain					
	level to physicia	•					
		sessment of cardiac					
	system to identif	y changes associated					
	with exacerbatio	n for early intervention					
	of complications	;					
	- Obtain pulse or	ximetry measurement					
	upon recertificat	ion to confirm baseline					
	and times 3 as no	eeded shortness of					
	breath, oxygen u	se, activity intolerance;					
		sessment of respiratory					
	1 -	y changes associated					
		n for early intervention					
	of complications						
	1	ncontinence screening					
		; SN to provide skilled					
	I -	to urinary incontinence					
	_	lay obtain urinalysis and					
		tivity times 3 if indicated					
	1 -	mptoms of urinary tract					
	infection or reter						
		ion/assessment of					
	~	system to identify					
	_	ed with exacerbation of					
		tion of complications, tilled teaching regarding					
	_	trol diarrhea/constipation					
	as well as prever	_					
	as well as pievel	ining related					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
TAG	complications, S saline enema tim removal of fecal neededSN to evaluate a to improve balan fallsSN to instruct paper preventive measurable ulcer riskSN to establish a risk of hospitalization care plan, and as disease managen hospitalizationSN to provide in discharge planning for all disciplines upon requestSkilled instruction regimen to identification intervention. GOALS; -Pulse oximetry a changes in respidentified and reprompt intervention associated risks; -Improvement in Improvement in Improvement in incontinence;	N for administration of es 3 as needed, SN for impaction times 3 as and provide interventions ce and reduce the risk of atient/caregiver on ares to reduce pressure supports to minimize ation, patient/primary instructed in emergency pects of cardiovascular ment to reduce avoidable astructions related to a savailable to physician on of medication fy ations for early		TAG	DEFICIENCY)		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOIT EIEF				WEBSTER ST		
	_AKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		,		TAG	Diricilité 1 y		DATE
	will be promptly						
		plemented to minimize					
	risks to patient.						
	-Patient/caregive						
		ity to manage altered					
	bowel elimination						
		re bowel patency;					
		able to perform activities					
		nd individual activities of					
	, , ,	decreased risk for falls;					
		er will demonstrate					
	1 1 1	es of pressure ulcer					
	prevention,						
	-Patient will hav	re appropriate agency					
	supports to preve	ent rehospitalization,					
	avoidable hospit	alizations will be					
	reduced;						
	-Patient's dischar	rge instruction needs will					
	be met. Dischar	ge summary for all					
	disciplines availa	able to physician upon					
	request;						
	-Patient/caregive	er will demonstrate					
	ability to safely	manage medications.					
	A 751 03.5						
		Recertification Outcome					
	Assessment and						
	(OASIS)Visit N	•					
		titled "Braden Risk					
		le" stated, "Total Score					
	~	total score of 12 or less					
		be at high risk of					
	developing press	sure ulcers): 18. Based					
	on the score, the	risk level for this patient					
	is: LOW." The	section titled					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	IULTIPLE CO. UILDING	NSTRUCTION 00	COMPL		
11.12.12.11.	or condition	157586	B. W		00	11/19/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2			WEBSTER ST		
GREAT I	LAKES CARING				1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
		rovided," stated, "1. caregiver in position					
		e equipment to alleviate					
		s/comments: instruct in					
		icluding using pillows for					
		ring skin over bony					
		d position changes at					
		ours. Instruct in					
		ing schedule 10.					
	- ·	ional requirement to					
		in integrity and healing."					
	B. The Visit	Note Report section					
	titled "Integume	ntary/Wound" stated,					
	"No problems id	lentified," and failed to					
	evidence the pat	ient needed skin integrity					
	instructions to a	void pressure ulcer risks					
		ducation to promote					
	healing.						
	C The SN F	Recertification OASIS					
		rt dated 10/26/15 section					
	_	et," previously on 10/6/15					
		s being re-instructed on					
	_	n 10/26/15 visit and listed					
		atient/caregiver will					
	verbalize unders	tanding of instructions					
	given related to	pressure relief and ulcer					
	prevention. 2. 0	Cardiac exacerbations are					
	identified promp	otly and interventions					
	initiated quickly	to minimize associated					
	risks 5. Pati	ient/caregiver					
	demonstrate und	lerstanding of					
	pharmacological	and nonpharmacologic					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
		1		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			WEBSTER ST		
GREATI	_AKES CARING				10, IN 46902		
					10, 11 10002		
(X4) ID		STATEMENT OF DEFICIENCIES	PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	_	asures this visit. 6.					
		iratory status are					
	identified and re	eported to physician for					
	prompt interven	tion to minimize					
	associated risks.	9. Exacerbations of					
	gastrointestinal of	disease are promptly					
	_	iterventions implemented					
		s to patient." The Goals					
		idence the reflective of					
	the needs of the						
		• •					
	assessment data	recorded.					
	D. The SN R	Recertification OASIS					
	Visit Note Repo	ort dated 10/26/15					
	narrative section	stated, "Patient					
	recertified this v	visit nursing not need at					
		to continue with PT at					
	_	record failed to evidence					
		discharged from SN					
	services.	discharged from 51v					
	Services.						
	5 21 11 1 1	1.0					
		record for patient # 12					
		1 11/18/15. The start of					
		19/15. The POC was					
	dated 9/17-11/1:	5/15. The 5 day window					
	for recertificatio	n was 9/12-9/16/15.					
	A. The recer	tification was not					
	completed until	9/22/15. The agency					
	_	ge the patient and left the					
	POC dated 9/17-	- 1					
		11/10/10.					
	D The Dhave	iaian Varhal Ordar datad					
	-	ician Verbal Order dated					
	9/16/15 stated, "	Patient refused visit					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	ľ	ILDING	nstruction 00	(X3) DATE COMP! 11/19	
	PROVIDER OR SUPPLIEI	3	•	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	1 -	fication. Intervention: sed visit for Friday					
	Report dated 9/1 called to set up a for recert and was staying with primary CG [car visit. Could be Tuesday. Patier new Glucometer [daughter in law on how to use it	at apparently received a r from Dr. and DIL r] would like instructions . Will notify PCP hysician] of delay along					
	dated 9/18/15 st. for visit on 9/18, recert outside of E. The Visit 9/22/15 stated, "Supervisory" Timing: 1-Early	_					
	1:50 PM, the Ac	terview on 11/18/15 at Iministrator stated the ave been discharged once					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	IULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W		00	11/19/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			WEBSTER ST		
GREAT I	AKES CARING			KOKOM	IO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		d out they would not be the recertification visit					
	within the 5 day						
	within the 3 day	window.					
	8. The clinical r	record for patient # 16					
		n 11/9 and 11/16/15 and					
	was chosen from	n the OASIS list for					
	Deteriorating W	ound Status and was					
	listed as having	had been a patient of the					
	South Bend brar	nch. Patient # 16 lived in					
	I -	viced by the acquired					
		tient was discharged to					
	hospice on 5/8/1	5.					
	A O 11/16	/15 / 11 25 ANS /1					
		/15 at 11:35 AM, the					
		ated the acquired agency arts for all the patients					
		ervices for and patient #					
		l most services by the					
	acquired agency						
	acquired agency	•					
	B. The plan	of care dated					
	3/23-5/21/15 wit	th start of care date					
	3/23/15, contain	ed orders for skilled					
	nursing (SN) 1 t	ime a week for 9 weeks					
		visits for pain, falls,					
	respiratory/cardi						
	,	gastrourinary, and					
	1 -	omplications; Physical					
		time for 1 week then 2					
		4 weeks; Occupational					
		time for 1 week then 2 3 weeks then 1 time for					
	i week; Medical	Social Worker 1 time					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	COM	TE SURVEY IPLETED 19/2015		
	PROVIDER OR SUPPLIER LAKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	2 weeks; Home	1 visit every 2 weeks for Health Aide (HHA) 2 1 week then 3 times a s.						
	16 was provided acquired agency 5/5/15 by emplo 4/10, 4/13, 4/17,	ord evidenced patient # SN services from the on 3/23, 4/14, 5/1, and yee QQ; 3/30, 4/3, 4/7, 4/21, 4/24, 5/6, and yee NN; and 4/28/15 by						
	16 was provided acquired agency 4/6, 4/8, 4/10, 4/	ord evidenced patient # HHA services from the on 3/25, 3/27, 3/30, 4/1, 115, 4/17, 4/21, 4/24, 8/15 by employee WW; oyee LL.						
	was provided PT acquired agency	ord evidenced patient # 16 Services from the on 3/26/15 by employee , 4/10, 4/13, 4/17, 4/20, apployee UU.						
	was provided TO	rd evidenced patient # 16 O services from the on 4/2 by employee CC.						
	12:40 PM, the A OASIS submissi	terview on 11/13/15 at dministrator stated the ons are done by the ans, and the Corporate						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUILDIN B. WING			00 COMPLETED 11/19/2015				
NAME OF F	PROVIDER OR SUPPLIER		-		DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	office in Michiga State agency.	an submits the data to the					
	10:30 AM, the A agency does not	derview on 11/16/15 at dministrator stated the have and agreement or porate office to submit the State agency.					
	And Reporting C reviewed March electronically rep collect in accordance regulations. GLC behalf of GLC w	policy titled "Encoding DASIS Data," # B-250, 2015 stated, "GLC will port all OASIS data ance with federal C and agents acting on ill ensure confidentiality fic information in the					
	Necessary Disclot Health Information March 2015 state recurring discloss information 1. Of disclosures of hemakes on a routing that are not related has determined the heath information achieve the purposure Non-routine disconformation 3	ures of health GLC has identified alth information it ne and recurring basis ed to treatment. 2. GLC ne minimum amount of n that is needed to ose of these requests losures of health					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL	
		157586	B. W		00	11/19/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIER				WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
IAG		minimum a mount		TAG	DEFECT.)		DATE
	1	request if from a public					
	_	care provider, a health					
	· ·	•					
		nal providing service to ss associate, or a					
		provides appropriate					
	`	Disclosures of entire					
	· · · · · · · · · · · · · · · · · · ·	GLC does not disclose					
		ntire medical record in					
		y request not related to					
	treatment for any	-					
		such a disclosure is					
	documented."	such a disclosure is					
	documented.						
	11. The agency's	s policy titled					
	"Client/Family F						
		" # C-390, reviewed					
	March 2015 state						
		ave the right to:					
	_	of written, verbal and					
	1	ted health information					
	including your m						
		at your health, social and					
		stances or about what					
	takes place in yo	ur home State of					
		ım: Sec. 3. (a) The					
	patient or the pat	tient's legal					
	representative ha						
	_	patient's rights through					
		of communication. The					
	home health age	ncy must protect and					
	_	cise of these rights and					
	-	owing: (2) Maintain					
		howing it has complied					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
TAG	with the requirer (E) Confidential maintained by the The home health patient of the aggreed procedures regardelinical records.' 12. The agency's "Management of B-435, reviewed Physical Security limit access to an computer network with a confirmed Data Security Pothis policy applies or created by entipurisdiction of Genot limited to, da Branches supports systems departm Computer Security Computer Security Pothis policy applies or created by entipurisdiction of Genot limited to, da Branches supports systems departm Computer Security Pothis policy applies or created by entipurisdiction of Genot limited to, da Branches supports systems departm Computer Security 13. The agency's "Responding to Genote Pothis Pot	nents of this section lity of the clinical records he home health agency. he agency shall advise the ency's policies and ding disclosure of he spolicy titled he electronic Data," # March 2015 stated, "4. y These procedures he agency shall advise the ency's policies and ding disclosure of he spolicy titled he electronic Data," # March 2015 stated, "4. y These procedures he agency shich contain he aguipment to those he a		TAG		ALE	DATE	
	document the ex catheter with eac	tated, "Measure and ternal length of the the dressing change."						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		lì í	IULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
THIS TEXT	or condition	157586	B. W		00	11/19/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	₹			WEBSTER ST		
GREAT I	AKES CARING			KOKOM	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		ssing Change," # I-240					
		entation Guidelines 1. e clinical record: d.					
		ter visible at exit site. e.					
	Any physician n						
	Any physician n	ouncation.					
	15. The agency	's policy titled "Care					
	"	reviewed March 2015					
		Care Plan shall include,					
	but not be limite	ed to: a. Problems and					
	needs identified	related to diagnosis					
	c. A list of spec	ific interventions with					
	plans for implen	nentation 4. The					
	1 ^ -	of Care may be used as a					
		ific interventions are					
	1 *	d for home care staff to					
		re needs State of					
		um: The nursing plan					
		ain: 1. A plan of care					
		patient identifying					
		5. Medications, diet,					
	and acclivities."						
	16. The agency	's policy titled					
		or Blood Specimen					
		140, revised 7/30/14					
	· ·	Praw from Central					
	·	Devices Procedure:					
		ician order. 2. Use strict					
	sterile technique						
	17. The agency	'a naliay titlad					
		f Client Services," #					
		l March 2015 stated, "3.					
	C-300, Teviewed	i iviaicii 2013 Stateu, 3.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE COI JILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157586	B. W	ING	<u> </u>	11/19/		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	Registered Nurse communicate the visit with the Cli ensure: a. Clari care orders	assessment, the admitting e/Therapist shall e findings of the initial nical Supervisor to fication of the plan of e. Need for other eferral to community						
	and Reporting O	s policy titled "Encoding ASIS Data," # B-250, 2015 stated, "2. Data t status at time of						
	C-145, reviewed Reassessments a client needs, phy	Client Assessment," # March 2015 stated, "16. re conducted based on visician orders, gment and/or OASIS or						
	Recertification/F of Care," # C-15 stated, "5. Each will be responsible care/services at 1	s policy titled "Client Follow-Up/Resumption 5, reviewed March 2015 professional discipline ple for reassigning east every fifty-six to ys while the client is services."						
		s policy titled "Clinical ' # C-680, reviewed						

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/19/2015
	ROVIDER OR SUPPLIER		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
G 0239 Bldg. 00	that there is an asservices provided ongoing need for conformance with modifications to interdisciplinary. 22. The agency's Record Confider reviewed March Authorized users b. Staff member providing and surface and the agency failed confidentiality of allowing an acquiservices to 26 of on both the Soutipatient list and the active patient list 30, 31, 31, 33, 34, 42, 43, 44, 45, 51), for 1 of 1 refrom the parent and assessment and	involvement." s policy titled "Clinical titality," # C-880, 2015 stated, "1. will be identified as: s and contract staff pervising client care." FRECORDS Transaction is safeguarded authorized use. review and interview,	G 0239	G 239 To assure compliance with 484.48(b) Protection of Record the following interventions have been implemented: • • • • • • • • • • • • • • • • • • •	h ent ncy ne C

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	COMPLETED	
		157586	B. Wl	ING		11/19/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8			WEBSTER ST	
GREAT I	_AKES CARING			KOKON	MO, IN 46902	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	, , , , , , , , , , , , , , , , , , ,			TAG		DATE
	_	agreement was in place			as PT, OT, SLP, SN, MSW an HHA.	ď
	_	office in Michigan to			1	
		ata to the State agency			•□□□□□□□ The OASIS review	
	for 1 of 1 agency	у.			and lock process was revised	on
					12/13/15 to have the specific	
	Findings include	2:			provider number Clinical	_
					Supervisors or RNs review an lock their responsible areas	u
	1. During interv	view on 11/5/15 at 1:40			OASIS.	
	PM, the Admini	strator stated that some				
	of the current So	outh Bend patients were			•	h
		gency in Warsaw that had			2015, a contractual arrangeme	
	1	y the Great Lakes			was secured between the Gre	
		nese patients were listed			Lakes Caring Corporate office and the agency to submit OAS	
	_	nd branch active patient			data to the state.	
		he acquired agency's				
		t due to the acquired			• December 3	rd
	_	-			2015-All agency South Bend	
		ccept the insurance			branch patients were assigned the correct South Bend RN	d to
	^	inistrator stated that the			Clinical Supervisor.	
		had its own provider			Cirrical Capervicor.	
	number.				•	
					15th, 2015 – no new patients	
	_	riew on 11/6/15 at 10:15			were accepted to service for the	
	1	strator stated there was			agency that would normally be admitted to the acquired agen	
		an agreement for the			provider number.	Cy S
	acquired agency	to provide services to the			provider manners	
	South Bend patie	ents. The Administrator			•====== As of 12/23/15 – A	
	stated the acquir	red agency staff were			'acquired agency's' patients w	ere
	Great Lakes emp	ployees. The			discharged from the agency.	
	Administrator st	ated when the			•=====================================	
	corporation acqu	ired the agency provider			12/23/15 The Electronic Medic	eal
		th Bend branch provided			Record access of all employee	
	· ·	counties already serviced			in the state of Indiana was	
	by the acquired				thoroughly reviewed and upda	
		ated the revenue for			to assure employees only hav	
	1 Millinguator St	acca and revenue 101	I		access to the locations they a	re l

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		157586	B. W	ING		11/19/	2015
NAME OF F	DOMINED OD GIDDI IED		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		3115 S	WEBSTER ST		
	AKES CARING				лО, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	assigned or contracted throug	h	DATE
		patients would go to the			New hire employees and inter		
	South Bend branch. The Administrator				employee transfers will need to		
	_	cies allocate speech		go through an HR process to			
		n them, but the acquired			assure computer access		
	" "	ot bill the patients. The			integrity.		
		ated the staff at the					
	acquired agency	did have access to the			An audit will be performed wee	ekly	
	medical records	of the patients they			by the administrator/designee		
	provide services	for, even though the			assure 100% compliance with		
	patients were als	o listed on the South			239 with the applicable provide		
	Bend branch ros				number Clinical Supervisors/R		
					reviewing and locking the OAS for a period of 4 weeks. After		
	A The South B	end active roster was			consecutive weeks of 100%	7	
		he acquired agency's			compliance, the audit will		
	_	oss referenced on 11/5	decrease to 50% of all OASIS for				
					another 4 weeks. After that 4		
		tients listed on the South			weeks of 100% compliance is	o to	
		er and also the acquired			obtained the audit will decreas 10% quarterly and will be	e io	
	agency list inclu	aea:	completed through the clinical				
		1 . (0.2.5)			record review process. (Exhibi		
		care date (SOC)					
	10/27/15				An audit to assure compliance		
	# 27, SOC 10				with G 239 will be performed the administrator/designee on	y	
	# 28, SOC 10	/18/15			100% of all new South Bend		
	# 29, SOC 7/1	18/15			admissions with a SOC date of	n	
	# 30, SOC 9/2	26/15			or after November 15th for a		
	# 31, SOC 8/1	14/15			period of 8 weeks. After 8		
	# 32, SOC 9/2				consecutive weeks of 100%		
	# 33, SOC 10				compliance, the audit will decrease to 10% quarterly and	۱ ا	
	# 34, SOC 11				will be completed through the	1	
	# 35, SOC 9/2				clinical record review process.		
	# 36, SOC 10				(Exhibit 1)		
	# 30, SOC 10 # 37, SOC 10						
					An audit will be completed by		
	# 38, SOC 9/1				administrator/designee on 20% all employees in regards to the		
	# 39, SOC 9/1	11/15	1		an employees in regalus to the	211	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ЛLDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	/2015
NAME OF B	DOLUDED OD GLIDDI IEE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	C		3115 S	WEBSTER ST		
	AKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	medical record access to assu	uro.	DATE
	# 40, SOC 10/3/15 # 41, SOC 10/10/15				compliance with protection of	ii e	
					records until 100% compliance	9	
	# 42, SOC 8/				has been obtained for 4		
	# 43, SOC 11	/1/15			consecutive weeks. After 4		
	# 44, SOC 10	0/22/15			weeks of 100% compliance au		
	# 45, SOC 10	0/31/15			will decrease to 10% quarterly		
	# 46, SOC 3/2	24/15			and will be completed by Hum Resources. (Exhibit 17)	all	
	# 47, SOC 9/	14/15			resources. (Exhibit 17)		
	# 48, SOC 9/2	29/15					
	# 49, SOC 9/2	28/15					
	# 50, SOC 7/						
	# 51, SOC 9/2	, , , , , , , , , , , , , , , , , , ,					
	01, 200 37.	20, 10.					
	R During in	terview on 11/6/15 at					
	_	Administrator provided					
	the South Bend						
		•					
		ated this roster was only					
	-	whom South Bend					
	•	This roster failed to					
	evidence patient	s 26-51.					
	3. During interv	riew on 11/6/15 at 11:12					
	_	strator indicated the					
	acquired agency						
		nd Clinical Supervisor,					
	but she was also	•					
	Aummstrator IC	or the acquired agency.					
	4. During interv	riew on 11/6/15 at 11:30					
	_	strator stated since the					
	-	red agency were all					
	•	ployees, there was not a					
	_	identiality of medical					
		-					
	records. The Ac	lministrator stated the	1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	/2015
	PROVIDER OR SUPPLIER		<u> </u>	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	those counties be number was acq stated Great Lak	ach was approved for efore other provider uired. The Administrator es acquired the Warsaw er number in October,					
	was reviewed on was chosen from Deteriorating W listed as having South Bend bran the territory serv	ecord for patient # 16 a 11/9 and 11/16/15 and a the OASIS list for ound Status and was had been a patient of the ech. Patient # 16 lived in iced by the acquired ient was discharged to 5.					
	Administrator st maintains the ch they provided se	715 at 11:35 AM, the ated the acquired agency arts for all the patients rvices for and patient # most services by the					
	12:05 PM, the A patient # 16 is m	atterview on 11/16/15 at dministrator stated anaged by the acquired South Bend branch had in the care.					
	3/23/15, contain	of care dated th start of care date ed orders for skilled time a week for 9 weeks					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	2015
NAME OF B	DOWNER OF CLIDITIES			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			3115 S	WEBSTER ST		
	AKES CARING			<u> </u>	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
		visits for pain, falls,					
	respiratory/cardi						
	,	gastrourinary, and					
		omplications; Physical					
		time for 1 week then 2					
		4 weeks; Occupational					
	Therapy (OT) 1	time for 1 week then 2					
	times a week for	3 weeks then 1 time for					
	1 week; Medical	Social Worker 1 time					
	for 1 week then	1 visit every 2 weeks for					
	2 weeks; Home	Health Aide (HHA) 2					
	•	1 week then 3 times a					
	week for 2 week						
	D. The reco	rd evidenced patient # 16					
		I services from the					
	*						
		on 3/23, 4/14, 5/1, and					
		yee QQ; 3/30, 4/3, 4/7,					
		4/21, 4/24, 5/6, and					
		yee NN; and 4/28/15 by					
	employee PP.						
	E The reces	ed avidanced nations # 16					
		rd evidenced patient # 16					
		HA services from the					
		on 3/25, 3/27, 3/30, 4/1,					
		15, 4/17, 4/21, 4/24,					
	· · · · · ·	8/15 by employee WW;					
	and 5/1 by emplo	oyee LL.					
	F The recor	d evidenced patient # 16					
		services from the					
		on 3/26/15 by employee					
		, 4/10, 4/13, 4/17, 4/20,					
	and 5/1/15 by en	nployee UU.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
	PROVIDER OR SUPPLIER		•	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	was provided Of acquired agency	rd evidenced patient # 16 Γ services from the on 4/2 by employee CC.					
	PM, the Adminisubmissions are clinicians, and the	strator stated the OASIS done by the nurses or ne Corporate office in ts the data to the State					
	AM, the Admini	strator stated the agency d agreement or contract ffice to submit OASIS agency.					
	And Reporting (reviewed March electronically re- collect in accord regulations. GL behalf of GLC w	policy titled "Encoding DASIS Data," # B-250, 2015 stated, "GLC will port all OASIS data ance with federal C and agents acting on vill ensure confidentiality ific information in the					
	Necessary Discle Health Informati March 2015 state recurring disclose						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
THINDTERM	or condition	157586	B. W		00	11/19/	
		101000		CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	1 17 107	2010
NAME OF F	PROVIDER OR SUPPLIER				WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ealth information it					
		ne and recurring basis					
		ed to treatment. 2. GLC					
		he minimum amount of					
		n that is needed to					
		ose of these requests					
		closures of health					
		3. GLC relies on					
	•	hat the information					
	•	minimum a mount					
	,	request if from a public					
	· ·	care provider, a health					
		nal providing service to					
	GLC as a busine	, , , , , , , , , , , , , , , , , , ,					
	,	provides appropriate					
	· · · · · · · · · · · · · · · · · · ·	Disclosures of entire					
		GLC does not disclose					
	an individual's e	ntire medical record in					
	fulfillment of an	y request not related to					
	treatment for any						
	justification for s	such a disclosure is					
	documented."						
		s policy titled "Clinical					
		ntiality," # C-880,					
	reviewed March	*					
		s will be identified as:					
	b. Staff member	rs and contract staff					
	providing and su	pervising client care."					
	11. The agency'	s policy titled					
	"Client/Family F	Rights &					
	Responsibilities,	" # C-390, reviewed					
	March 2015 state	ed, "Privacy and					

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	OF CORRECTION	IDENTIFICATION NUMBER:	l í	ULTIPLE CO JILDING	NSTRUCTION 00	COMPL	
I I I I I I I I I I I I I I I I I I I	or condition	157586	B. W		00	11/19/	
		107000		CTREET	DDDEGG CITY CTATE ZID CODE	1 17 107	2010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT I	AKES CARING				10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROLEMENT)		OPRIATE CONTINUE TO THE PROPERTY OF THE PROPER	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	eve the right to:					
	1	of written, verbal and					
	•	ted health information					
	including your n						
		at your health, social and					
		stances or about what					
	1 1	ur home State of					
		im: Sec. 3. (a) The					
	patient or the pat	_					
	representative ha	_					
	_	patient's rights through					
		of communication. The					
	_	ncy must protect and					
	•	cise of these rights and					
		owing: (2) Maintain					
		howing it has complied					
	_	nents of this section					
	` ′	lity of the clinical records					
	_	e home health agency.					
		agency shall advise the					
	-	ency's policies and					
		ding disclosure of					
	clinical records.'	1					
		41 - 224 - 4					
	12. The agency'						
	1	electronic Data," #					
		March 2015 stated, "4.					
		y These procedures					
		reas, which contain					
	•	rk equipment to those					
		l "need to know" 2.					
		olicy a. Scope. i.					
		es to all data maintained					
	or created by ent	ities within the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPI		
		157586	B. W		<u>00 </u>	11/19	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	1	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST	11710	2010
GREAT	_AKES CARING			KOKOM	IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
	not limited to, da Branches suppor systems departm Computer Securieffort will be madata and facilitie need-to-know." 13. The agency's Supervision," # 0 2015 stated, "Po other therapeutic under the supervision. The Reg Manager will be ongoing supervision of GLC. It will the administ responsibilities be organization. Purequirement of s and provide super all staff delivering services. To assiperformance is a that care is direct achievement of g are provided bas accordance with Care Special Regional Directors is a superformal delivering services. To assiperformance is a superformance is a superformance in the care is direct achievement of g are provided bas accordance with Care Special Regional Directors is a superformance in the care is direct achievement of g are provided bas accordance with Care Special Regional Directors is a superformance in the care is directors.	ppropriately supervised,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILI		NSTRUCTION 00	(X3) DATE S COMPLI		
		157586	B. WING			11/19/	2015
NAME OF PRO	OVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT LAI	KES CARING				O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	contract staff. He responsible for or GLC's ongoing for Regional Directo coordinate the dathe organization and Administrator. 3 Supervisor will properties relevant services furnished development of passignment of personal properties.	articipate with the r/Clinical Manager in all t to the professional d. This includes the pualification and the					
Bldg. 00 F	HHAs must electro data collected in ac Based on record railed to ensure a agreement was in	sis information onically report all OASIS occordance with §484.55 review, and interview, on arrangement or a place for corporate on to submit Outcome	G 032	0	G 320 To assure compliance with 484.20 Reporting of Oasis Information, the following interventions have been		12/23/2015

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	COMPLETED
AND I LAIN	o. condenion	157586	B. WING	UU	11/19/2015
			CTDEET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER	2		S WEBSTER ST	<u>.</u>
	AKES CARING		коко	MO, IN 46902	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	COMPLETION COMPLETION DATE
TAG		ormation Set (OASIS)	TAG	implemented:	DATE
		agency for 1 of 1 agency		implemented.	
		led to ensure the accuracy		G 321	
		ata for 2 of 20 records			
		322); and failed to		• 2015, a contractual arrang	
	`			was secured between the	-
	_	Its for whom the agency S data were patients of		Lakes Caring Corporate of	
		•		and the agency to submit	OASIS
		anches for 1 of 20		data to the state.	
		d, and failed to ensure an		G322	
	"	agreement was in place		0022	
		fice in Michigan to		· All clinical staff wer	l l
		lata to the State agency		educated by 12/24/15 on	
	(See G 324).			B-250 Encoding and Repo	
				on the requirement that th	
		20		OASIS assessment must	
		effect of these systemic		the patient's condition at	
		ed in the home health		assessment which require	l l
	"	y to ensure the provision		ongoing assessment and to the plan of care. All ca	
	of quality health	care in a safe		demonstrate a skilled nee	l l
	environment.				
				A weekly audit will be per	
				by the administrator/designassure compliance with G	
				100% of all admissions ar	
				recertification visits until 1	00%
				compliance is met for 4	A weeks
				consecutive weeks. After of 100% compliance, the	
				decrease to 10% quarterly	
				will be completed through	the
				clinical record review prod	cess.
				G 324	
				• As of Novemb	
				2015, a contractual arrang	gement

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	00	COMPLETED 11/19/2015	
	ROVIDER OR SUPPLIER	<u> </u>	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	ı
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				was secured between the Gre Lakes Caring Corporate office and the agency to submit OA data to the state.	9
				• Online As of November 6 2015, a contractual arrangem was secured between the aggreferred to as Community Holled Health Network of Indiana, LL dba Great Lakes Caring CCN 157586 (agency) and the acquired agency of AC and Associates dba Great Lakes Caring(acquired agency) to provide the agency services as PT, OT, SLP, SN, MSW and HHA.	ent ency me .C
				As of November 15th, 2015 – no new patients were accepted to service for agency that would normally b admitted to the acquired ager provider number. As of 12/23/15 – A acquired agency's' patients were accepted to service for the acquired agency.	e ncy's
				discharged from the agency. On 12/21/15- 12/23/15 The Electronic Medi Record access of all employe in the state of Indiana was thoroughly reviewed and upda to assure employees only hav access to the locations they a assigned or contracted throug New hire employees and inte employee transfers will need go through an HR process to assure computer access	es ated ve ire gh. rnal

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	of Correction identification number: 157586	A. BUILDING B. WING	00	COMPLETED 11/19/2015			
	PROVIDER OR SUPPLIER AKES CARING	3115 S	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
			integrity. A weekly audit to assure compliance with G 324 will be performed by the administrator/designee on 100 of all new South Bend admissi with a SOC date on or after November 15th for a period of weeks. After 8 consecutive weeks of 100% compliance, th audit will decrease to 10% quarterly and will be completed through the clinical record reviprocess. (Exhibit 1) A weekly audit will be completed by the administrator/designee 20% of all employees in regard to their medical record access assure compliance with protect of records until 100% compliance has been obtained for 4 consecutive weeks. After 4	ed on ds to tion nice			
G 0321 Bldg. 00	484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set.		weeks of 100% compliance au will decrease to 10% quarterly and will be completed by Hum. Resources.				
	Based on record review, and interview, the agency failed to ensure an arrangement or agreement was in place	G 0321	G 321 To ensure compliance v 484.20(a) Encoding Oasis Dat the following interventions hav been implemented: As of	a,			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	(X3) DATE COMPL			
		157586	B. WI		<u>00 </u>	11/19/		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	R	3115 S WEBSTER ST					
GREAT I	AKES CARING			KOKON	1O, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG		ice in Michigan to		IAG	November 6th 2015, a contrac	ctual	DATE	
		Assessment Information		arrangement was s	arrangement was secured	cured		
	Set (OASIS) data to the State agency for 1 of 1 agency.			between the Great Lakes Caring Corporate office and the agency to submit OASIS data to the	-			
					Су			
					state.			
	Findings include):						
	~	riew on 11/5/15 at 12:15						
	does not do look	strator stated the agency						
		the if the clinician OASIS						
		and if the agency gets the						
	same scores.							
	_	riew on 11/13/15 at 12:40						
	· ·	strator stated the OASIS						
		done by the nurses or						
		ne Corporate office in						
	_	ts the data to the State						
	agency.							
	3. During interv	riew on 11/16/15 at 10:30						
	_	strator stated the agency						
	does not have an	d agreement or contract						
	with corporate o	ffice to submit OASIS						
	data to the State	agency.						
	4 The	1:4:41-4 UF4:						
	1	policy titled "Encoding DASIS Data," # B-250,						
		2015 stated, "GLC will						
		port all OASIS data						
		ance with federal						
	regulations. GL	C and agents acting on						
	behalf of GLC w	vill ensure confidentiality						

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		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	ETED	
		157586	B. W	ING		11/19/	/2015	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ific information in the		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
G 0322	clinical record." 484.20(b)							
Bldg. 00	The encoded OAS reflect the patient assessment. Based on record to ensure the acc Assessment and data for 2 of 20 and 13) Findings include 1. The clinical rewas reviewed or care date was 9/29/26-11/24/15 care follow for SN 1 time as a week for 2 week for 7 weeks, 3 as gastrointestinal/cardiac, impaire and functional deaching and interventional dair if no drainage-Observation and	record for patient # 10 n 11/17/15. The start of 26/15. POC dated contained diagnosis of ring Surgery, with orders week for 1 week, 2 times eks, then 1 times a week is needed for falls, pain, gastrourinary, respiratory, d skin integrity, diabetes, ecline. Need for skilled ervention related to cervical spine incision. dry. May leave open to	G 0	322	G322 To assure compliance with 484.20(b) Accuracy of Encode Oasis Data • All clinical staff were educated by 12/24/15 on polic B-250 Encoding and Reporting OASIS Data. Education focuse on the requirement that the OASIS assessment must mate the patient's condition at assessment which requires ongoing assessment and update to the plan of care. All care m demonstrate a skilled need. An audit will be performed by administrator/designee to assure compliance with G 164 on 100 of all admissions and recertification visits to assure patient interventions match diagnosis on the plan of care to 100% compliance is met for 4 consecutive weeks. After 4 we of 100% compliance, the audit decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 12)	y g ed ch ates ust the ure y%	12/24/2015	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	A. BUILDING <u>00</u>			COMPLETED	
		157586	B. W	'ING		11/19/2015		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R			WEBSTER ST			
GREAT	LAKES CARING				1O, IN 46902			
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	with exacerbation	on for early intervention						
		s; observation/assessment						
	of gastrointestinal system to identify changes associated with exacerbation of							
	1	ntion of complications;						
	1	nt and develop plan of						
		ter signed by physician;						
		sessment of respiratory						
		fy changes associated						
		on for early intervention						
	of complication							
		etions related to discharge						
	1 .	harge summary for all						
	_	lable to physician upon						
	request;							
	1	and provide assistance to						
	patient for unde	•						
	management of	feelings. SN may						
	perform Hamilt	on anxiety scale and/or						
	mini mental exa	nm;						
	-Provide assessi	ment and						
	teaching/reinfor	recement of management of						
	depression inclu	ading disease process,						
	medication man	nagement, coping skills						
	and identify cha	anges associated with						
	depressive disor							
	_	N may perform geriatric						
		e and/or mini mental						
	exam;							
	-Provide teaching/reinforcement in etiology of confusion or altered cognition, safety measures and home							
	1 -	bservation and assessment						
	of pain, effectiv							
	or pain, effectiv	chess of pain						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO JILDING	NSTRUCTION 00	COMPL		
THINDTERM	or condition	157586	B. W		00	11/19/	
		107000		CTREET	DDDEGG CITY CTATE ZID CODE	1 17 107	2010
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	l regimen and skilled					
	_	to pain management, SN					
	to report increase	•					
		ompt intervention;					
	-Skilled teaching						
		plan, disease process					
	including self ma						
		ypertension disease;					
	-SN to obtain pu	_					
		nes 3 as needed for					
		th, oxygen use, activity					
	intolerance;						
		on/reinforcement of					
	_	system related teaching,					
	_	culitis and irritable					
	bowel syndrome						
	_	killed teaching regarding					
	measures to cont	rol diarrhea/constipation					
	as well as prever	nting related					
	•	killed teaching and					
	training of emerg	gency care plan, disease					
	process laminect	omy surgery including					
	_	t of neurologic disease;					
	_	ssessment and					
	_	cement of management of					
	diabetes includir	ng disease process,					
	medication mana	agement, coping skills					
	and identify char	nges associated with					
	diabetes for early	y intervention. SN may					
	perform blood g	lucose level as needed					
	for signs and syr	nptoms of					
	hyper/hypoglyce	emia or for baseline					
	testing. SN ass f	feet and reinforce					
	diabetes mellitus	foot care;					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ľ í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	-SN observation integumentary stackin integrity; -SN to instruct pand symptoms of cervical spine surplications to a complications to symptoms of cervical spine surplications to symptoms of complications to symptoms of cervical spine surplications to symptoms of cervical spine surplications of cervical spine surplications of cervical spine instructed and aspects of cervical disease manager hospitalization; -Skilled instructions of cervical spine spine instructions of cervical spine spine instructions of cervical spine spine instructions of cervical spin	and reaching atus to promote optimum atient/caregiver on signs f infection related to tures to reduce the wound; supports to minimize ration patient/caregiver d in emergency care plan, ervical spine surgery nent to reduce avoidable on of medication ify						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157586	B. W	ING		11/19/	/2015	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE			
		X.	3115 S WEBSTER ST					
GREAT I	_AKES CARING			KOKON	1O, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
1710	-	xiety are identified and		1110			DATE	
		tiated to allow patient to						
	manage feelings	•						
	-Patient/caregive							
	_	strate understanding the						
		depression by the end of						
		symptoms are identified						
	and managed to	maintain patient safety in						
	the home; Patier	nt/caregiver will						
	demonstrate und	lerstanding of etiology of						
	confusion and m	aintain patient safety in						
	the home;							
	-Improvement ir	n pain interfering with						
	activity;							
	-Pain controlled	at level of 3 or less or at						
	a level acceptable	le to the patient;						
	-Patient/caregive	er demonstrate						
	understanding of	f pharmacological and						
		gic pain control measures;						
		nonstrate ability to self						
	_	ascular hypertension						
	_	and reduce caregiver						
		ed with disease process;						
		results obtained;						
		er will demonstrate						
		anage gastrointestinal						
	disease process;	1 11 1						
	-Patient/caregive							
		lity to manage altered						
		on. Patient will have						
	bowel patency;	1.:1:44						
		bility to self manage						
	1	se process and reduce						
	caregiver burder	associated with disease						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	<u>00</u>	COMPL 11/19/	ETED		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
GREAT L	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	symptoms of new-Patient/caregive demonstrate undo management of depisode and symmanaged to main home; -Demonstrated in conditions and earn in skin; -Wound complicing and complete and symmanaged to main home; -Demonstrated in conditions and earn in skin; -Wound complicing and complete and size or healing of of cert period; -Patient will have supports to preveauvoidable hospitated reduced; -Patient/caregive ability to safely reduced; -Patient will be about of daily living and daily living with and ally living with the proper technique prevention. The agency failed was notified of general supports to general supports to prevention.	r will verbalize erstanding the liabetes by the end of the ptoms are identified and stain patient safely in the mprovement in existing arly identification and dditional compromises ations avoided; entary status will enced by a decrease in f wound/decub by end e appropriate agency ent rehospitalization, alizations will be r will demonstrate manage medications; ble to perform activities and individual activities of decreased risk for falls; r will demonstrate s of pressure ulcer d to ensure the physician oals being met and of als needing to be changed						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	2015
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
		nursing staff to ensure					
		education on goals met					
	was not being co	ontinued.					
	A. The initia	l start of care was					
		ient Coordination Note					
	•	late entry for 9/26/15 of patient] states the					
		pain ever gets is a # 8 on					
		ently patient takes					
	-	grams tablets for pain."					
	The agency faile	d to ensure the goal of					
	"Pain controlled	at level of 3 or less or at					
	_	e to the patient" was					
	revised.						
	B. The start of	of care Outcome					
	Assessment and	Information Set					
	assessment form	dated 9/26/15 stated					
	"(M1018) Condi	tions prior to medical					
	_	en change or inpatient					
		ast 14 days 3-					
		" The Pain assessment					
		ain All of the time					
		g: 9 What activities					
	-	e: Movement. When is					
	-	Always in Pain. How					
	-	evain last? Constant. Can eved? No." The section					
	-	e/Hematopoietic" stated					
		ine/Hematopoietic					
	assessment (mar	•					
	· ·	d problems Is the					
		sulin? No Is the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î í	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER		-		DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	COMPLETION DATE
	patient taking an	antidiabetic agent? Yes.					
	•	e blood sugars check?					
	l '	y often. What are the					
	Below 130."	ood sugar readings?					
		ed "Care Coordination"					
		if you communicated					
		olines involved in this					
	case: YES. Wh	at discipline did you					
	communicate wi	th? Physician,					
	_ , ,	inical Supervisor.					
	_	physician not contacted:					
		Contacted physician for					
		osed plan of care: No.					
		physician not contacted:					
		nds." The section titled ed: "3. Patient/caregiver					
		standing of basic					
		ation requirements." The					
		to evidence the SN					
	provided teaching	g/reinforcement of					
	management of	=					
	2 The clinical r	ecord for patient # 13					
		11/19/15. The start of					
		2/15. Diagnosis of					
		orea. The POC dated					
	_	ontained orders for SN					
		15, 1 time a week for 1					
		vo weeks for 4 weeks, 1					
	every 3 weeks for	or 3 weeks, and 3 as					
	needed for cardi	ac/respiratory,					
	-	strointestinal, endocrine,					
	mental, pain, ski	n, wound status changes,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		r í	JILDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
PREFIX	and falls. SN for -Evaluate patient care, observation effectiveness of pregimen and skill pain management level to physician -Observation/ass system to identify with exacerbation of complications - Obtain pulse on upon recertificate and times 3 as no breath, oxygen u -Observation/ass system to identify with exacerbation of complications - SN for urinary i and intervention; teaching related to management. M culture and sensi for signs and syn infection or reter -SN for observat gastrointestinal s changes associate or early intervent SN to provide sk	cy Must be preceded by full LSC IDENTIFYING INFORMATION) and develop plan of and assessment of pain, pain management and led teaching related to t, report increase in pain n; essment of cardiac ty changes associated in for early intervention tion to confirm baseline teded shortness of se, activity intolerance; essment of respiratory ty changes associated in for early intervention sessment of respiratory ty changes associated in for early intervention to continence screening SN to provide skilled to urinary incontinence any obtain urinalysis and tivity times 3 if indicated inproms of urinary tract attion. ion/assessment of		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
	as well as preven complications, S	iting related N for administration of					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ì í	LDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF I	PROVIDER OR SUPPLIER		I		DDRESS, CITY, STATE, ZIP CODE		
GREAT I	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	removal of fecal neededSN to evaluate a to improve balan fallsSN to instruct paper preventive measurable of hospitalization and as disease managen hospitalizationSN to provide in discharge planning for all disciplines upon requestSkilled instruction regimen to identification intervention. GOALS; -Pulse oximetry and associated risks; -Improvement in incontinence;	results obtained. iratory status will be ported to physician for ion to minimize urinary incontinence; management of urinary f gastrointestinal disease					

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	PROVIDER OR SUPPLIER			3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	risks to patientPatient/caregive demonstrate abil bowel elimination and all patient will have a patient will be a of daily living are daily living with and all patient will have proper technique prevention, and all patient will have supports to prevent avoidable hospit reduced; avoidable hospit reduced; are patient's dischart disciplines availare request; ability to safely to the sessment and (OASIS) Visit Note 10/26/15 section and Assessment Scalar (patients with a transport of the score, the is: LOW." The	ity to manage altered on. e bowel patency; able to perform activities of individual activities of decreased risk for falls; or will demonstrate agency ent rehospitalization, alizations will be rege instruction needs will ge summary for all able to physician upon or will demonstrate manage medications. ecertification Outcome Information Set one Report dated titled "Braden Risk et stated, "Total Score total score of 12 or less of be at high risk of sure ulcers): 18. Based risk level for this patient					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO JILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF F	PROVIDER OR SUPPLIER		_		DDRESS, CITY, STATE, ZIP CODE	•	
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		caregiver in position		-			
	changes/adaptive	e equipment to alleviate					
	•	s/comments: instruct in					
	•	cluding using pillows for					
		ring skin over bony					
	-	l position changes at					
	least every 1-2 h						
	~ .	ng schedule 10. ional requirement to					
		in integrity and healing."					
	promote good sk	in megney and nearing.					
	B. The Visit	Note Report section					
	titled "Integument	ntary/Wound" stated,					
	•	entified," and failed to					
	•	ient needed skin integrity					
		void pressure ulcer risks					
		ducation to promote					
	healing.						
	C. The SN F	Recertification OASIS					
	Visit Note Repor	rt dated 10/26/15 section					
	titled "Goals Me	t," previously on 10/6/15					
	_	being re-instructed on					
	_	n 10/26/15 visit and listed					
		atient/caregiver will					
		tanding of instructions					
		pressure relief and ulcer					
	*	Cardiac exacerbations are otly and interventions					
		to minimize associated					
	risks 5. Pati						
	demonstrate und	_					
		and nonpharmacologic					
		sures this visit. 6.					
							l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 11/19/2015				
	ROVIDER OR SUPPLIER AKES CARING		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE			
	prompt intervent associated risks. gastrointestinal didentified and into minimize risks. Met failed to evict the needs of the passessment data. D. The SN R Visit Note Report narrative section recertified this vict this time patient this time." The rethe patient was diservices. 2. The agency's	ported to physician for ion to minimize 9. Exacerbations of disease are promptly terventions implemented is to patient." The Goals dence the reflective of patient per the recorded. eccertification OASIS at dated 10/26/15 stated, "Patient disit nursing not need at the continue with PT at record failed to evidence discharged from SN						
	reviewed March	ASIS Data," # B-250, 2015 stated, "2. Data t status at time of						
G 0324 Bldg. 00	OASIS data in a for requirements of pasection.	r all assessments previous month, transmit prmat that meets the aragraph (d) of this	G 0324	G 324	12/23/2015			
		review, and interview, I to ensure all patients for	G 0324	To assure compliance with 484.20©(2) Transmittal of Oas				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		157586	B. W	ING		11/19/2	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	3			WEBSTER ST		
	LAKES CARING				MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	Ţ	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	Data, the following interventio	ne	DATE
	_	sy submitted Outcome			have been implemented:	113	
		ormation Set (OASIS)					
	_	ts of the agency or			• • • • • • • • • • • • • • • • • • •	th	
	branches for 1 of 20 records reviewed (# 16), and failed to ensure an arrangement				2015, a contractual arrangement		
					was secured between the Gre		
	or agreement wa	as in place for corporate			Lakes Caring Corporate office		
	office in Michig	an to submit OASIS data			and the agency to submit OAS data to the state.	010	
	to the State ager	acy for 1 of 1 agency.			data to the state.		
	Findings include: 1. The survey OASIS report dated				• • • • • • • • • • • • • • • • • • •	_{th}	
					2015, a contractual arrangem		
					was secured between the age		
					referred to as Community Hor		
	1	oidable Event Report:			Health Network of Indiana, LL dba Great Lakes Caring CCN		
		dated 5/2015-7/2015			157586 (agency) and the		
	•	at Care for Wound			acquired agency of AC and		
	_	riorating Wound Status,"			Associates dba Great Lakes		
	· ·	t # 16 as being a South			Caring(acquired agency) to		
	•	•			provide the agency services s		
	Bend branch pat	ICIII.			as PT, OT, SLP, SN, MSW ar HHA.	ıu	
	2 During interv	view on 11/5/15 at 1:40					
	_	strator stated that some			• • • • As of November		
	· ·	outh Bend patients were			15th, 2015 – no new patients		
		gency in Warsaw that had			were accepted to service for t agency that would normally be		
					admitted to the acquired agen		
		y the Great Lakes			provider number.		
		nese patients were listed			, ·		
		nd branch active patient			•====== As of 12/23/15 – A		
		the acquired agency's			'acquired agency's' patients w	ere	
	active patient lis	t due to the acquired			discharged from the agency.		
	agency did not a	accept the insurance			•====== On 12/21/15-		
	plans. The Adm	ninistrator stated that the			12/23/15 The Electronic Medi	_{cal}	
	acquired agency	had its own provider			Record access of all employe		
	number.	-			in the state of Indiana was		
					thoroughly reviewed and upda		
	3 During inters	view on 11/6/15 at 10:15			to assure employees only hav		
	J. During interv	16w 011 11/0/13 at 10.13			access to the locations they a	re	

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING		<u>00</u>	COMPLETED 11/19/2015	
	ROVIDER OR SUPPLIER		3	115 S \	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	not a contract or acquired agency South Bend paties stated the acquired Great Lakes emp Administrator state corporation acquired agency number, the South coverage of the coby the acquired at Administrator state those particular processes agency would not Administrator state acquired agency would not Administrator state acquired agency medical records of provide services	atted when the ired the agency provider the Bend branch provided counties already serviced agency. The atted the revenue for patients would go to the ch. The Administrator tries allocate speech at them, but the acquired at bill the patients. The atted the staff at the did have access to the of the patients they for, even though the olisted on the South			assigned or contracted through New hire employees and interremployee transfers will need to go through an HR process to assure computer access integrity. A weekly audit to assure compliance with G 324 will be performed by the administrator/designee on 100 of all new South Bend admissis with a SOC date on or after November 15th for a period of weeks. After 8 consecutive weeks of 100% compliance, th audit will decrease to 10% quarterly and will be completed through the clinical record reviet process. (Exhibit 1) A weekly audit will be completed by the administrator/designee of 20% of all employees in regard to their medical record access assure compliance with protect of records until 100% compliance has been obtained for 4 consecutive weeks. After 4 weeks of 100% compliance au will decrease to 10% quarterly and will be completed by Human Resources (Exhibit 17)	% ons 8 e d ed on ds to tion ace dit	
G 0339 Bldg. 00	ASSESSMENT	COMPREHENSIVE re assessment must be red (including the					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586			onstruction 00	(X3) DATE : COMPL 11/19/	ETED
	PROVIDER OR SUPPLIER		•	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	of every 60 days to care date, unless elected transfer; or condition resulting assessment; or dissame HHA during Based on record the agency failed recertification of 5 day window for reviewed. (# 12) Findings include 1. The clinical rewas reviewed on care date was 7/1 dated 9/17-11/15 for recertification A. The recert completed until 9/16/15 stated, "It today for recertification Reschedule miss 9/18.15." C. The Client Report dated 9/1 called to set up a for recert and was for rec	r patients was within the or 1 of 20 records : ecord for patient # 12 11/18/15. The start of 19/15. The POC was 6/15. The 5 day window in was 9/12-9/16/15.	G 0.	339	G 339 To assure compliance with 484.55(d)(1) Update of the comprehensive assessment, t following interventions have be implemented: • □ □ □ □ □ □ All clinical staff we educated by 12/24/15 on police C-145 comprehensive client assessment and C-155 Client Recertification/Follow-up/and Resumption of Care. Education included the requirement to recertify within the five day window. An audit will be performed by administrator/designee to assicompliance with G 339 of 100 of all recertification visits to ve that they were completed between day 56 and 60 until 100% compliance is met for 4 weeks. After 100% compliance met for 4 weeks the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 17)	re y n the ure % rify e is	12/24/2015

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE COI UILDING	NSTRUCTION 00	COMPL			
		157586	B. W	ING		11/19/	/2015	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
TAG	primary CG [car visit. Could be of Tuesday. Patient new Glucometer [daughter in law on how to use it. [primary care physical with clinical sup D. The Physical dated 9/18/15 stated 9/18/15 stated of E. The Visit 9/22/15 stated, "Supervisory" Timing: 1-Early status Patient that leaving hom contraindicated."	regiver] respite and to done Monday or a apparently received a from Dr. and DIL] would like instructions Will notify PCP sysician] of delay along ervisor." ician Verbal Order form ated, "Patient unavailable Medicare week." Note Report dated Recertification Visit + "(M-0110) Episode y," "Homebound t has a condition such are is medically		TAG	DEFICIENCY)		DATE	
	the agency found	ave been discharged once d out they would not be the recertification visit window.						
	C-145, reviewed	Client Assessment," # March 2015 stated, "16. re conducted based on						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 11/19/2015	
GREAT L	ROVIDER OR SUPPLIER		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	other regulatory 3. The agency's Recertification/F of Care," # C-15 stated, "5. Each will be responsible care/services at 1	policy titled "Client Follow-Up/Resumption 5, reviewed March 2015 professional discipline ble for reassigning east every fifty-six to ys while the client is			
N 0000 Bldg. 00	survey. Facility #: 0112 Medicaid #: 200 Survey Dates: N 13, 16, 17, 18, an	0849420 ovember 5, 6, 9, 10, 12, and 19, 2015	N 0000	Please accept this plan of correction as our credibleallegation of compliar Submission ofthis plan of correction does not indicate wagree with the findings notedthroughout this survey report.	
	Skilled: 4455 Home Health Ai Personal Care O	-			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPL	ETED	
		157586	B. WI	NG		11/19/	2015	
NAME OF B	DOLUBED OD GUIDDU IED		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER			3115 S	WEBSTER ST			
	AKES CARING				лО, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
1710	Total: 4455	ESC ISENTI TING IN GRAINTIEN		1710			DITTE	
	10tai. 4433							
	Sample:							
	RR w/HV: 10							
	RR w/o HV: 10							
	Total: 20							
	10tai. 20							
N 0440	410 IAC 17-12-1(a	•						
	Home health ager							
Bldg. 00	administration/ma	nagement Organization, services						
		strative control, and lines of						
		elegation of responsibility						
	•	nt care level shall be:						
	(1) clearly set fort							
	(2) readily identifi		NO	140			12/22/2015	
		review, and interview,	N 0	440	To ensure compliance with 41	0	12/23/2015	
		d to ensure accuracy of			IAC 17-12-1(a): Home Health			
	•	al chart, and failed to			agency			
	•	red agency was not listed			administration/management th			
	•	ional chart for 1 of 1			following interventions have be implemented:	∍en		
	agency.				implemented.			
					•====== As of 12/22/15			
	Findings include	::			Individual agency organization			
					charts were created to separate	te		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING	11/19/2015		
				STREET /	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
CDEATI	_AKES CARING				MO, IN 46902		
GREATI	LAKES CARING			KOKOK	MO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					out each distinct provider num	ber	
	1. The organizational chart evidenced the inclusion of an acquired agency				down to the patient care level.		
					•====== On 12/22/15 Policy		
	located in Warsa	lw.			125 was updated to coincide v		
					the new organization charts ar		
	2. During interv	riew on 11/5/15 at 1:40			includes the ability of the ager	icy	
	PM, the Admini	strator stated that some			parent to make arrangements	4_	
	· ·	outh Bend patients were			through contractual agreemen for certain functions such as	เร	
		gency in Warsaw that had			billing/payroll.		
					billing/payroll.		
		y the Great Lakes			• • • • • • • • • • • • • • • • • • •		
	Corporation. Tw	renty six (26) of seventy			was educated on the revised		
	three (73) patien	ts were listed on the			Policy B 125 on 12/22/15.		
	South Bend bran	nch active patient list and					
		ired agency's active			•□□□□□□□ As of November 6t	:h	
	-	o the acquired agency did			2015, a contractual arrangeme	ent	
	_				was secured between the age	ncy	
	_	surance plans. The			referred to as Great Lakes Ca	ring	
		ated that the acquired			CCN 157586 (agency) and the	9	
	agency had its o	wn provider number.			acquired agency of AC and		
					Associates dba Great Lakes	_	
	3. During interv	view on 11/6/15 at 10:15			Caring (acquired agency) for t	ne	
	_	strator stated there was			provision of Home Health Services such as PT, OT, SLF	,	
		an agreement for the			SN, MSW and HHA.	,	
		•			CIV, MOVV and Till IV.		
		to provide services to the			• • • • • • • • • • • • • • • • • • •	h	
	1	ents. The Administrator			2015, a contractual arrangement		
	stated when the	corporation acquired the			was secured between the Gre		
	agency provider	number, the South Bend			Lakes Caring Corporate office		
	branch provided	coverage of the counties			and the agency to submit OAS		
	_	by the acquired agency.			data to the state.		
	anoug serviced	of the acquired agency.					
					• and and As of December 3r	d d	
	4. During interview on 11/6/15 at 11:30				2015-All agency South Bend		
	AM, the Administrator stated Great			branch patients were assigned	d to		
	Lakes acquired the Warsaw agency's				the correct South Bend RN		
	provider number	in October, 2014.			Clinical Supervisor.		
		, , , ,			.		
					•□□□□□□□ As of November		

ISTS86 NAME OF PROVIDER OR SUPPLER GREAT LAKES CARING SIMMARTY STATISHINFO OF DEFICINCIES PRESENT ACACH DEFENSACY MAST REPRESEDED BY TELL PRESENT AAM, the Administrator indicated the acquired agency, and the Supervisor at the South Bend branch had no involvement in the care. 7. The agency's policy titled "Parent Agency Responsibilities," in relation to coordination of care provided through branches. All services not furnished directly by the parent agency will have defined responsibilities in relation to coordination of care provided through branches. All services not furnished directly by the parent agency are monitored and controlled Special Instructions 1. The HIA's policies and procedures, or other forms of documentation (e.g., or ganizational charts) will be used to determine compliance with this standard. 2. SIRRET ADDRESS, CITY, STATE ZIP CODE. 3115 SWERSTERS T KOKOMO. IN 469902 SWERSTERS ST KOKOMO. IN 469902 1015 SWERSTERS ST KOKOMO. IN 469902 1025 SWERSTERS ST KOKOMO. IN 469902 1025 SWERSTERS ST KOKOMO. IN 469902 10315 SWERSTERS ST KOKOMO. IN 469902 1045 1051	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		 ULTIPLE CO UILDING	00	(X3) DATE COMPL		
STREET ADDRESS, CITY, STATE, ZIP CODE 3115 SWEBSTER ST KOKOM, IN 46902 SIMMARY STATIMENT OF DETICINCIES PREITS TAG SEQUENCES (SECRETIVE NOTES TO PRECEDED BY PILL) ANA, the Administrator indicated the acquired agency, that she was also the Alternate Administrator for the acquired agency. The Administrator stated the supervisor at the South Bend branch is responsible for the day to day scheduling of staff and over seeing care provided for the patients. 6. During interview on 11/16/15 at 12:05 PM, the Administrator stated patient # 16 is managed by the acquired agency, and the South Bend branch had no involvement in the care. 7. The agency's policy titled "Parent Agency Responsibilities," # B-125, reviewed March 2015 stated, "The parent agency will have defined responsibilities in relation to coordination of care provided through branches. All services not furnished directly by the parent agency are monitored and controlled Special Instructions 1. The HIHA's policies and procedures, or other forms of documentation (e.g., organizational charts) will be used to determine compliance with this standard. 2.	ANDIEM	or conduction			00		
GREAT LAKES CARING (A4 ID SIMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC LIDENTIFYING INFORMATION) 5. During interview on 11/6/15 at 11:12 AM, the Administrator indicated the acquired agency had their own organizational charts, Administrator, and Clinical Supervisor, but she was also the Alternate Administrator for the acquired agency. The Administrator stated the supervisor at the South Bend branch is responsible for the day to day scheduling of staff and over seeing care provided for the patients. 6. During interview on 11/16/15 at 12:05 PM, the Administrator stated patient # 16 is managed by the acquired agency, and the South Bend branch had no involvement in the care. 7. The agency's policy titled "Parent Agency Responsibilities," # B-125, reviewed March 2015 stated, "The parent agency will have defined responsibilities in relation to coordination of care provided through branches. All services not furnished directly by the parent agency are monitored and controlled Special Instructions 1. The HHA's policies and procedures, or other forms of documentation (e.g., organizational charts) will be used to determine compliance with this standard. 2.			107000	CTREET	ADDRESS CITY STATE ZID CODE	11/10/	2010
COMONO, IN 46902 COMPLETION	NAME OF F	PROVIDER OR SUPPLIEF	R				
PRETX TAG REGULATORY OR LDE CIDENTPYING INFORMATION REGULATORY OR LDE CIDENTPYING INFORMATION	GREAT L	AKES CARING					
5. During interview on 11/6/15 at 11:12 AM, the Administrator indicated the acquired agency had their own organizational chart, Administrator, and Clinical Supervisor, but she was also the Alternate Administrator for the acquired agency. The Administrator stated the supervisor at the South Bend branch is responsible for the day to day scheduling of staff and over seeing care provided for the patients. 6. During interview on 11/16/15 at 12:05 PM, the Administrator stated patient #16 is managed by the acquired agency, and the South Bend branch had no involvement in the care. 7. The agency's policy titled "Parent Agency Responsibilities," #B-125, reviewed March 2015 stated, "The parent agency will have defined responsibilities in relation to coordination of care provided through branches. All services not furnished directly by the parent agency are monitored and controlled Special Instructions 1. The HHA's policies and procedures, or other forms of documentation (e.g., organizational charts) will be used to determine compliance with this standard. 2.					PROVIDER'S PLAN OF CORRECTION		
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responsible for the day to day scheduling of staff and over seeing care provided for the patients. A weekly organization chart audit will be performed by the administrator/designee to assure 100% compliance for a period of 4 consecutive weeks. After 4 consecutive weeks. After 4 consecutive weeks of 2 compliance, ongoing compliance with this standard will be completed through annual policy review as organizational charts are imbedded in our policy manual. (Exhibit 3) 7. The agency's policy titled "Parent Agency Responsibilities," # B-125, reviewed March 2015 stated, "The parent agency will have defined responsibilities in relation to coordination of care provided through branches. All services not furnished directly by the parent agency are monitored and controlled Special Instructions 1. The HHA's policies and procedures, or other forms of documentation (e.g., organizational charts) will be used to determine compliance with this standard. 2.					discharged from the agency.		
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charts) will be used to determine compliance with this standard. 2.							
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		compliance with	this standard. 2.				
Regardless of the formal organizational		Regardless of the	e formal organizational				
structure, the overall responsibility for all		structure, the ov	erall responsibility for all				
services provided, whether directly,		services provide	d, whether directly,				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		Ĺ	ILDING	nstruction <u>00</u>	(X3) DATE S COMPL 11/19/	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
N 0441 Bldg. 00	with the HHA the responsibility for implementing plane Board of director authority and responsibility for implementing plane Board of director authority and responsibility and responsibility and the parent or branch determined function Billing/payroll/in at the parent branch clearly identified chart." 410 IAC 17-12-1(ale Home health agendaministration/markule 12 Sec. 1(a) supervisory responsibility and all services office, shall be most the parent agency Based on record the agency failed of care to 26 of 7 Bend branch activated by the parent record responsibility and patient record responsibility.	r admitting patients and ans of care 4. The rs assumes full legal ponsibility for all agency, regardless if status. 5. Certain tions (ie. atake) will be localized arch. The functions are a on the organizational on the organizational on the organization, of furnished directly, provided through a branch anitored and controlled by to ensure the provision of a patients on South or ecensus was not equired agency for 1 of 1 wiewed (# 16) who is by the acquired agency.	N 04	141	To ensure compliance with 410 IAC 17-12-1(a): Home Health agency administration/management th following interventions have be implemented: • • • • • • • • • • • • • • • • • • •	e een d	12/23/2015	

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 299 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			UILDING	00	COMPL 11/19/	ETED		
		137300	Б. W	_		11/19/	2015	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
GREAT I	AKES CARING				MO, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
1.10	REGUERITORI OR	Esc is Extrin Tinto Introduction ()			Clinical Supervisor.		D.II.D	
	1. The South Be	end branch active patient			·			
		73 patients. Twenty six			• As of November			
		ied as having services			15th, 2015 – no new patients were accepted to service for the	20		
	provided to them by the acquired agency.				agency that would normally be			
	1	<i>y</i> 1 <i>2 y</i>			admitted to the acquired agen			
	2. During interv	iew on 11/5/15 at 1:40			provider number.			
		strator stated that some			•======= As of 12/23/15 – A	П		
		uth Bend branch patients			'acquired agency's' patients w			
	were serviced by	an agency in Warsaw			discharged from the agency.			
	that had been acc	quired by the Great						
	Lakes Corporation	on. These patients were			•□□□□□□□ On 12/22/15 the Administrator, Directors and			
	listed on the Sou	th Bend branch active			Clinical Supervisors were			
	patient list due to	the acquired agency did			educated on Policies C 121 ar	nd		
	not accept the in	surance plans for those			C 300.			
	26 patients. The	Administrator stated						
	that the acquired	agency had its own			An audit will be performed by	the		
	provider number				administrator/designee of 100 of all new South Bend admiss			
	3 During interv	iew on 11/6/15 at 10:15			with a SOC date on or after			
	_	strator stated there was			November 15th for a period of weeks. After 8 weeks of 100%			
	· ·	an agreement for the			compliance, the audit will)		
		to provide services to the			decrease to 10% quarterly and	b		
	1 2 3	ents. The Administrator			will be completed through the			
	_	corporation acquired the			clinical record review process. (Exhibit 1)			
		number, the South Bend			(EXHIDIC 1)			
		coverage of the counties						
		by the acquired agency.						
	4. During interv	iew on 11/6/15 at 11:12						
	_	strator indicated the						
	acquired agency							
		nart, Administrator, and						
	1 -	sor, but she was also the						

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 300 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			JILDING	<u>00</u>	COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
	AKES CARING	TATEL TENT OF DEFICIENCIES	1	<u> </u>	10, IN 40902		ave.	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	agency. The Adsupervisor at the responsible for the of staff and over the patients on the 5. During interv AM, the Administrates acquired to provider number 6. During interv PM, the Administrates acquired to provider number 1. The agency's Agency Responsively agency will have in relation to cooprovided through not furnished diragency are monits agency are monits agency are monits of the structure, will be used the structure, the over	policy titled "Parent ibilities," # B-125, 2015 stated, "The parent defined responsibilities ordination of care in branches. All services ectly by the parent tored and controlled ons 1. The HHA's redures, or other forms of e.g., organizational sed to determine						

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 301 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING				COMPLETED 11/19/2015	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	with the HHA the responsibility for implementing pleared of director authority and responsibility and the parent or branch determined functions billing/payroll/in at the parent branch determined functions at the parent branch determined functions." 7. The agency's Policy," # C-12's stated, "Criteriant 2. The client must area served by Gomade by local learner area served by Gomade by local learner area deposite area	r admitting patients and ans of care 4. The rs assumes full legal eponsibility for all eagency, regardless if status. 5. Certain					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 302 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING B. WING	00	COMPLETED 11/19/2015				
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST						
	AKES CARING			MO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	responsibilities be organization. Pur requirement of stand provide superall staff delivering services. To assuperformance is at that care is direct achievement of grare provided base accordance with Care Special Regional Director be responsible for provided and supproviding therapy contract staff. Heresponsible for of GLC's ongoing for Regional Director coordinate the datthe organization Administrator. 3 Supervisor will provided and Director activities relevants services furnished.	ppropriately supervised, ted toward the goals, and that services ed on client need and in the physician's Plan of Instructions 1. The or/Clinical Manager shall or the quality of care pervision of all staff eutic services, including e/she will also be rganizing and directing functions. 2. The or/Clinical Manager shall by-to-day operation of and work with the or/Clinical Manager in all out to the professional d. This includes the qualification and the							

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 303 of 518

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157586		X2) MULTIPLE CONSTRUCTION X3) DATE SURV. A. BUILDING 00 COMPLETED B. WING 11/19/2015				ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
N 0446 Bldg. 00	also be the supervegistered nurse reshall do the follow (3) Employ qualificadequate staff edu Based on record the administrator health aide (HHz checks included 5 Home Health areviewed (C, I, N) the filed skills contransfer and range of 5 files reviewed to ensure the according acquired agency for 4 of 73 patient listed on the South Findings included 1. Employee filed 4/2/12, first patient failed to evidence was observed present a staff of the supervegence of the	nagement (17-12-1(c)(3) administrator, who may vising physician or equired by subsection (d), ing: ed personnel and ensure ucation and evaluations. review, and interview, refailed to ensure home A) skills competency bathing patients for 4 of Aide (HHA) files N, and P); failed to ensure competencies included ge of motion (ROM) for 2 ed (I and N); and failed quired agency had an agreement for the provide HHA services atth Bend branch census.	N 04	146	To ensure compliance with 41 IAC 17-12-1(c)(3): Home Heal agency administration/management th following interventions have be implemented:	th ne een th ow e nt is first on	12/23/2015

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 304 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. WING			11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				WEBSTER ST		
GREATI	AKES CARING				10, IN 46902		
	ANLO CANINO			KOKON	10, 111 40902		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Documentation f	for Skills Demonstration			physician or nurse practitioner		
	Checklists" dated	d 4/4/12 stated "Where			prior to the employee's first		
	Observed: Lab.'	•			patient contact date. This date	WIII	
					be recorded in the employee personnel file for all employee:	_	
	D. The decom	ment titled "Skills			hired on or after 12/23/2015 by		
					the human resources department		
	_	ment Detail," dated			•		
		evidence how and where			on or after 12/23/2015 shall ha		
	the annual skills	were evaluated and			a physical examination by a		
	failed to evidenc	e they were performed			physician or Nurse Practitione	-	
	on a patient.				that documents that the emplo	yee	
	1				will not spread infectious or		
	2 Employee file	e N, HHA, date of hire			communicable diseases to		
					patients. This physical		
		ient contact date 5/17/14,			examination will be documented	_	
	failed to evidence	e the skills competency			and certified by the physician on the	or	
	was observed pro	oviding care for a patient.			Certificate of Employee Physic	·al	
					Examination form.	, ai	
	A. The docur	ment titled "Competency			•======= As of 12/23/2015, a	all	
		entation Checklist for			education and human resource		
		de (CHC)," dated			staff have been educated on the	ne	
					new process and human		
	· ·	evidence bathing was			resources staff have also beer		
	observed and con	mpetencied.			educated on the state addend	ım	
					in Policy D-240.		
	B. The docur	ment titled "Skills			•	ne	
	Checklist Assign	ment Detail," dated			personnel records of all employees who deliver home		
	6/2/15 failed to 6	evidence how and where			health services shall include		
		were evaluated and			documentation of a limited		
		e they were performed			criminal history from the Indiar	ıa İ	
		e mey were performed			central repository for criminal		
	on a patient.				history information.		
					•□□□□□□□ Any employee who		
	1 2	e P, HHA date of hire			delivers home health services		
	5/26/15, first pat	ient contact date 5/31/15,			hired prior to 12/23/2015, who	_	
	failed to evidenc	e the skills competency			may have had documentation		
		oviding care for a patient.			national and local criminal hist	-	
	•	tled "Skills Checklist			conducted by a third party ven		
	The document th	iicu okiiis Ciicckiist	1		has a limited criminal history fr	Offi	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
CDEATI	AKEC CADING				WEBSTER ST		
GREAT	LAKES CARING			KUKUN	MO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Assignment Det	ail," dated 5/26/15 failed			the Indiana central repository t	for	
	to evidence how	and where the skills			criminal history information ad	ded	
		and failed to evidence			to their personnel record.		
					•□□□□□□□ The human		
	they were perior	emed on a patient.			resources department is		
					responsible for conducting the		
	4. Employee file	e I, HHA, date of hire			limited criminal history for all		
	10/15/12, first pa	atient contact date			employees who deliver home		
	_	to evidence bathing was			health services from the Indiar	ıa	
		ved being performed on			central repository for criminal history information. The human	n	
	a patient.	vea semig performed on			resources department will	11	
	a patient.				maintain documentation of the		
					limited criminal history conduc		
	A. The docu	ment titled "Competency			on every employee who delive		
	Based Skills Ori	entation Checklist for			home health services in the		
	Home Health Ai	de (CHC)," dated			employee's personnel record.		
		o evidence bathing was			•====== As of 12/23/2015, a	all	
	observed and co	· ·			human resources staff have be	een	
	observed and co	impetencied.			educated on the new process.		
	B. The docum	ment titled "Summary			An audit will be performed by t		
	Documentation:	for Skills Demonstration			administrator/designee of 100	%	
	Checklists" date	d 10/16/12 stated "Where			of all new home health aides		
	Observed: Lab.				hired on or after December 21	,	
	Observed. Edb.				2015 to ensure Competency		
	5 51 61	C IIIIA 1-4. C1			Based Skills Checklist is	h	
		e S, HHA, date of hire			completed prior to home health aide seeing patient	11	
		tient contact date 9/26/15,			independently. Audit will conti	nue	
	failed to evidence	ee the skills competency			until 100% compliance is		
	was observed pr	oviding care for a patient.			maintained for 4 consecutive		
	·				weeks. After 4 weeks of 100%	, 0	
	Δ The door	ment titled "Skills			compliance audit will decrease	e to	
					10% quarterly and will be		
	_	nment Detail," dated			completed by Human Resource	es.	
		evidence how and where			(Exhibit 5)		
		were evaluated and			A	ul	
	failed to evidence	e they were performed			An audit will be performed by t	ine	
	on a patient.				Vice President of Human Resources or designee of 100	0/2	
	•				of all personnel records of	/0	
	l		1		or an personner records of		l

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 306 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ľ í	JILDING	onstruction 00	(X3) DATE : COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER LAKES CARING			3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	PM, employee T they do HHA sk on-boarding in the to be checked of Employee T individual and the maximum and th	the lab at the office, then HHA is sent with an RN if out in the field. It is at they do a bed bath in in the lab and verbally shower. The one of 11/19/15 at 2:00 is stated the agency does ompetency check offing for employees C, I, N, ere was a process change are being done. The one of 11/19/15 at 2:05 is strator stated "the nat does not have the prompted from similar another state. The dicated the criminal ex company was called in the office of 11/19/15 at 2:30 indicated the annual dies are performed in the			employees hired on or after 12/23/15 who will deliver home health services. The audit will conducted to ensure that each personnel record contains the "Certificate of Employee Physi Examination" completed prior the first date the employee had direct patient contact until 100 compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% of all newly hired employees quarterly. Auresults will be provided to the Administrator immediately after each audit is conducted. (Exhibit 20) An audit will be performed by the Vice President of Human Resources or designee of 100 of all personnel records of employees hired on or after 12/23/15 who will deliver home health services. The audit will conducted to ensure that each personnel record contains a limited criminal history from the Indiana central repository for criminal history information conducted on or before the employee's first date of hire with the Agency until 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% of all newly hired employees quarterly. Automorphism of the provided to 10% of all newly hired employees quarterly.	be cal to s % udit r the % e be	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. WI	ING		11/19/	2015
NAME OF 1	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
GREAT I	LAKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	stated, "Job Qua 1. a State-estable health Aide train the requirements and a competence 2. a State licens the requirements (e) within the particle competency evaluation programed irect patient can 11. The agency "Executive Direct patient can 11. The agency "Executive Direct patient can in assuring compof state for Medicoaching policy development, stamonitoring active departments in a	lifications: Education: ished or other Home sing program that meets as of 42 CFR 484.36 (a) by evaluation program, or the program that meets as of 42 CFR 484.36 (b) or st 24 months, or 3. a suluation program or State in that meets the 42 CFR 484.36 (b) or (e) 44 months. Otherwise, by complete a Home ining and competency am prior to providing re." Is job description titled ctor," dated 4/14/15 and diministrator stated, 2.0 Supervises and on to agency personnel in the quality and continuity 2.8 Assists departments beliance with requirements and procedure aff education and inties 2.10 Assists ssuring all agency cedures are adhered to by continued and procedures are adhered to by continued and procedures are adhered to by cedures are adhered to by continued and procedures are adhered to by cedures are adhered to by cedures are adhered to by continued and procedures are adhered to by cedures are adhered to by cedu		TAG	results will be provided to the Administrator immediately after each audit is conducted. (Exhibit 21)		DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			WEBSTER ST		
GREAT L	AKES CARING			KOKOMO, IN 46902			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	OF DEFICIENCIES ID PROVIDER'S PL		PROVIDER'S PLAN OF CORRECTION	ER'S PLAN OF CORRECTION	
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	12. The agency	's job description titled					
	"Clinical Superv	visor," dated 7/20/12					
	stated, "Coordin	ation of services: 2.4					
		ion and training related to					
		issues and regulation and					
	_	changes Supervision					
		provides clinical direction					
	-	•					
	_	d Nurse, Licensed					
		Therapist, Home Health					
	-	taff to ensure quality and					
	-	vices provided 3.6					
	Assures complia	ance with the					
	requirements of	State licensure, Medicare					
	certification, and	d any other applicable					
	-	ies through policy and					
		opment, staff education,					
	•	nitoring activities."					
		intornig activities.					
N 0449	410 IAC 17-12-1(c)(6)					
IN UTTO	Home health age						
Bldg. 00	administration/ma						
g. 00		(6) The administrator, who					
	l .						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ſ ′		(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	B. W.		00		
		157586	D. W			11/19	/2015
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
00547					WEBSTER ST		
GREATI	_AKES CARING			KOKO	MO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		upervising physician or					
	shall do the follow	equired by subsection (d),					
		ie home health agency					
		d regulations for licensure.					
		review, and interview,	N 0	449	To ensure compliance with 4°		12/23/2015
	the administrator	r failed to ensure			IAC 17-12-1(c)(6): Home Hea	ılth	
	supervision of th	ne agency's South Bend			agency	ho	
	•	ensure the South Bend			administration/management to following interventions have be		
	, , , , , , , , , , , , , , , , , , ,	direct care for 26 of 73			implemented:		
		its active patient			•====== As of 12/22/15		
	-	ensure an agreement or			Individual agency organization		
	•	ed for the acquired			charts were created to separa		
	~	le services for 26 of 73			out each distinct provider nun down to the patient care level		
					• On 12/22/15 Police		
	-	the South Bend branch			125 was updated to coincide	•	
		ed to ensure an agreement			the new organization charts a		
	-	isted for the corporate			includes the ability of the age		
	_	an to submit Outcome			parent to make arrangements		
		Information Set (OASIS)			through contractual agreemer for certain functions such as	าเร	
	_	nts eligible for OASIS			billing/payroll.		
	data collection to	o the State of Indiana for			• • • • • • • • • • • • • • • • • • •		
	1 of 1 agency.				was educated on the revised		
					Policy B 125, and on policies		
	Findings include				C121 and C300, on 12/22/15.		
					• • • • • • • • • • • • • • • • • • •		
	1. The organiza	tional chart evidenced			2015, a contractual arrangem was secured between the age		
	the inclusion of	an acquired agency			referred to as Great Lakes Ca		
	located in Warsa	, ,			CCN 157586 (agency) and th	•	
					acquired agency of AC and		
	2. During interv	riew on 11/5/15 at 1:40			Associates dba Great Lakes	tho	
	1	strator stated that some			Caring (acquired agency) for provision of Home Health	uıe	
	· ·	outh Bend branch patients			Services such as PT, OT, SLI	Ρ,	
		an agency in Warsaw			SN, MSW and HHA.	-	
	<u>-</u>	quired by the Great			•		
		• •			15th, 2015 – no new patients		
	Lakes Corporati	on. These patients were			were accepted to service for t	the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	NG		11/19/	2015
				CTD FET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	2					
ODEATI	AKEO OADINIO				WEBSTER ST		
GREAT	LAKES CARING			KOKON	MO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	listed on the Sou	th Bend branch active			agency that would normally be		
	patient list and a	lso on the acquired			admitted to the acquired agend	cy's	
	-	patient list due to the			provider number.		
		did not accept the			•====== As of 12/23/15 – A		
		•			'acquired agency's' patients w	ere	
	_	The Administrator			discharged from the agency.		
		equired agency had its			•□□□□□□□ As of December 3r	u	
	own provider nu	mber.			2015-All agency South Bend branch patients were assigned	l to	
					the correct South Bend RN	0	
	3. During interv	view on 11/6/15 at 10:15			Clinical Supervisor.		
	_	strator stated there was			•□□□□□□□□ The OASIS review		
		an agreement for the			and lock process was revised	on	
					11/19/15 to have the specific		
		to provide services to the			provider number Clinical		
	_	ents. The Administrator			Supervisors/RN review and loc		
	stated when the	corporation acquired the			their responsible areas OASIS	-	
	agency provider	number, the South Bend					
	branch provided	coverage of the counties			• • • • • • • • • • • • • • • • • • •		
	already serviced	by the acquired agency.			2015, a contractual arrangement was secured between the Green		
					Lakes Caring Corporate office	aı	
	1 During inters	view on 11/6/15 at 11:12			and the agency to submit OAS	SIS	
	_				data to the state.		
		strator indicated the					
	acquired agency				A weekly organization chart at	ıdit	
	organizational cl	hart, Administrator, and			will be performed by the		
	Clinical Supervi	sor, but she was also the			administrator/designee to assu		
	Alternate Admir	nistrator for the acquired			100% compliance for a period		
		ministrator stated the			4 consecutive weeks. After 4		
	, ,	South Bend branch is			consecutive weeks of compliance, ongoing complian	00	
	_				with this standard will be	U C	
	_	he day to day scheduling			completed through annual poli	CV	
		seeing care provided for			review as organizational charts		
	the patients.				are imbedded in our policy		
					manual. (Exhibit 3)		
	5. During interv	view on 11/6/15 at 11:30					
	_	strator stated Great			An audit will be performed by t		
	1	the Warsaw agency's			administrator/designee of 100°		
	•	0 1			of all new South Bend admissi	ons	
	provider number	in October, 2014.	1		with a SOC date on or after		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ľ í	JILDING	onstruction 00	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	included 26 of 7	end branch census 3 active patients, 26 were ng provided services the			November 15th for a period of weeks. After 8 weeks of 100% compliance, the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 1)	d		
	PM, the Administration does not do look evaluations to se	strator stated the agency behind OASIS are if the clinician OASIS and if the agency gets the			An audit will be performed were by the administrator/designee assure 100% compliance with applicable provider number Clinical Supervisors/RNs reviewing and locking the OAS for a period of 4 weeks. After	to the		
	 8. During interview on 11/13/15 at 12:40 PM, the Administrator stated the OASIS submissions are done by the nurses or clinicians, and the Corporate office in Michigan submits the data to the State agency. 9. During interview on 11/16/15 at 10:30 AM, the Administrator stated the agency does not have and agreement or contract with corporate office to submit OASIS data to the State agency. 				consecutive weeks of 100% compliance, the audit will decrease to 50% of all OASIS another 4 weeks. After that 4 weeks of 100% compliance is obtained the audit will decreas 10% quarterly and will be completed through the clinical	for se to		
					record review process. (Exhibi	t 4)		
	And Reporting (reviewed March electronically recollect in accord regulations. GL behalf of GLC w	s policy titled "Encoding DASIS Data," # B-250, 2015 stated, "GLC will port all OASIS data ance with federal C and agents acting on vill ensure confidentiality ific information in the						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586				ILDING	00	COMPLETED 11/19/2015	
NAME OF P	ROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Agency Responsive reviewed March agency will have in relation to cooprovided through not furnished diragency are moni Special Instruction policies and proof documentation (charts) will be us compliance with Regardless of the structure, the overservices provided through arranger with the HHA the responsibility for implementing plane Board of director authority and responsibility for implementing plane authority and responsibility for implementing plane authority and responsibility for implementing plane authority and responsibility for implementing plane authority and responsibility for implementing plane authority and responsibility for implementing plane authority and responsibility for implement or branch determined functions at the parent branch determined function at the parent branch dearly identified chart."	a branches. All services ectly by the parent tored and controlled ons 1. The HHA's redures, or other forms of e.g., organizational sed to determine this standard. 2. e formal organizational erall responsibility for all d, whether directly, nents or contracts, rests at has assumed r admitting patients and ans of care 4. The rs assumes full legal ponsibility for all agency, regardless if status. 5. Certain					
		etor," dated 4/14/15 and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF	PROVIDER OR SUPPLIEF			1	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT	LAKES CARING			1	10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	signed by the Ad "Management: 'A provides direction an effort to ensure of services 'A in assuring composite for Medicoaching policy development, state monitoring active departments in a policies and provides and provides and provides and provides tated." 13. The agency' Supervision," # 2015 stated, "Po other therapeutic under the supervision of GLC. It will the administ responsibilities to organization. Pur requirement of sand provide supervision." all staff delivering services. To assigner of the provide supervision of the provides and provides upon the provides and provides upon the provide	Iministrator stated, 2.0 Supervises and on to agency personnel in re quality and continuity 2.8 Assists departments claimace with requirements claimace with requirements diance with requirements and procedure off education and dities 2.10 Assists ssuring all agency cedures are adhered to by he locations as s policy titled "Clinical C-300, reviewed March licy Skilled nursing and ce services are provided dision of a Registered dional Director/Clinical available to provide sion during the operating Under no circumstances drative or supervisory one delegated to another dirpose To meet the date/federal guidelines dervision and direction to disp home health care dure employee delegated yupervised,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			JILDING	00	(X3) DATE COMPI					
		107 000	D. W1		DDDECC CITY CTATE 7D CO	-	12010			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST							
GREAT L	AKES CARING			KOKOMO, IN 46902						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO		(X5)			
PREFIX TAG	-	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETION DATE			
		ed on client need and in		1.10			Dille			
		the physician's Plan of								
		Instructions 1. The								
	-	or/Clinical Manager shall								
	be responsible for	or the quality of care								
	provided and sup	pervision of all staff								
	providing therap	eutic services, including								
	contract staff. H	e/she will also be								
	-	rganizing and directing								
		functions. 2. The								
	_	or/Clinical Manager shall								
		ny-to-day operation of								
	_	and work with the								
	Administrator. 3									
		participate with the								
	_	or/Clinical Manager in all								
		t to the professional								
		d. This includes the								
	-	qualification and the								
	assignment of pe	ersonnei."								
N 0458	410 IAC 17-12-1(f									
Bldg. 00	Home health agen administration/mar	-								
Blag. 00		Personnel practices for								
	, ,	e supported by written								
		byees caring for patients in								
		ubject to Indiana licensure, pistration required to								
		ctive service. Personnel								
	records of employ	ees who deliver home								
		all be kept current and								
	the job, include docu	mentation of orientation to he following:								
	(1) Receipt of job									

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
	AKES CARING			KOKOMO, IN 46902				
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	pursuant to IC 16- (4) A copy of curror registration. (5) Annual perform Based on record the administrator employees had a employment for reviewed (C, E, I failed to ensure has kills competence bathing patients: Aide (HHA) files P); failed to ensure of motion (ROM reviewed (I and I criminal backgroundiana State Pol for 5 of 11 employ, O, R, and S). Findings include 1. During intervent PM, employee Lasted the agency official first patie employees are us orientation and sa approximately a	ted criminal history 27-2. Tent license, certification, mance evaluations. Teview, and interview, failed to ensure all physical prior to 8 of 173 employee files M, N, O, Q, R, and S); mome health aide (HHA) by checks included for 4 of 5 Home Health for ethe HHA field skills cluded transfer and range for 2 of 5 files N); and failed to ensure mund checks included the lice Repository (ISPR) byee files reviewed (E, iew on 11/19/15 at 12:20 g, Human Resources, for does not keep track of ent care dates, as the stually in the office for	N 04	158	To ensure compliance with 41 IAC 17-12-1(f): Home Health agency administration/management th following interventions have be implemented: • □ □ □ □ □ □ Beginning September 21, 2015 the skills competency checks included bathing patient, transfer and range of motion as well as all other required skills. • □ □ □ □ □ □ □ On December 22, 2015 the Competency Based Skills Checklist for home healt aides was revised to include h and where the skill was performed that the skill was performed on a patient, the employee who observed these skills as well as the signature of home health aide. The revised Competency Based Skills Checklist will be used for all Home Health Aides hired on oafter December 21, 2015. • □ □ □ □ □ □ The training schedule for all employees who will have direct patient contact updated to include the date of patient contact. Communication of this date by the education department will ensure that employees will have the required physical examination by a physician or nurse practitioner.	h ow e of I r is first on	12/23/2015	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		157586	B. WING			11/19/2	2015
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	,		DATE
TAG	2. Employee file 4/2/12, first patie failed to evidence was observed propatient; and failed. A. The documentation: Checklists" date Observed: Lab. B. The documentation: Checklist Assign 6/11/15 failed to the annual skills failed to evidence on a patient. C. The file complete the file of the annual skills failed to evidence on a patient. C. The file complete the file of the annual skills failed to evidence on a patient. 3. Employee file 5/12/14, first patient of the failed to evidence was observed propatient; failed to background checkly through the ISPI	e C, a HHA, date of hire ent contact date 4/7/12, we the skills competency oviding care for a ed to evidence a physical. ment titled "Summary for Skills Demonstration d 4/4/12 stated "Where " ment titled "Skills ment Detail," dated evidence how and where were evaluated and see they were performed entertial entert		TAG	prior to the employee's first patient contact date. This date be recorded in the employee personnel file for all employee hired on or after 12/23/2015 by the human resources departm • • • • • • • • • • • • • • • • • • •	e will s y ent. d ave r pyee ed or cal all es he um the of a ory dor	DATE
	background chec	ck included search			hired prior to 12/23/2015, who may have had documentation national and local criminal hist	of a ory dor om	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	COMPLETED	
		157586	B. Wl	NG		11/19/	2015	
				CTDEET A	ADDRESS CITY STATE ZID CODE			
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE			
ODEATI	AKEO OADINO				WEBSTER ST			
GREAT	AKES CARING			KOKON	MO, IN 46902			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	A. The docu	ment titled "Competency			criminal history information add	ded		
	Based Skills Orientation Checklist for				to their personnel record.			
		ide (CHC)," dated			●□□□□□□□ The human			
		o evidence bathing was			resources department is			
	· ·	<u> </u>			responsible for conducting the			
	observed and co	mpetenciea.			limited criminal history for all			
					employees who deliver home			
	B. The docum	ment titled "Skills			health services from the Indiar central repository for criminal	ıa		
	Checklist Assign	nment Detail," dated			history information. The human	,]		
	_	evidence how and where			resources department will	1		
	the annual skills	were evaluated and			maintain documentation of the			
		te they were performed			limited criminal history conduct			
		te they were performed			on every employee who delive			
	on a patient.				home health services in the			
					employee's personnel record.			
	C. The file c	ontained a copy of a			•======= As of 12/23/2015, a			
	prescription note	e dated 5/9/14 from a			human resources staff have be			
	Nurse Practition	er and stated "Free of			educated on the new process.			
	Communicable 1	Disease "						
		2 10 4 40 4 .			An audit will be performed by t	ho		
	4 Emmloyaa fil	a D IIII A data of him			administrator/designee of 1009			
		e P, HHA date of hire			of all new home health aides	70		
	-	tient contact date 5/31/15,			hired on or after December 21	.		
		ee the skills competency			2015 to ensure Competency	,		
	was observed pr	oviding care for a patient.			Based Skills Checklist is			
	The document ti	tled "Skills Checklist			completed prior to home healtl	n		
	Assignment Det	ail," dated 5/26/15 failed			aide seeing patient			
	_	and where the skills			independently. Audit will conti	nue		
		and failed to evidence			until 100% compliance is			
					maintained for 4 consecutive weeks. After 4 weeks of 100%	_		
	iney were perfor	med on a patient.			compliance audit will decrease			
					10% quarterly and will be	,		
	5. Employee file	e I, HHA, date of hire			completed by Human Resourc	es.		
	10/15/12, first pa	atient contact date			(Exhibit 5)			
	10/20/12, failed	to evidence bathing was			An audit will be performed by t	:he		
		rved being performed on			Vice President of Human			
	a patient.	oung performed on			Resources or designee of 100	%		
	a patient.				of all personnel records of			
					employees hired on or after			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t.			WEBSTER ST		
GREAT I	_AKES CARING				MO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A. The docu	ment titled "Competency			12/23/15 who will deliver home		
	Based Skills Ori	entation Checklist for			health services. The audit will		
	Home Health Ai	de (CHC)," dated			conducted to ensure that each	l	
		evidence bathing was			personnel record contains the "Certificate of Employee Physi	cal	
	observed and co	_			Examination" completed prior		
	obscivcu aliu co.	impetencieu.			the first date the employee has		
	D 771 1	4 (21 1 10			direct patient contact until 100		
		ment titled "Summary			compliance is met for 4		
		for Skills Demonstration			consecutive weeks. After 4		
		d 10/16/12 stated "Where			consecutive weeks of 100%		
	Observed: Lab.'	1			compliance the audit will decrease to 10% of all newly		
					hired employees quarterly. At	ıdit	
	6. Employee file	e S, HHA, date of hire			results will be provided to the	idit	
		tient contact date 9/26/15,			Administrator immediately after	er	
	_	e the skills competency			each audit is conducted.		
		oviding care for a			(Exhibit		
	-	_			20)		
	patient, and faile	ed to evidence a physical.					
	A. The docu	ment titled "Skills			An audit will be performed by	the	
		nment Detail," dated			Vice President of Human		
	_	evidence how and where			Resources or designee of 100	%	
		were evaluated and			of all personnel records of employees hired on or after		
					12/23/15 who will deliver home	9	
		e they were performed			health services. The audit will		
	on a patient.				conducted to ensure that each		
					personnel record contains a		
	B. The file c	ontained a letter dated			limited criminal history from the	е	
	9/22/15 from a p	hysician that stated "I am			Indiana central repository for		
	not aware of [em	nployee S] having any			criminal history information conducted on or before the		
	communicable d	iseases."			employee's first date of hire w	ith	
	C. The criminal background check dated as requested on 9/14/15 failed to				the Agency until 100%		
					compliance is met for 4		
					consecutive weeks. After 4		
	•	ormation was obtained			consecutive weeks of 100%		
		ormanon was obtained			compliance the audit will		
	from the ISPR.				decrease to 10% of all newly	ıdit	
					hired employees quarterly. Au	uit	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED		
		157586	B. W	ING		11/19/	/2015	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	WAVE OF TROVIDER OR SOFTELER			3115 S	WEBSTER ST			
	AKES CARING		KOKOMO, IN 46902					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE	
	7. Employee file E, licensed practical				results will be provided to the Administrator immediately afte			
	•	re 7/28/14, first patient			each audit is conducted. (Exhi			
		14, failed to evidence the			21)			
		ound check included						
	search through t	he ISPR; and failed to						
	evidence a physi	ical.						
	A. The crimi	inal background check						
		ed on 7/18/14 failed to						
	•	ormation was obtained						
	from the ISPR.	01111 01 1						
	nom the 151 K.							
		ontained a letter dated						
	_	physician that stated						
	"[employee E] is	s free of communicable						
	disease."							
	8 Employee fil	e M, Registered Nurse						
		re 2/23/15, first patient						
	· /·	7/15, failed to evidence a						
		· · · · · · · · · · · · · · · · · · ·						
		le contained a copy of a						
		e dated 2/23/15 from a						
		er, and stated "Patient						
		icable disease as of						
	2/3/15 office vis	it. No job restrictions."						
	9. Employee file	e O, RN, date of hire						
	7/7/14, first pation	ent contact date 7/12/14,						
	failed to evidence							
		ck included search						
	~	R; and failed to evidence						
	a physical.	, with initia to orinoito						
	a pirysioui.							
	A. The crimi	inal background check						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 CCC B. WING 11			COMPL 11/19/	ETED		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
		ed on 6/26/14 failed to ormation was obtained						
	6/30/14 from a p was seen in my of and was found to Communicable I	Diseases." le Q, physical therapist,						
	date 11/20/12, fa physical. The fi 11/19/12 from a [employee Q] is	5/12, first patient contact tiled to evidence a le contained a letter dated physician that stated: a patient in our clinic. free of communicable me."						
	Worker, date of contact date 3/3/ failed to evidence background check	le R, Medical Social hire 2/24/14, first patient 14, failed to evidence the criminal k included search R; and failed to evidence						
	dated as requeste	nal background check ed on 1/17/14 failed to ormation was obtained						
		ontained a letter dated hysician that stated "My						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		lì í	JILDING	NSTRUCTION 00	(X3) DATE COMPL 11/19/	ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	office fro an app	e R] was last seen in my ointment on 1/15/14. mmunicable disease."						
	PM, employee T they do HHA sk on-boarding in the the next day the to be checked of Employee T indi	he lab at the office, then HHA is sent with an RN If out in the field. It icated they do a bed bath In in the lab and verbally						
	PM, employee T not have filed co sheets for bathin	rview on 11/19/15 at 2:00 stated the agency does empetency check off g for employees C, I, N, ere was a process change are being done.						
	PM, the Administration list the baths on it was prequirements in Administrator in background checkground checkgrou	rview on 11/19/15 at 2:05 strator stated "the nat does not have the prompted from similar another state. The dicated the criminal ek company was called e ISPR is included in the						
	PM, employee L	rview on 11/19/15 at 2:20 y, Human Resources, ninal background check						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 COMPLE B. WING 11/19/2					
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	search but it may As of 11/19/15 a not available to b	•					
	PM, employee T	view on 11/19/15 at 2:30 indicated the annual ies are performed in the nequin.					
	reviewed March Indiana Addendu Indiana each employer direct patient comphysical examinanurse practitioner hundred eighty (that the employer contact. The physical examinanurse of sufficient sufficie	ening," # D-240, 2015 stated, "State of um: *In the State of ployee who will have					
	18. The agency's "Licensed Practic stated, "Physical Demands 7. requirements of a 19. The agency's	s job description titled cal Nurse," dated 7/20/12 and Environmental Meet the health the agency." s job description titled pist," dated 4/16/14					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
NAME OF P	ROVIDER OR SUPPLIER		_		DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	applicable agency procedures related and required test. Environmental En	y policies and at to health screening ing Physical and bemands 7. Meet the ents of the agency." s job description titled se," dated 7/20/12 stated, avironmental Demands ealth requirements of the sijob description titled ide," dated 6/6/14 stated, ons: Education: 1. a or other Home health ogram that meets the 42 CFR 484.36 (a) and a uation program, or 2. a rogram that meets the 42 CFR 484.36 (b) or (e) 4 months, or 3. a uation program or State			CROSS-REFERENCED TO THE APPROPRIAT	rE	
	with in the last 2 must successfull Health Aide train evaluation progra	42 CFR 484.36 (b) or (e) 4 months. Otherwise, y complete a Home hing and competency am prior to providing e Health Status:					
	procedures relate and required test	ble agency policies and od to health screening ing Physical and Demands 7. Meet the					

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING		COMPLETED 11/19/2015	
	ROVIDER OR SUPPLIER		3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
N 0470 Bldg. 00	410 IAC 17-12-1(n Home health agen administration/mar Rule 12 Sec. 1(m) shall be written an control of commun	cy nagement Policies and procedures d implemented for the				
	record review, the all staff followed guidelines for 6 c	ation, interview, and e agency failed to ensure infection control of 10 home visit 1, 4, 6, 7, 8, and 9)	N 0470	To ensure compliance with 41 IAC 17-12-1(m): Home Health agency administration/management th following interventions have be implemented:	e 12/25/2015	
	11/10/15 at 9:30	visit for patient #1 on AM, employee C, home A) failed to place her		•	on lab	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	· /	JILDING	onstruction 00	(X3) DATE COMPL 11/19/	ETED
	PROVIDER OR SUPPLIER			3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	on the client's cuchair. Employed obtain vital signs pressure, temper Employee C fail pressure cuff priplacing back into 2. During home 11/10/15 at 12:3 licensed practical changing 3 wet to A. During drapatient's arm wo to wash hands or removing the old donning new glot the wound and patient's hip wow wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u removing the old donning new glot the wound and patient's left toe failed to wash hands or u remove the old donning new glot the wound and patient's left toe failed to wash hands or u remove the old donning new glot the wound and patient's left toe failed to wash hands or u remove the old donning new glot the wound and patient's left toe failed to wash hands or u remove the old donning new glot the wound and patient's left toe failed to wash hands or u remove the old donning new glot the wound and patient's left toe failed to wash hands or u remove the old donning new glot the wound and patient's left to	visit for patient #4 on 0 PM, employee E, all nurse, was observed to dry wound dressings. ressing change for the und, employee E failed to use hand sanitizer after d dressing and prior to oves, and after cleansing prior to applying Santyl. ressing change for the und, employee E failed to see hand sanitizer after d dressing and prior to oves, and after cleansing prior to applying Santyl. ressing change for the und, employee E failed to oves, and after cleansing prior to applying Santyl. ressing change for the wound, employee E ands or use hand sanitizer the old dressing and prior gloves, and after			RN preceptor by 12/24/15. All home health aides completed a mandatory in-service by 12/24/15with rev of N-120 bag technique, and N-100 Standard Infection Con Procedures for Home Care, Education included hands on demonstration by the home health aide staff of bag technique and N-100, Standard Infection Control Procedures for Home Care wi focus on cleaning equipment procedure between patients, u of barrier and hand washing p to and after all patient care. Clinical supervisors will compl onsite home supervisory visits with 10% of all direct care field staff monthly to visualize evidence that the proper infect control techniques are followe until 100% compliance is met. Ongoing compliance will be completed through the annual onsite supervisory visit proces (Exhibit 2)	iew trol que. re 20 th per see rior ete	

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PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D. During interview on 11/10/15 at 1:30 PM, employee E stated she was not sure what the policy said about using	A. BUILDING 00 COMPLETED B. WING 11/19/2015	IDENTIFICATION NUMBER: 157586	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D. During interview on 11/10/15 at 1:30 PM, employee E stated she was not sure what the policy said about using (X COMPLIATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D. During interview on 11/10/15 at 1:30 PM, employee E stated she was not sure what the policy said about using	3115 S WEBSTER ST		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D. During interview on 11/10/15 at 1:30 PM, employee E stated she was not sure what the policy said about using	ID (X5)		
1:30 PM, employee E stated she was not sure what the policy said about using	PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION COMPL		PREFIX (EACH DEFICIENC
hand santizer or wash hands in between glove changes. 3. During home visit for patient # 6 on 11/12/15 at 9:30 AM, employee B, registered nurse, failed to clean the blood pressure cuff before and after obtaining vital signs, and prior to placing back into clinical bag. 4. During home visit for patient # 7 on 11/12/15 at 10:30 AM, employee H, physical therapist, failed to clean the blood pressure cuff, thermometer, and pulse oximeter before and after obtaining vital signs, and prior to placing back into clinical bag. 5. During home visit for patient # 8 on 11/12/15 at 1:30 PM, employee I, HHA, failed to clean the blood pressure cuff before and after obtaining vital signs, and prior to placing back into clinical bag. 6. During home visit for patient # 9 on 11/13/15 at 9:30 AM, employee J, physical therapy assistant, failed to clean the blood pressure cuff before and after obtaining vital signs, and prior to placing back into clinical bag.		poloyee E stated she was not policy said about using or or wash hands in between so. me visit for patient # 6 on the said AM, employee B, and prior to placing back into the place of the said after obtaining and prior to placing back into the said prior to placing back into clinical bag. me visit for patient # 9 on the said prior to placing assistant, failed to clean saure cuff before and after all signs, and prior to placing the said place in the said plac	1:30 PM, employ sure what the pol hand sanitizer or glove changes. 3. During home 11/12/15 at 9:30 registered nurse, pressure cuff before vital signs, and polinical bag. 4. During home 11/12/15 at 10:30 physical therapis blood pressure cupulse oximeter be vital signs, and polinical bag. 5. During home 11/12/15 at 1:30 failed to clean the before and after comprise prior to placing before the prior to placing before any physical therapy the blood pressure obtaining vital signs, and polysical therapy the blood pressure obtaining vital signs, and polysical therapy the blood pressure obtaining vital signs, and polysical therapy the blood pressure obtaining vital signs, and polysical therapy the blood pressure obtaining vital signs, and polysical therapy the blood pressure obtaining vital signs, and polysical therapy the blood pressure obtaining vital signs, and polysical therapy the blood pressure obtaining vital signs, and polysical therapy the blood pressure obtaining vital signs, and polysical therapy the vital sign

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 327 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING		COMPLETED 11/19/2015		
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING			3115 S WEBSTER ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	stated the agency to wipe with alco but the blood prebe washed daily. The Administratusing hand sanitibetween glove cl. 8. The agency's Technique," # Nstated, "The bloobelt are kept in a cleaned with caviday, and as neces. All other reusables the bag should be alcohol wipes be Never return one bag, even if not a when in a client's a clean and dry s. 9. The agency's Washing," # N-1 stated, "Note: Tiwashing dependent duration, and second before and after touching open were stated to when we washing open we washing open were stated to wipe and after touching open were stated to wipe and stated touching open were stated to wipe and stated to wipe and stated to wipe and stated to wipe and stated to wipe and stated to wipe and stated to wipe and stated to wipe and stated to wipe and	policy titled "Bag -120, revised 5/6/11 od pressure cuff and gait separate pocket and are icide at the end of each ssary if items are soiled. e items removed from e cleaned with provided fore returning to the bag. e time use items to the used such as gloves s home, place the bag on surface." policy titled "Hand 30, revised 5/16/11 he need for hand s on the type, intensity, quence of activities. er handling dressings or					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 328 of 518

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULT: A. BUILD B. WING		NSTRUCTION 00	(X3) DATE : COMPL 11/19/	ETED
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	revised 12/18/20 4. Put on clean and dressing and discussions 7. Don clean Cleanse wound I 13. Don clean 11. The agency' "Application of G-110, revised I hands 4. Do Remove old dresshands 10. E Wash hands 19. Remove waste 20. V 12. The agency' Infection Contro Care," # N-100,	ds policy titled Wet-to-Dry dressing," # 1.2/18/14 stated, "1. Wash on clean gloves. 5. Ssing 8. Wash Don clean gloves 13. 14. Don clean gloves. gloves and dispose of Wash hands." ds policy titled "Standard of Procedures for Home the revised 5/16/11 stated, before and after client					
N 0474	410 IAC 17-12-2(I Q A and performa						
Bldg. 00	shall provide at leaservices: (1) Nursing treater) The home health agency ast one (1) of the following atment and procedure. th aide services.					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 329 of 518

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		157586	B. W	NG		11/19/	2015
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
CDEATI	AKEC CADING				WEBSTER ST		
GREAT	LAKES CARING			KUKUI	MO, IN 46902		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(3) Physical the	erapy.					
	(4) Speech-lan	guage pathology.					
	(5) Occupation						
	(6) Social servi						
	Based on record	review, and interview,	N 0	474	To ensure compliance with 41	0	12/23/2015
	the agency failed	I to ensure the provision			IAC 17-12-2(b): QA and		
	"	ts was not delegated to an			Performance Improvement the		
	_	for 26 of 73 active			following interventions have be implemented:	;611	
					Implemented.		
	l ~	the South Bend branch			•□□□□□□□ As of November 6t	h	
	census.				2015, a contractual arrangement		
					was secured between the age		
	Findings include:				referred to as Great Lakes Car		
					CCN 157586 (agency) and the	٠ ١	
	1 The organizat	tional chart evidenced			acquired agency of AC and		
	_				Associates dba Great Lakes		
		an acquired agency			Caring (acquired agency) for the		
	located in Warsa	W.			provision of Home Health		
					Services such as PT, OT, SLF),	
	2. During interv	view on 11/5/15 at 1:40			SN, MSW and HHA.		
	PM. the Adminis	strator stated that some			• and an As of November 6t		
	1	uth Bend branch patients			2015, a contractual arrangement		
		an agency in Warsaw			was secured between the Gre		
		9 5			Lakes Caring Corporate office		
		quired by the Great			and the agency to submit OAS data to the state.	ار	
	•	on. These patients were			• • • • • • • • • • • • • • • • • • •	Rrd	
	listed on the Sou	th Bend branch active			2015-All agency South Bend	,,u	
	patient list due to	the acquired agency did			branch patients were assigned	_{t to}	
	_	surance plans for those			the correct South Bend RN		
		Administrator stated			Clinical Supervisor.		
	_				•□□□□□□□ As of November		
	_	agency had its own			15th, 2015 – no new patients		
	provider number	•			were accepted to service for the	ne	
					agency that would normally be		
	3. The South Be	end branch census			admitted to the acquired agen	cy's	
	included 26 of 7	3 active patients, 26 were			provider number.		
		ve patients being			•□□□□□□□ As of 12/23/15 – A		
		s by the acquired agency.			'acquired agency's' patients w	ere	
	provided service	s by the acquired agency.			discharged from the agency.		
					Í.		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	/2015
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			WEBSTER ST		
	_AKES CARING				10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		riew on 11/6/15 at 10:15			An audit will be performed by t		
	AM, the Administrator stated there was not a contract or an agreement for the				administrator/designee of 100°		
					of all new South Bend admissions with a SOC date on or after		
	acquired agency	to provide services to the			November 15th for a period of	8	
		ents. The Administrator			weeks. After 8 weeks of 100%		
	_	corporation acquired the			compliance, the audit will		
		number, the South Bend			decrease to 10% quarterly and	t	
		-			will be completed through the		
		coverage of the counties			clinical record review process.		
	already serviced	by the acquired agency.			(Exhibit 1)		
	5. During interv	riew on 11/6/15 at 11:12					
	AM, the Administrator indicated the						
	acquired agency	had their own					
	organizational cl	hart, Administrator, and					
	_	sor, but she was also the					
	_	nistrator for the acquired					
		ministrator stated the					
	_	South Bend branch is					
	•	he day to day scheduling					
		seeing care provided for					
	the patients.						
		riew on 11/6/15 at 11:30					
	AM, the Admini	strator stated Great					
	Lakes acquired t	he Warsaw agency's					
	_	in October, 2014.					
		*					
	7. The agency's	policy titled "Parent					
		sibilities," # B-125,					
		2015 stated, "The parent					
		e defined responsibilities					
		ordination of care					
	-	h branches. All services					
	not furnished dir	ectly by the parent					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8			WEBSTER ST		
GREAT L	AKES CARING			KOKOMO, IN 46902			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	agency are moni	tored and controlled					
	Special Instructi	ons 1. The HHA's					
	policies and pro-	cedures, or other forms of					
	documentation (e.g., organizational					
	charts) will be used to determine						
	compliance with this standard. 2.						
	•	e formal organizational					
	_	erall responsibility for all					
	,	d, whether directly,					
	-	ments or contracts, rests					
	with the HHA th	-					
		r admitting patients and					
		• .					
		ans of care 4. The					
		rs assumes full legal					
	-	sponsibility for all					
	-	e agency, regardless if					
	-	status. 5. Certain					
	determined func	,					
	Billing/payroll/i	ntake) will be localized					
	at the parent bra	nch. The functions are					
	clearly identified	d on the organizational					
	chart."						
N 0478	410 IAC 17-12-2(•					
Dida 00	Q A and performa	Ince Improvement If personnel under					
Bldg. 00		d by the home health					
		Ill be a written contract					
	between those pe	rsonnel and the home					
		t specifies the following:					
	(1) That patients	are accepted for care only					

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	00	(X3) DATE COMPL	
		157586	B. W	ING		11/19/	2015
	PROVIDER OR SUPPLIEF			3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	(2) The services (3) The necessity applicable home is including personn. (4) The responsity developing plans (5) The manner is controlled, coording the primary home. (6) The procedure notes, scheduling periodic patient ev. (7) The procedure services furnished Based on record the parent agency agreement or arracquired agency of 73 active pating branch certain supervision of the ensure it provided of 73 active pating branch list for 1 reviewed who reacquired agency agreement or arracquired agency of 73 active pating branch certain supervision. It is for 1 reviewed who reacquired agency of 73 active pating branch certain dependent or arracquired agency of 73 active pating branch certain dependent of the certain supervision supervision supervision of the certain supervision supervision supervision supervision supervision su	y to conform to all nealth agency policies el qualifications. bility for participating in of care. In which services will be nated, and evaluated by health agency. The services is for submitting clinical of visits, and conducting	NO	478	To ensure compliance with 41 IAC 17-12-2(d): QA and Performance Improvement habeen implemented: • • • • • • • • • • • • • • • • • • •	ve te ber / B vith nd ncy ts	12/23/2015

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 333 of 518

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	A. BUILDING <u>00</u>		(X3) DATE : COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		•	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	State agency for eligible for OAS 4455 patients. Findings included 1. The organization the inclusion of elocated in Warsa 2. The South Beincluded 26 of 7 identified as also acquired agency 3. During intervent PM, the Administration to see data is accurate a same scores. 4. During intervent PM, the Administration of the current Sowere serviced by that had been accurated agency insurance plans.	all the agency's patients IS data collection out of tional chart evidenced an acquired agency w. and branch census 3 active patients, 26 were being listed on the census. tiew on 11/5/15 at 12:15 strator stated the agency		TAG	acquired agency of AC and Associates dba Great Lakes Caring (acquired agency) for t provision of Home Health Services such as PT, OT, SLF SN, MSW and HHA.	he c, ne c cy's II ere d d to on ck chent at SIS udit ure of	DATE
	stated that the ac	equired agency had its			completed through annual poli	icy	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t.			WEBSTER ST		
GREAT I	AKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	own provider nu	mber.			review as organizational charts are imbedded in our policy	5	
	5. During interv	riew on 11/6/15 at 10:15			manual. (Exhibit 3)		
	_	strator stated there was			An audit will be performed by the		
	· ·	an agreement for the			administrator/designee of 100°		
		to provide services to the			of all new South Bend admissi		
	' '	•			with a SOC date on or after		
	_	ents. The Administrator			November 15th for a period of		
		corporation acquired the			weeks. After 8 weeks of 100%		
	• • •	number, the South Bend			compliance, the audit will decrease to 10% quarterly and		
	branch provided coverage of the counties already serviced by the acquired agency.				will be completed through the	ı	
					clinical record review process.		
					(Exhibit 1)		
	6. During interv	riew on 11/6/15 at 11:12			,		
		strator indicated the			An audit will be performed wee	ekly	
	acquired agency				by the administrator/designee		
	' '				assure 100% compliance with	the	
	•	hart, Administrator, and			applicable provider number		
	_	sor, but she was also the			Clinical Supervisors/RNs reviewing and locking the OAS	212	
		nistrator for the acquired			for a period of 4 weeks. After		
	agency. The Ad	ministrator stated the			consecutive weeks of 100%		
	supervisor at the	South Bend branch is			compliance, the audit will		
	responsible for t	he day to day scheduling			decrease to 50% of all OASIS	for	
	of staff and over	seeing care provided for			another 4 weeks. After that 4		
	the patients.				weeks of 100% compliance is		
	1				obtained the audit will decreas 10% quarterly and will be	е то	
	7 During inters	riew on 11/6/15 at 11:30			completed through the clinical		
	I -				record review process. (Exhibi	t 4)	
	· · · · · · · · · · · · · · · · · · ·	strator stated Great			1 1 2 3 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2	- ',	
		he Warsaw agency's					
	provider number	in October, 2014.					
	8. During interv	riew on 11/16/15 at 12:05					
	PM, the Admini	strator stated patient # 16					
	is managed by the	ne acquired agency, and					
	the South Bend 1						
	involvement in t						
	involvenient in t						

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	PROVIDENSUPPLIENCLIA NTIFICATION NUMBER: 57586	A. BUILDING 00 B. WING		COMPLETED 11/19/2015	
NAME OF PROVIDER OR SUPPLIER GREAT LAKES CARING		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID SUMMARY STATES PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
9. During interview PM, the Administrate submissions are done clinicians, and the Co Michigan submits the agency. 10. During interview 10:30 AM, the Administrate agency does not have contract with corpora OASIS data to the St 11. The agency's polyand Reporting OASIs reviewed March 2011 electronically report collect in accordance regulations. GLC and behalf of GLC will ended the of all client specific in clinical record." 12. The agency's polyagency Responsibility reviewed March 2011 agency will have defining relation to coording provided through branch furnished directly agency are monitored Special Instructions	to on 11/13/15 at 12:40 tor stated the OASIS to by the nurses or corporate office in the data to the State w on 11/16/15 at inistrator stated the the and agreement or rate office to submit tate agency. blicy titled "Encoding BIS Data," # B-250, 15 stated, "GLC will that all OASIS data the with federal and agents acting on tensure confidentiality information in the blicy titled "Parent tities," # B-125, 15 stated, "The parent fined responsibilities that on of care anches. All services by by the parent and and controlled				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			WEBSTER ST		
GREATI	_AKES CARING				10, IN 46902		
					.0,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG			DATE
		e.g., organizational					
	· ·	sed to determine					
	compliance with this standard. 2. Regardless of the formal organizational structure, the overall responsibility for all						
	services provide	ed, whether directly,					
	through arrange	ments or contracts, rests					
	with the HHA th	nat has assumed					
	responsibility fo	r admitting patients and					
	implementing pl	lans of care 4. The					
		ors assumes full legal					
		sponsibility for all					
	1	e agency, regardless if					
	_	status. 5. Certain					
	determined func						
		· ·					
		ntake) will be localized					
	_	nch. The functions are					
	1	d on the organizational					
	chart."						
		's policy titled "Clinical					
	Supervision," #	C-300, reviewed March					
	2015 stated, "Po	licy Skilled nursing and					
	other therapeutic	c services are provided					
	under the superv	vision of a Registered					
	-	ional Director/Clinical					
	_	available to provide					
	_	sion during the operating					
		Under no circumstances					
		trative or supervisory					
		be delegated to another					
	*	urpose To meet the					
	_	•					
	_	state/federal guidelines					
	and provide sup	ervision and direction to					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 337 of 518

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		IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING			COMPLETED 11/19/2015	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST				
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	services. To assiperformance is a that care is direct achievement of gare provided base accordance with Care Special Regional Director be responsible for provided and supproviding therapcontract staff. Heresponsible for of GLC's ongoing for Regional Director coordinate the dathe organization Administrator. Supervisor will provided activities relevant services furnished	ppropriately supervised, and toward the goals, and that services and on client need and in the physician's Plan of Instructions 1. The pr/Clinical Manager shall or the quality of care pervision of all staff entic services, including e/she will also be granizing and directing functions. 2. The pr/Clinical Manager shall pry-to-day operation of and work with the price of the clinical manager in all and to the professional direction and the					
N 0484 Bldg. 00	410 IAC 17-12-2(g Q A and performa Rule 12 Sec. 2(g)						

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AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPL	X3) DATE SURVEY COMPLETED 11/19/2015	
	OF PROVIDER OR SUPPLIED	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) IE PREFE TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	appropriately comsupport the object. The means of corresults shall be do record or minutes. Based on record the agency failed communicated of Peripherally Inst. (PICC) line means physician for 1 or receiving PICC failed to ensure referral were into (POC) and intititive records reviewed ensure the Homolital signs to the aide care plan for receiving HHA. Findings included 1. The clinical referral week for 1 week weeks, then 1 times with 3 as needed respiratory, gast gastrourinary, not the support of the support	o assure that their efforts uplement one another and tives of the patient's care. Inmunication and the ocumented in the clinical of case conferences. review and interview, do to ensure the nurses changes in length of certed Central Catheter surements to the of 1 record reviewed line management (# 3); all disciplines ordered on cluded on the plan of care atted timely for 1 of 20 do (# 10); and failed to be Health Aide reported enurse as ordered on the or 2 of 9 records reviewed services. (# 2 and 12) Services. (# 2 and 12) Services as week for 8 me a week for 1 week, do visits for cardiac,	N 0	484	To ensure compliance with 41 IAC 17-12-2(g): QA and Performance Improvement the following interventions have be implemented: • • • • • • • • • • • • • • • • • • •	eeen aff 5, s. v of an ng as cal o a sits.	12/23/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLET	ΓED
		157586	B. W	ING		11/19/2	015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t			WEBSTER ST		
GREATI	LAKES CARING				MO, IN 46902		
	_			RORON			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE '	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and falls. SN fo	r: Instruct on			included the need to provide a		
	lab/venipuncture procedure, obtain lab results and report to physician. SN to				disciplines indicated, detailed	and	
					timely physician order and updating the care plan.		
		cin trough week of			updating the care plan.		
	1	MP [basic metabolic			An audit will be performed by	,	
		eekly until instructed			the administrator or designed		
		•			of 100% of all patients with a		
		N to change PICC			PICC line until 100%		
		terile technique every			compliance is met for 4		
	week and as nee	ded times 3 for soiled or			consecutive weeks. After 4		
	loose dressing.				consecutive weeks of 100%		
					compliance the audit will		
	A. The start	of care assessment form			decrease to 10% quarterly		
	dated 10/23/15 b	ov employee G			and will be completed		
		e (RN) stated, "Indicate			through the clinical record		
	_				review process. (Exhibit 6)		
		d PICC catheter from			An audit will be performed		
	insertion site to				by the administrator or		
	centimeters: 10.	0."			designee of 100% of HHA visits to ensure compliance		
					with reporting as outlined in		
	B. The SN V	isit Report dated			Policies C-800 and C-200		
	10/30/15 by emp	oloyee G stated, "Indicate			until 100% compliance is me	t I	
		d PICC catheter from			for 4 consecutive weeks.		
	insertion site to				After 4 weeks of 100%		
		0." The record failed to			compliance the audit will		
		vsician was notified of			decrease to 10% quarterly		
	1 .				and will be completed		
		longer measurement of			through the clinical record		
	the PICC line.				review process. (Exhibit 7)		
					An audit will be performed by		
	C. The SN V	isit Note Report dated			the administrator/designee o	of	
	11/6/15 by employee G stated, "Indicate PICC Catheter Site Assessment: Red Indicate length of exposed PICC catheter from insertion site to catheter hub in				100% of all new admissions		
					to ensure all ordered		
					disciplines are added to the		
					plan of care until 100%		
					compliance is met for 4 consecutive weeks. After 4		
		0." The record failed to			consecutive weeks. After 4		
	evidence the phy	vsician was notified of			Consecutive weeks of 100 %		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	KOVIDER OR SUPPLIER			3115 S	WEBSTER ST		
	AKES CARING			KOKOM	лО, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	the redness at the	e PICC catheter site.			compliance, the audit will		
					decrease to 10% quarterly and will be completed		
	D. The SN V	isit Note Report dated			through the clinical record review process. (Exhibit 8)		
	11/13/15 by emp	oloyee V, LPN stated,					
	"Indicate length	of exposed PICC			(2/2.0)		
	catheter from ins	sertion site to catheter					
	hub in centimete	ers: 3.0." The record					
	failed to evidence	ee the physician was					
		centimeter PICC					
	measurement.						
	measurement.						
	E. During in	terview on 11/17/15 at					
	10:05 AM, the A	Administrator stated she					
	· · · · · · · · · · · · · · · · · · ·	se that measured the					
		entimeters on 11/13 and					
		e measured only what					
		der neath the dressing,					
	_	C line is sutured in place.					
	and that the rice	e fine is sutured in place.					
	2. The clinical r	record for patient # 2 was					
	reviewed on 11/	16/15. The start of care					
	date was 10/10/1	15. The record contained					
	a plan of care (P	OC) dated 10/10-12/8/15					
		HHA effective 10/11/15					
	2 visits a week f						
	A. The Aide	Care Plan Report dated					
		ated, "Vital Signs that					
	Require Physician Notification by SN:						
	Blood Pressure Upper 170/90, Lower						
	80/50."	- rr					
	30,00.						
	B The Visit	Note Report dated					
		ployee C, HHA, stated,					
	10/1-1/15 by chip	10,00 C, 1111/1, Stated,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		174/82 Physician					
		Comments: [patient]					
	said feeling fine." The visit note failed to evidence the HHA notified the nurse of the vital signs.						
	C. The Visit	Note Report dated					
	10/17/15 by emp	oloyee W, HHA, stated,					
	"Blood Pressure	173/91 Physician					
	Contacted: No.	Comments: SYS					
	[systolic]: 173 over 91 DIAS [diastolic]						
	." The visit note failed to evidence the						
	HHA notified the nurse of the vital signs.						
		e none of the view biging.					
	D. During in	terview on 11/16/15 at					
		Iministrator stated the					
		t find any notes saying					
	, , ,	I the nurses on 10/14 or					
		fy of vital signs being					
	high.						
	A 751 1: 1	1.6					
		record for patient # 10					
		11/17/15. The start of					
		26/15. POC dated					
		ontained orders for SN 1					
	time a week for	1 week, 2 times a week					
	for 2 weeks, the	n 1 times a week for 7					
	weeks, 3 as need	led for falls, pain,					
	gastrointestinal/	gastrourinary, respiratory,					
	cardiac, impaire	d skin integrity, diabetes,					
	and functional d	ecline. Need for skilled					
		ervention related to					
	_	cervical spine incision.					
		dry. May leave open to					
	1 recep cican and	ary. Iviay reave open to					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157586	B. W	ING	<u> </u>	11/19/		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	(3115 S WEBSTER ST					
GREAT I	_AKES CARING			KOKOM	1O, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
1710	air if no drainag	,		mo	·		DATE	
	un n no urumug							
	A. The Clini	cal Coordination Note						
	Report dated 9/2	25/15 stated "Received						
	referral from	Cleveland Clinic						
	Start of care tom	norrow 9/26/15. Patient						
	will need SN, P	Γ [Physical Therapy], OT						
	[Occupational T	herapy] due to						
	1	pertension, diabetes						
		depression." The record						
		ee PT and OT were						
		OC; failed to evidence						
		until 10/14/15; and failed						
	to evidence OT	was ordered.						
	D. The Clien	at Coordination Note						
		/12/15 stated, "Patient's						
	_	o inform GLC that						
		and Clinic has ordered						
		y. Informed [caregiver]						
		obtain the order and						
		out for an evaluation."						
	·							
	C. During in	terview on 11/17/15 at						
	3:30 PM, the Ac	lministrator stated the						
	patient's spouse	called the agency on						
	10/12/15 to say	the Cleveland Clinic had						
	_	referral to the agency.						
		or stated she did not see						
	1 -	ne patient for the PT and						
	OT services, and	I the OT was not started.						
	4 The clinical r	record for patient # 12						
		11/18/15. The start of						
	was icviewed of	1 11/10/13. THE Start Of						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W		<u></u>	11/19/	
	PROVIDER OR SUPPLIER		<u> </u>	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902	<u> </u>	
				<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
		19/15. The POC dated ontained orders for HHA r 3 weeks.					
	9/17-11/15/15 st Require Physicia	Care Plan Report dated ated, "Vital Signs that an Notification by SN: Upper 170/90, Lower					
	10/28/15 by emp "Blood Pressure Contacted: No. [diastolic]: No The visit note fa	Note Report dated ployee X, HHA, stated, 147/95 Physician Comments: DIAS dizziness from patient." iled to evidence the HHA e of the vital signs.					
	Health Aide: Do reviewed March Home Health Ai for reporting any	policy titled "Home ocumentation," # C-800, 2015 stated, "2. The de shall be responsible changes in the client's er pertinent observations upervisor."					
	Health Aide Car reviewed March	policy titled "Home e Plan," # C-751, 2015 stated, "Policy aide staff will follow the					
	7. The agency's Health Aide Serv	policy titled "Home vices," # C-220,					

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUILDI B. WING		JILDING					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
GREAT L	AKES CARING			KOKOM	1O, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
IAU	reviewed March Instructions 1. It services may incoobservations of treporting the rest Nurse/Therapist. 8. The agency's "Responding to Chines," # I-230 s Migration: It is central venous canother location Certain types of susceptible to canother location Certain types of susceptible to canother location Certain types of susceptible to canother location Certain types of susceptible to canother location Certain types of susceptible to canother location Certain types of susceptible to canother location Certain types of susceptible to canother location Certain types of susceptible to canother location Certain types of susceptible to canother location Certain types of susceptible to canother location. Period certain types of susceptible to canother location. Period certain types of susceptible to canother location. Period verification by x performed on all placed catheters. 9. The agency's "PICC Line Dress stated, "PICC Line Dress stated, "PICC Line Dress stated, "PICC Line Dress stated, "PICC Line Dress stated, "PICC Line Dress stated, "Document in the canother location in the location control of the location in the loc	2015 stated, "Special Home Health Aide lude: g. Making he client's condition and ults to the Registered " undated policy titled Complications of PICC tated, "Catheter Tip possible for any type of atheter to migrate to while in the body. clients are more theter tip migration wery active sure and document the f the catheter with each This will assist in early dic catheter tip -ray study should be long-term, centrally " undated policy titled ssing Change," # I-240 he dressing changes will		IAU			DATE	
	Any physician ne	otification."						

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GREAT L	AKES CARING			5 S WEBSTER ST KOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO I	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	#C-360, reviewe "Purpose To coordinated betw interdisciplinary initial assessment Registered Nurse communicate the visit with the Cli ensue: a. Clariff care orders oskilled nursing c services and/or r resources." 11. The agency' Orders," # C-635 stated, "1. When receives a verbal physician, he/she given and then rephysician verifying receiving the ordinaterpreted the ordinaterpreted the ordinaterpreted the ordinaterpreted with the caregiver. The incorporate interpreted with the caregiver.	Client Services," d March 2015 stated, ensure services are veen members of the team 3. After the it, the admitting e/Therapist shall e findings of the initial nical Supervisor to fication of the plan of d. Client's need for are, e. Need for other eferral to community s policy titled "Physician for reviewed March 2015 in the nurse or therapist order from the e shall write the order as ead the order back to the fing that the person ler heard it correctly and order correctly." s policy titled "Care reviewed March 2015 wing the initial are Plan shall be						

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 346 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLET					
		157586	B. WING 11/19/2015				
	ROVIDER OR SUPPLIER		<u> </u>	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) and the client goals for re."		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
N 0508 Bldg. 00	or her rights as a pagency as follows (2) The patient in following: (E) Confidentialismaintained by the The home health a patient of the ager procedures regard records. Based on record the agency failed confidentiality of allowing an acquiservices to 26 of on both the Sout patient list and the active patient	p(2)(E) pas the right to exercise his patient of the home health pas the right to the ty of the clinical records home health agency. Agency shall advise the ney's policies and ling disclosure of clinical review and interview, I to ensure the f medical records by hired agency to provide 73 active patients listed he Bend branch active he acquired agency's 14 (# 16, 26, 27, 28, 29, 4, 35, 36, 37, 38, 39, 40, 5, 46, 47, 48, 49, 50, and cord reviewed chosen higher to accord to ensure an agreement was in place office in Michigan to atta to the State agency	N 0	508	To ensure compliance with 41 IAC 17-12-3(b)(2)(E): Patient Rights the following intervention have been implemented: • • • • • • • • • • • • • • • • • • •	chent	12/23/2015

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	OO	(X3) DATE (COMPL			
		157586	B. W		00	11/19/		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
	Findings included 1. During interve PM, the Adminited by Corporation. The on the South Bellist and also on the active patient list agency did not a plans. The Adminited agency mumber. 2. During interve AM, the Adminited agency of the acquired agency South Bend paties tated the acquired agency South Bend paties tated the acquired agency acquired agency South Bend paties tated the acquired agency or acquired agency south Bend paties tated the acquired agency acquired agency south Bend paties tated the acquired	riew on 11/5/15 at 1:40 strator stated that some buth Bend patients were gency in Warsaw that had with the Great Lakes arese patients were listed and branch active patient the acquired agency's at due to the acquired accept the insurance dinistrator stated that the had its own provider the agency staff were bloyees. The atted when the agency provider the Bend branch provided counties already serviced			CROSS-REFERENCED TO THE APPROPRIA	rd d to he e cy's ill rere the % ions f 8		
		n them, but the acquired						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	00	COMPLETED 11/19/2015	
	PROVIDER OR SUPPLIER LAKES CARING		3115 S	ADDRESS, CITY, STATE, ZIP CO WEBSTER ST MO, IN 46902	ODE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE COMPLETION
	Administrator st acquired agency medical records provide services patients were als Bend branch ros A. The South compared with the	n Bend active roster was he acquired agency's			
	and 11/6/15. Pa	oss referenced on 11/5 tients listed on the South er and also the acquired ded:			
	# 26, start of 10/27/15 # 27, SOC 10 # 28, SOC 10 # 29, SOC 7/ # 30, SOC 9/2 # 31, SOC 8/ # 32, SOC 9/2 # 33, SOC 10 # 35, SOC 9/2 # 36, SOC 10 # 37, SOC 10 # 38, SOC 9/2 # 40, SOC 10 # 41, SOC 10 # 42, SOC 8/ # 43, SOC 11	0/18/15 18/15 26/15 14/15 26/15 0/26/15 0/26/15 0/27/15 0/27/15 0/24/15 10/15 11/15 0/3/15 0/10/15			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19	/2015
NAME OF I	PROVIDER OR SUPPLIEF	}	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		•			WEBSTER ST		
	AKES CARING			<u> </u>	10, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	# 44, SOC 10	0/22/15					
	# 45, SOC 10	0/31/15					
	# 46, SOC 3/	24/15					
	# 47, SOC 9/	14/15					
	# 48, SOC 9/	29/15					
	# 49, SOC 9/	28/15					
	# 50, SOC 7/	8/15, and					
	# 51, SOC 9/	26/15.					
	B. During in	terview on 11/6/15 at					
		Administrator provided					
	the South Bend	-					
		ated this roster was only					
		whom South Bend					
	_	This roster failed to					
	evidence patient	s 26-51.					
	3. During interv	riew on 11/6/15 at 11:12					
		strator indicated the					
	acquired agency	had their own					
	Administrator as	nd Clinical Supervisor,					
	but she was also	the Alternate					
	Administrator fo	or the acquired agency.					
	4 During inters	view on 11/6/15 at 11:30					
		strator stated since the					
		red agency were all					
	•	ployees, there was not a					
	1	fidentiality of medical					
		lministrator stated the					
		nch was approved for					
		efore other provider					
		uired. The Administrator					
	_	es acquired the Warsaw					
		=					l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B. B. W		00		
		157586	D. W			11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
CDEATI	_AKES CARING				WEBSTER ST 10, IN 46902		
				<u> </u>			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	 	er number in October,					
	2014.	or manneer in October,					
	2014.						
	5. The clinical r	record for patient # 16					
		n 11/9 and 11/16/15 and					
		n the OASIS list for					
		ound Status and was					
	1	had been a patient of the					
	_	nch. Patient # 16 lived in					
	the territory serviced by the acquired						
	agency. The patient was discharged to						
	hospice on 5/8/15.						
	A. On 11/16	/15 at 11:35 AM, the					
	Administrator st	ated the acquired agency					
	maintains the ch	arts for all the patients					
	they provided se	ervices for and patient #					
	16 was provided	services by the acquired					
	agency.						
	_	nterview on 11/16/15 at					
	12:05 PM, the A	Administrator stated					
	_	nanaged by the acquired					
		South Bend branch had					
	no involvement	in the care.					
		C 1 4 1					
	C. The plan						
		th start of care date					
		ed orders for skilled					
		ime a week for 9 weeks					
		visits for pain, falls,					
	respiratory/cardi						
		gastrourinary, and					
	integumentary complications; Physical						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	COM	(X3) DATE SURVEY COMPLETED 11/19/2015			
	OF PROVIDER OR SUPPLIED	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION DATE		
	times a week for Therapy (OT) 1 times a week for 1 week; Medica for 1 week; Medica for 1 weeks; Home times a week for week for 2 weeks. D. The reco was provided Sn acquired agency 5/5/15 by employee PP. E. The reco was provided H acquired agency 4/6, 4/8, 4/10, 4/13, 4/10, 4/18, 5/5, and 5/1 by employee PP. F. The reco was provided Pracquired agency 4/6, 4/3, 4/6 and 5/1/15 by employee PP. G. The reco was provided Pracquired agency SS; 4/1, 4/3, 4/6 and 5/1/15 by employee PP.	rd evidenced patient # 16 N services from the on 3/23, 4/14, 5/1, and oyee QQ; 3/30, 4/3, 4/7, o, 4/21, 4/24, 5/6, and oyee NN; and 4/28/15 by rd evidenced patient # 16 HA services from the on 3/25, 3/27, 3/30, 4/1, o/15, 4/17, 4/21, 4/24, oyee LL. rd evidenced patient # 16 T services from the on 3/26/15 by employee						

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 352 of 518

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
NAME OF PROVID			3.	115 S \	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		II PRE	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ΓE	(X5) COMPLETION DATE
PM subsclin Mic ager 7. I AM does with data 8. T And revi elected coll regulation of a clin 9. T Nece Heat Main recuinfor discommand that	The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record." The agency's particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agency particular record. The agen	policy titled "Encoding ASIS Data," # B-250, 2015 stated, "GLC will bort all OASIS data ance with federal C and agents acting on ill ensure confidentiality fic information in the policy titled "Minimum bosures of Protected on," # C-385, reviewed ed, "Routine and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BU	A. BUILDING 00 B. WING			COMPLETED 11/19/2015	
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
GREAT I	LAKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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
	heath information achieve the purp Non-routine discinformation	n that is needed to ose of these requests closures of health 3. GLC relies on hat the information minimum a mount request if from a public care provider, a health nal providing service to ss associate, or a provides appropriate Disclosures of entire GLC does not disclose natire medical record in y request not related to y reason unless a such a disclosure is s policy titled "Clinical natiality," # C-880, 2015 stated, "1. s will be identified as: as and contract staff pervising client care." s policy titled tights & "# C-390, reviewed ed, "Privacy and ave the right to: of written, verbal and ted health information					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BU	A. BUILDING 00 B. WING			COMPLETED 11/19/2015	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
	_AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	(X5) COMPLETION DATE
TAG	information about financial circums takes place in your Indiana Addenduration of the patterpresentative has informed of the perfective means of home health agent promote the exert shall do the follor documentation should be documentation should be the comparison of the pattern of the agent clinical records." 12. The agency's "Management of B-435, reviewed Physical Security limit access to an computer network with a confirmed Data Security Pothis policy applied or created by entipurisdiction of Grout limited to, day Branches support	is the right to be patient's rights through of communication. The incy must protect and reise of these rights and wing: (2) Maintain showing it has complied ments of this section ity of the clinical records to the home health agency. agency shall advise the ency's policies and ding disclosure of the section of the clinical records to the ency's policies and ding disclosure of the clinical records to the ency's policies and ding disclosure of the clinical records the ency's policies and ding disclosure of the clinical records the ency's policies and ding disclosure of the clinical records the ency's policies and ding disclosure of the ency's policies and		TAG	DEFICIENCY)		DATE

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 355 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	00	(X3) DATE COMPL		
		157586	B. W	ING		11/19	/2015
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT I	AKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID	•	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ity Ethics 1. Every					
		de to restrict access to					
		es to those people with a					
	need-to-know."						
	13. The agency'	s policy titled "Clinical					
	Supervision," #	C-300, reviewed March					
	2015 stated, "Po	licy Skilled nursing and					
	other therapeutic	e services are provided					
	-	rision of a Registered					
	_	ional Director/Clinical					
	_	available to provide					
	" " '	sion during the operating					
		Under no circumstances					
		trative or supervisory					
		be delegated to another					
	_	irpose To meet the					
		tate/federal guidelines					
		ervision and direction to					
		ng home health care					
	services. To ass						
	that care is direc	ppropriately supervised,					
		goals, and that services					
	l '	ed on client need and in					
		the physician's Plan of					
		l Instructions 1. The					
	_	or/Clinical Manager shall					
	_	or the quality of care					
	_	pervision of all staff					
	1 ^	eutic services, including					
		le/she will also be					
		organizing and directing					
		functions. 2. The					
	l						l

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 356 of 518

[·		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BU B. WI		00		11/19/2015	
		137360	D. W			11/19/	2015	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST			
GREAT L	AKES CARING		KOKOMO, IN 46902					
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
	Regional Director coordinate the dathe organization Administrator. 3 Supervisor will provide Regional Director activities relevant services furnished development of assignment of personal control of the services furnished assignment of personal control of the services furnished assignment of personal control of the services furnished assignment of personal control of the services furnished assignment of personal control of the services furnished assignment of personal control of the services furnished assignment of personal control of the services furnished assignment of personal control of the services furnished assignment of personal control of the services furnished assignment of the services furnished	or/Clinical Manager shall ay-to-day operation of and work with the B. The Clinical participate with the par/Clinical Manager in all at to the professional ad. This includes the qualification and the ersonnel."						
N 0522 Bldg. 00	a written medical pand periodically redentist, chiropractor podiatrist, as follows Based on record the agency failed visits were provided and periodically redentially redentially redentially and periodically redentially redentially and periodically redentially redentially and periodically redentially and periodically redentially rede	Medical care shall follow blan of care established eviewed by the physician, or, optometrist or ws: review, and interview, I to ensure discipline ded as ordered on the C) for 2 of 20 clinical I (# 2 and 13).	N 0	522	To ensure compliance with 41 IAC 17-13-1(a): Patient Care to following interventions have be implemented: • • • • • • • • • • • • • • • • • • •	he een re iies 5	12/23/2015	

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 357 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		157586	B. WING		11/19/2015	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	8		S WEBSTER ST		
	AKES CARING			MO, IN 46902	<u> </u>	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	
TAG		LSC IDENTIFYING INFORMATION)	TAG		BATE	
	1. The clinical r	ecord for patient #2 was		care. Education focus include		
	reviewed on 11/2	16/15. The start of care		the need to provide all discipling and services as ordered by the	l l	
	date was 10/10/1	5. The POC dated		physician, documentation of	5	
	10/10-12/8/15 co	ontained orders for		missed visits, and the		
		N) 1 time a week for 3		requirement to notify the		
	`	weeks for 2 weeks, then		physician of changes in the pla		
		for 4 weeks, with 3 as		of care including missed visits		
	*	*		A	u	
		pain, falls, cardiac		An audit will be performed by		
	complications.			administrator/designee of 100 of all missed visits until	/0	
				compliance is met for 4		
		d failed to evidence a SN		consecutive weeks. After 4		
	visit was comple	eted the week of		weeks of 100% compliance th	e	
	10/18-21/2015.			audit will decrease to quarterly	l l	
				and will be completed through	l l	
	B. During in	terview on 11/16/15 at		clinical record review process.		
		lministrator stated the		(Exhibit 9)		
	· · · · · · · · · · · · · · · · · · ·	t find any missed visits				
	" "	es for the week of				
	10/18-21/2015.	as for the week of				
	10/18-21/2013.					
		ecord for patient # 13				
	was reviewed on	11/19/15. The start of				
	care date was 5/2	2/15. Diagnosis of				
		orea. The POC dated				
		ontained orders for SN 1				
		1 week, 1 every two				
		ks, 1 every 3 weeks for 3				
		•				
	weeks, and 3 as a					
	cardiac/respirato	-				
	1 0	strointestinal, endocrine,				
	mental, pain, skin, wound status changes,					
	and falls; HHA 2	2 times a week for 3				
	weeks, then 1 time a week for 2 weeks;					
	PT starting 9/6 1	time a week for 1 week,				
	<u> </u>	· · · · · · · · · · · · · · · · · · ·				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		157586	B. W			11/19	
NAME OF	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST	<u> </u>	
GREAT	_AKES CARING			1	IO, IN 46902		
(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 APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
		or 6 weeks, then 1 time a ; and TO 1 time a week					
	for PT on 9/19 1						
	HHA conducted of 8/30-9/5/15, a	d failed to evidence the a second visit the week and failed to conduct a week of 9/6-9/12/15.					
	10:22 AM, the A agency does not missed visits for	terview on 11/19/15 at administrator stated the have any records of HHA 8/30-9/5 or missed visit records for 7/15.					
	Policy," # C-12 stated, "Criteria 6. Services for a Nursing, Therap Services or Hom must follow a we established and p a doctor of medi podiatric medici	policy titled "Admission 1, reviewed March 2015 for Client Admission: a client receiving Skilled y, Medical Social he Health Aide services ritten Plan of Care beriodically reviewed by cine, osteopathy, or ne 7. There must be hectation that the client's					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE : COMPL		
(157586	B. W			11/19/	
	PROVIDER OR SUPPLIER		<u> </u>	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	met in the client's expectation shall GLC's personnel adequate and suit services the client. 4. The agency's "Frequencies," # 2015 stated, "1. the home health aphysician to any need to alter the physician or or plan of care and notified. The homaintain docume record indicating	eeds can be adequately s home. 8. Reasonable consider: a. Whether and resources are table for providing the at requires."					
N 0524 Bldg. 00	plan of care shall: (A) Be developed home health agen	1) As follows, the medical in consultation with the cy staff.					
	(B) Include all ser skilled service is b (B) Cover all perti	• .					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 11/19/2015	
	PROVIDER OR SUPPLIEI		311 KO		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APPROP	BE COMPLETION
	required. (iii) Frequency a (iv) Prognosis. (v) Rehabilitation (vi) Functional li (vii) Activities pe (viii) Nutritional re (ix) Medications (x) Any safety against injury. (xi) Instructions referral. (xii) Therapy mote treatment. (xiii) Any other appeared interview, the appeared interview, the appeared interview and the patients where all discipposes physician upon the start of care records reviewed ensure intervent frequency for 1 and 1. Findings included 1. During home patient #7 on 11	rices and equipment and duration of visits. In potential. Initations. Inited. Inited. Inited. Indicated to equipments. In and treatments. In easures to protect If or timely discharge or indicate to ensure all equipment (DME) used in a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan for a factor of the plan fac	N 0524	To ensure compliance with IAC 17-13-1(a)(1): Patient of the following interventions in been implemented: • • • • • • • • • • • • • • • • • • •	Care nave will /15 on ME 85. d to will n of e ve 635 on olines ing the ing luding

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 361 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
or .				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹		3115 S	WEBSTER ST		
GREAT I	LAKES CARING			KOKON	MO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<u> </u>	R LSC IDENTIFYING INFORMATION)		TAG			DATE
		9/19-11/17/15 failed to			orders.		
	contain the walk	ter.			•□□□□□□□ All skilled nursing staff received education on		
					documentation requirements	or	
	2. During home	visit observation with			wound care, as well as hands		
	patient # 8 on 11	1/12/15 at 1:30 PM, DME			competency checks in a skills	lab	
	in the home included a walker. The POC				for wound care, and infection		
	dated 10/30-12/28/15 failed to contain				control with wound care, by a	า	
	the walker.				RN preceptor by 12/24/15.		
					An audit will be performed by	the	
	3. During home visit observation with patient # 9 on 11/13/15 at 9:30 AM,				administrator/designee of 100		
					of all 485's to ensure that DM		
	DME in the home included a walker.				listed until 100% compliance i	S	
		11/8/15-1/6/16 failed to			met for 4 consecutive weeks.		
					After 4 weeks of 100% compliance the audit will		
	contain the walk	ter.			decrease to 10% quarterly an	d	
					will be completed through the	-	
		record for patient # 10			clinical record review process (Exhibit 10)		
		n 11/17/15. The start of					
	care date was 9/	26/15. POC dated					
	9/26-11/24/15 c	ontained orders for SN 1			An audit will be performed by	the	
	time a week for	1 week, 2 times a week			administrator/designee on 100		
	for 2 weeks, the	n 1 times a week for 7			of all admissions to verify plan		
	weeks, 3 as need	led for falls, pain,			care includes all disciplines		
	· ·	gastrourinary, respiratory,			ordered until 100% compliand	e is	
	-	d skin integrity, diabetes,			met for 4 consecutive weeks.		
		ecline. Need for skilled			After 4 weeks of 100% compliance, the audit will		
		ervention related to			decrease to 10% quarterly an	d	
	_				will be completed through the	-	
	wound incision cervical spine incision. Keep clean and dry. May leave open to				clinical record review process	<u>.</u>	
					(Exhibit 8)		
	air if no drainag	e noted.					
	A. The Clinical Coordination Note Report dated 9/25/15 stated "Received				An audit will be performed by	0/	
					administrator/designee of 100% of wound visits to ensure		
	_	Cleveland Clinic			measurements q week, as we	ll as	
		norrow 9/26/15. Patient			detailed orders and complete	40	
		10110 # 7/20/10. 1 utiont]		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	· ·		3115 S	WEBSTER ST		
	AKES CARING				1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	+	IAG	documentation of wound care		DATE
	[Occupational T	Γ [Physical Therapy], OT			provided until 100% compliand	e	
		***			is met for 4 consecutive weeks	S.	
	laminectomy, hypertension, diabetes mellitus II, and depression." The record failed to evidence PT and OT were ordered on the POC; failed to evidence PT was ordered until 10/14/15; and failed to evidence OT was ordered.				After 4 weeks of 100%		
					compliance the audit will decrease to 10% quarterly and		
					will be completed through the	4	
					clinical record review process.		
					(Exhibit 11)		
	D. Th. Cli	d Constitution Note					
	B. The Client Coordination Note						
	Report dated 10/12/15 stated, "Patient's [spouse] called to inform GLC that						
		and Clinic has ordered					
		y. Informed [caregiver]					
		obtain the order and					
	send a therapist	out for an evaluation."					
	C. During in	terview on 11/17/15 at					
	3:30 PM, the Ac	lministrator stated the					
		called the agency on					
	10/12/15 to say	the Cleveland Clinic had					
	ordered PT upor	referral to the agency.					
	The Administrat	tor stated she did not see					
	any refusal by th	ne patient for the PT and					
	OT services, and	d the OT was not started.					
	5. The clinical r	record for patient # 11					
		n 11/18/15. The start of					
		2/9/14. The POC dated					
		ntained orders for SN 3					
		r 1 week, 4 times a week					
		nes a week for 1 week, 4					
		r 1 week, 3 times a week					
		nes a week for 1 week, 3					
	1 1 WOOK, till	a	1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BU	A. BUILDING 00 B. WING			COMPLETED 11/19/2015	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
	week for 1 week for pain, falls, cat gastrointestinal/g wound complicate teaching and into heel, and poor sk with wound cleate cover with foam lower extremities compression wrater A. The POC frequency of the B. During into 11:25 AM, the Ashould be a frequency of the should be a frequency of the but not be limited needs identified a. A list of specific plans for implementation of care plan if specific address client callindiana Addendato of care will controlled.	•					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015	
	PROVIDER OR SUPPLIER AKES CARING	3	3115 S	ADDRESS, CITY, STATE, ZIP CO WEBSTER ST MO, IN 46902	DDE
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE COMPLETION
	information, and activities."	5. Medications, diet,			
	C-360, reviewed After the initial and Registered Nurs communicate the visit with the Cliensure: a. Claricare orders services and/or resources." 8. The agency's "Comprehensive C-145 reviewed addition to general assessment, GLC assessment tool m. Equipment 9. The agency's Orders," # C-63 stated, "1. When receives a verbal physician, he/she given and then rephysician verify	f Client Services," # I March 2015 stated, "3. assessment, the admitting e/Therapist shall e findings of the initial inical Supervisor to fication of the plan of e. Need for other referral to community policy titled e Client Assessment," # March 2015 stated, "In ral health status/system C comprehensive with OASIS will include: nt management." policy titled "Physician 5, reviewed March 2015 n the nurse or therapist I order from the e shall write the order as ead the order back to the ing that the person der heard it correctly and			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE C A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 11/19/2015		
	PROVIDER OR SUPPLIEF	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
N 0527 Bldg. 00	professional staff shall promptly ale for the medical co care to any changalter the medical passed on record the agency failed were notified of needing Skilled due to goals met reviewed (# 10 a notify physician goals needing rerecords reviewed Findings includes 1. The clinical was reviewed or care date was 9/26-11/24/15 co Aftercare follow for SN 1 time as a week for 2 weeks, 3 as gastrointestinal/grandiac, impaired	of the home health agency of the home health agency of the person responsible emponent of the patient's ges that suggest a need to plan of care. review, and interview, do to ensure physicians patients no longer Nursing (SN) services for 2 of 20 records and 13), and failed to to revise goals met and evised for pain for 1 of 20 dd (# 10).	N 0527	To ensure compliance with 4° IAC 17-13-1(a)(2): Patient Cathe following interventions have been implemented: • □ □ □ □ □ □ All clinical staff educated on policy C-360 Coordination of Client Service and C-660 Care Plans. Education focused on the nearevise goals as patient condition, interventions must match diagnosis and plan of care, painterventions meed to be detained address patient's pain. A goals are met they need to be discontinued, wound care mube discontinued when wound healed. An audit will be performed by administrator/designee on 10 of all admissions and recertification visits to assure patient interventions match diagnosis on the plan of care	es, ed to ion ain illed as e st the 0%	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	(X3) DATE COMPL		
111,12 12,111	or country.	157586	B. W		00	11/19/	
		107000		CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	1 17 1 67	20.0
NAME OF I	PROVIDER OR SUPPLIEF				WEBSTER ST		
GREAT I	_AKES CARING				10, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		ervention related to		TAG	100% compliance is met for 4		DATE
		cervical spine incision.			consecutive weeks. After 4 we	eks	
		dry. May leave open to			of 100% compliance, the audit		
	air if no drainage				decrease to 10% quarterly and	d	
	_	d assessment of cardiac			will be completed through the clinical record review process.		
		ry changes associated			(Exhibit 12)		
	_	n for early intervention			A 197 - 191 - 1		
		; observation/assessment			An audit will be performed by administrator/designee of 50%		
		al system to identify			all skilled nursing visits for	, 01	
	changes associated with exacerbation of or early intervention of complications; -Evaluate patient and develop plan of				updated goals when indicated and physician notification of		
					updated and patient specific goals until 100% compliance is	s	
	_	er signed by physician;			met for 4 consecutive weeks.		
		sessment of respiratory			After 4 consecutive weeks of		
		ry changes associated			100% compliance the audit wi		
	· ·	n for early intervention			decrease to 10% quarterly and will be completed through the	ı	
	of complications	;			clinical record review process.		
	-Provide instruct	tions related to discharge			(Exhibit 13)		
	planning. Disch	arge summary for all					
	disciplines availa	able to physician upon					
	request;						
		and provide assistance to					
	patient for under	C					
	_	feelings. SN may					
	-	on anxiety scale and/or					
	mini mental exa						
	-Provide assessn						
	_	cement of management of					
	_	ding disease process,					
		agement, coping skills					
	1	nges associated with					
	depressive disorders for early						
		may perform geriatric					
	depression scale	and/or mini mental					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
en on r				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·		3115 S	WEBSTER ST		
	AKES CARING			KOKOM	/IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
	exam;						
		g/reinforcement in					
	etiology of confi						
	cognition, safety measures and home						
	management; observation and assessment						
	of pain, effectiveness of pain						
	management and regimen and skilled						
	teaching related	to pain management, SN					
	to report increase in pain level to						
	physician for prompt intervention;						
	-Skilled teaching and training of						
	emergency care plan, disease process						
	including self m	• •					
	_	ypertension disease;					
	-SN to obtain pu	* *					
	_	nes 3 as needed for					
		ath, oxygen use, activity					
	intolerance;	atii, oxygen use, activity					
	-	on/reinforcement of					
	_	system related teaching, iculitis and irritable					
	1						
	bowel syndrome	* **					
	_	skilled teaching regarding					
		trol diarrhea/constipation					
	as well as preven	_					
	-	killed teaching and					
		gency care plan, disease					
	•	tomy surgery including					
	_	t of neurologic disease;					
	-SN to provide a	assessment and					
	teaching/reinfor	cement of management of					
	diabetes including disease process,						
	medication man	agement, coping skills					
		nges associated with					
	l ,	-					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		, ,	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	F PROVIDER OR SUPPLIEI	8	•	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	perform blood g for signs and syn hyper/hypoglyce testing. SN ass diabetes melliture -SN observation integumentary s skin integrity; -SN to instruct p and symptoms of cervical spine su complications to -SN to establish risk of hospitalize will be instructe and aspects of co disease manager hospitalization; -Skilled instruct regimen to ident changes/complic intervention; -SN to provide i balance and redu- SN to instruct p preventive meas ulcer risk; and -Licensed profes signs falling out established para 101, Pulse < 50 > 29, Systolic bl	emia or for baseline feet and reinforce s foot care; and reaching tatus to promote optimum eatient/caregiver on signs f infection related to atures to reduce the wound; supports to minimize eation patient/caregiver d in emergency care plan, ervical spine surgery ment to reduce avoidable tion of medication ify					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPL 11/19/	ETED	
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	fasting blood sugsaturation < 88. GOALS: Associal discharge instructed discharge summa available to physisymptoms of any interventions initimanage feelings: Patient/caregive verbalize/demon management of the episode and and managed to the home; Patient demonstrate und confusion and mithe home; Improvement in activity; Pain controlled a level acceptable Patient/caregive understanding of nonpharmacologe Patient will demonstrate will demonstrate understanding of nonpharmacologe and sease process a burden associate pulse oximetry repatient/caregive entry repatient/care	gar < 60 > 300, oxygen iated risks; Patient's ction needs will be met, ary for all disciplines sician upon request; kiety are identified and tiated to allow patient to gravill strate understanding the depression by the end of symptoms are identified maintain patient safety in t/caregiver will erstanding of etiology of aintain patient safety in a pain interfering with at level of 3 or less or at the to the patient; or demonstrate a pharmacological and dic pain control measures; constrate ability to self ascular hypertension and reduce caregiver d with disease process; the will demonstrate anage gastrointestinal		TAG	OROSS-REPERENCE I O THE APPROPRIAL DEFICIENCY)		DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		•			WEBSTER ST		
	_AKES CARING			<u> </u>	1O, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	demonstrate abil	lity to manage altered					
	bowel elimination	on. Patient will have					
	bowel patency;						
	-Demonstrated a	ibility to self manage					
	neurologic disea	se process and reduce					
	caregiver burder	associated with disease					
	process, improvement in signs and						
	symptoms of ne	urologic disease;					
	-Patient/caregive						
	demonstrate understanding the						
	management of diabetes by the end of the						
	episode and symptoms are identified and						
	managed to main	ntain patient safely in the					
	home;						
		mprovement in existing					
		arly identification and					
		additional compromises					
	in skin;						
	-Wound complic						
		entary status will					
		enced by a decrease in					
		f wound/decub by end					
	of cert period;						
		re appropriate agency					
		ent rehospitalization,					
	-	calizations will be					
	reduced;	111 1					
		er will demonstrate					
		manage medications;					
	_	ble to perform activities					
		nd individual activities of					
		decreased risk for falls;					
		er will demonstrate					
	proper technique	es of pressure ulcer					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	00	COMPLETED 11/19/2015		
NAME OF I	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING			S WEBSTER ST OMO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	(X5) COMPLETION DATE
	was notified of gunobtainable goal on the plan of calcoordinate with a instructions and was not being compared. A. The initia 9/26/15. The Clark Report dated as a stated "[Spouse of lowest patient's pain scale. Currous Claudia 2 milligned The agency failed "Pain controlled a level acceptable revised. B. The start of Assessment and assessment form "(M1018) Conditing treatment regimes stay within the pain section stated "Pain Scale Ratin make pain worse neck pain least?	nursing staff to ensure education on goals met ontinued. I start of care was ient Coordination Note late entry for 9/26/15 of patient] states the pain ever gets is a # 8 on ently patient takes rams tablets for pain." I d to ensure the goal of at level of 3 or less or at e to the patient" was				

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NAME OF PROVIDER OR SUPPLIER GREAT LAKES CARING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) neck pain be relieved? No." The section titled "Endocrine/Hematopoietic" stated "Indicate endocrine/Hematopoietic assessment (mark all that apply): STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 STREET ADDRESS, CITY, STATE, ZIP CODE
GREAT LAKES CARING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) neck pain be relieved? No." The section titled "Endocrine/Hematopoietic" stated "Indicate endocrine/Hematopoietic assessment (mark all that apply): 3115 S WEBSTER ST KOKOMO, IN 46902 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) PREFIX (FACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE) TAG DEFICIENCY) 1D PROVIDER'S PLAN OF CORRECTION (COMPLETION SHOULD BE COMPLETION DATE) COMPLETION DATE
GREAT LAKES CARING (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) neck pain be relieved? No." The section titled "Endocrine/Hematopoietic" stated "Indicate endocrine/Hematopoietic assessment (mark all that apply): (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG In the providers plan of Correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG In the providers plan of Correction SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (III) III) IIII) IIII) IIII) IIII) IIII) IIII) IIII) IIII) IIII) IIIII IIIII IIIII IIIIII
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG CROSS-REFERENCED
neck pain be relieved? No." The section titled "Endocrine/Hematopoietic" stated "Indicate endocrine/Hematopoietic assessment (mark all that apply):
titled "Endocrine/Hematopoietic" stated "Indicate endocrine/Hematopoietic assessment (mark all that apply):
assessment (mark all that apply):
Diabetes, thyroid problems Is the
patient taking insulin? No Is the
patient taking an antidiabetic agent? Yes.
How frequent are blood sugars check?
Not checked very often. What are the
patient's usual blood sugar readings?
Below 130."
The section titled "Care Coordination"
stated "Indicate if you communicated
with other disciplines involved in this
case: YES. What discipline did you
communicate with? Physician,
Caregiver(s), Clinical Supervisor.
Indicate reason physician not contacted:
Was Contacted. Contacted physician for
approval of proposed plan of care: No.
Indicate reason physician not contacted:
Not in on weekends." The section titled
"Goals Met" stated: "3. Patient/caregiver verbalizes understanding of basic
nutritional/hydration requirements." The
visit note failed to evidence the SN
provided teaching/reinforcement of
management of diabetes.
management of diabetes.
C. The Visit Note Report dated
10/2/15 stated "Pain: All of the time
Pain Scale Rating 9 Wound: no
problems identified Have the
patient's blood sugars remind stable for

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	IULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE		
		157586	B. W		<u>00</u>	11/19/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			WEBSTER ST		
GREAT L	AKES CARING			KOKOM	10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	-	ek? Not Applicable- not routinely checked."					
	_	ection stated "Pain never					
		a 6 Instructed on pain					
	_	e interventions." The					
	_	terventions" stated, "3.					
		ess pain intensity and					
		ohysical assessment					
		arrative note stated, "Has					
		that is constant. Pain					
during SN visit rated a 9 on 1-10 scale.							
Just took pain med 30 minutes before							
	SN arrival."						
	The record failed	d to evidence a pain					
		er than instruction was					
	provided; failed	to evidence the physician					
	was notified to c	change or revise the goal					
	of "Pain controll	ed at level of 3 or less or					
	at a level accepta	able to the patient;" and					
	failed to evidence	ee the SN provided					
	_	cement of management of					
	diabetes.						
	D The Visit	Note Report dated					
		-					
		-					
		•					
	Low Sodium/lov						
	_	agency failed to					
		ion to the patient on					
		d failed to clarify/verify					
	with the physicia						
	failed to evidence teaching/reinforce diabetes. D. The Visit 10/2/15 Intervent Instruct in cardio hypo/hypertenside Details/Commer Low Sodium/low Nutritional Requirolabetic." The evidence educate diabetic diet, and	Note Report dated ations Provided stated, "6. Divascular on disease process, ats: Dietary restrictions, w fat." The POC airements stated agency failed to ion to the patient on disaled to clarify/verify					

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	11/19/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO 3115 S WEBSTER ST KOKOMO, IN 46902	DE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG TAG TAG TAG TAG TAG TA	OULD BE COMPLETION
diet/nutritional needs of the patient, and failed to notify the physician to remove the Met Goals and modify/revise the POC.	
E. The Visit Note Report dated 10/2/15 Goals Met section stated, "1. Patient/caregiver will verbalize understanding of instructions given related to pressure ulcer relief and ulcer prevention, 2. Cardiac exacerbations are identified promptly and interventions initiated quickly to minimize associated risks 4. Pain management intervention completed this visit. 5. Patient/caregiver demonstrate understanding of pharmacological and nonpharmacologic pain control measures this visit. 6. Instruction in cardiovascular hypo/hypertension disease completed this episode- patient/primary caregiver independent. 7. Changes in respiratory status are identified and reported to physician for prompt intervention to minimize associated risks. 8. Instruction regarding self management of gastrointestinal disease completed this episode- patient /primary caregiver independent. 9. Instruction regarding self management of altered bowel elimination completed this episode- patient/primary caregiver independent. 10. Exacerbations of gastrointestinal disease are promptly identified and	

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUILDING 00 B. WING		COMPLETED 11/19/2015			
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT I	AKES CARING			10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſΈ	(X5) COMPLETION DATE
	risks to patient. self management depression comp patient/primary of 18. Instructions manage nutrition promote skin into episode- patient/ independent. 19 ability to self man requirements to a completed this episode- patient caregiver indeperegarding signs a infection and skin this episode- patient independent regarding wound this episode-patien independent stated understand fall preventions in hazards." F. The Visit 10/6/15 stated, "I and was rated at Endocrine/Heman "Have the patien	alleviate pressure pisode- patient/primary ndent. 20. Instructions and symptoms of n breakdown completed ient/primary caregiver 22. Instruction I management completed ent/caregiver . Instruction regarding complications completed ent/caregiver 29. Patient/caregiver ding of instructions of related to environmental Note Report dated Pain: All of the time," 9. The atopoietic section stated,				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	00	COMPI		
AND I LAN	o. conduction	157586	B. W		00	11/19	
		107000		CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	1 17 10	72010
NAME OF I	PROVIDER OR SUPPLIEF	2			WEBSTER ST		
GREAT I	AKES CARING				1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		on titled "Goals Met"					
	· · · · · · · · · · · · · · · · · · ·	iac exacerbations are					
		otly and interventions					
		to minimize associated					
	risks 5. Pat	•					
	demonstrate und	•					
		l and nonpharmacologic					
	•	asures this visit. 6.					
	Changes in resp	•					
	identified and reported to physician for						
	prompt intervention to minimize						
		7. Exacerbations of					
	_	disease are promptly					
		terventions implemented					
	to minimize risk	-					
	1	ding self management of					
	1	se completed this					
		/primary caregiver					
	independent. 9.	Assessment regarding					
		self manage wound care					
	completed this v						
	Patient/caregive	r stated understanding of					
	instructions of fa	all preventions related to					
	environmental h	azards."					
	G. The Visit	Note Report dated					
		"Pain, daily but not					
		d at 9. The section titled					
	"Wounds" stated						
		Narrative section stated,					
		ean, dry and intact,					
		infection or drainage,					
		will continue to monitor."					
	The section title						
	I		1				1

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 377 of 518

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COMP	ESURVEY LETED 9/2015
	OF PROVIDER OR SUPPLIED	8	3115	T ADDRESS, CITY, STATE, ZIP CODI S WEBSTER ST DMO, IN 46902	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		D BE	(X5) COMPLETION DATE
	Instruct patient/opharmacologica pain control mea patient/caregive injury and improte to prevent injury cardiovascular hyrocess, 12. and complication constipation/dia patients ability the process, details/diabetic skin care and inspect management wound treatment, details/comment treatment for efficients progressing." H. The Visit 10/14/15 Goals Patient/caregive understanding of related to pressure prevention. 2. are identified prinitiated quickly risks 5. Patient/saregive understant und	r regarding pain d principles, 5. caregiver regarding I and nonpharmacologic asures, 6. Instruct r in reduction of risk for ovement in environment r, 8. Instruct in oppo/hypertension disease Instruct regarding causes n of rrhea, 22. Assess o self manage disease comments: diabetic diet, re, proper skin care, foot ion, medication 26. Assess current t for effectiveness weekly hts: assess wound ectiveness and wound Note Report dated Met section stated, "1. r will verbalize f instructions given re ulcer relief and ulcer Cardiac exacerbations omptly and interventions to minimize associated ient/caregiver				

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 378 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. Wl	NG		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
					WEBSTER ST		
GREATI	_AKES CARING			KOKON	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	asures this visit. 6.					
	Instruction regarding injury prevention						
	-	pisode- patient/caregiver					
	-	Instruction regarding					
	managing chang	•					
	_	pisode- patient/caregiver					
	independent. 8.						
		ypo/hypertension disease					
	_	pisode-patient/caregiver					
	_	10. Changes in					
	respiratory status are identified and						
	reported to physician for prompt						
		ninimize associated risks.					
	11. Instruction i	-					
	management of	gastrointestinal disease					
	completed this e	pisode- patient/caregiver.					
	12. Instruction i	regarding self					
	management of	altered bowel elimination					
	completed this e	pisode- patient/caregiver					
	independent. 13	. Exacerbations of					
	gastrointestinal of	disease are promptly					
	identified and in	terventions implements					
	to minimize risk	s to patient 15.					
	Instruction regar	ding self management of					
	anxiety complete	ed this episode-					
	patient/caregiver	r independent 19.					
	Instruction regar	ding self management of					
	depression comp	pleted this episode-					
	patient/caregiver	r independent 23.					
		ding equipment to					
		e completed this episode-					
		r independent. 25.					
		ding sings and symptoms					
	of infection and						
	I						

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	OF CORRECTION			COMPLETED 11/19/2015			
NAME OF I	PROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	independent regarding wound this episode- pat independent. 28 avoiding wound this episode- pat independent wound care compatient/caregiver Patient/caregiver instructions of farenvironmental has I. The Goals 10/6/15 were represented on 10/14/15 visit an 10, 11, 12, 13, 25 failed to notify the Met Goals ar POC. J. The Visit 10/21/15 stated, Scale Rating: 8. "Integumentary/"Posterior neck is redness or edema stated, "There is neck approximatel length almost co	I management completed ient/caregiver Instruction regarding complications completed ient/caregiver 31. Instruction in pleted for this episode-independent 35. I stated understanding of a stated understanding of a stated to a state					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 380 of 518

	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE A. BUILDING B. WING	OO OO	COMI	e survey Pleted 9/2015
	FPROVIDER OR SUPPLIEI	8	3115	ET ADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST OMO, IN 46902	Е	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	instructions/inte 10/14/15. The V 10/21/15 stated, 1. Instruct patie changes/adaptiv pressure deta in pressure relie for support, morprominences and least every 1-2 h patient/caregive pharmacologica pain control measigns and sympt monitor depress routine basis instructed in avoidazards includin poor lighting, in obstructed pathw. L. The Visit 10/21/15 Goals Patient/caregive understanding or related to pressure identified prinitiated quickly risks 5. Pademonstrate understanding or selected to pressure identified prinitiated quickly risks 5. Pademonstrate understanding or selected to pressure identified prinitiated quickly risks 5. Pademonstrate understanding or selected to pressure identified prinitiated quickly risks 5. Pademonstrate understanding or selected to pressure identified prinitiated quickly risks 5. Pademonstrate understanding or selected to pressure identified prinitiated quickly risks 5. Pademonstrate understanding or selected to pressure identified prinitiated quickly risks 5. Pademonstrate understanding or selected to pressure identified prinitiated quickly risks 5. Pademonstrate understanding or selected to pressure identified prinitiated quickly risks 5. Pademonstrate understanding or selected to pressure identified prinitiated quickly risks 5. Pademonstrate understanding or selected to pressure identified p	I and nonpharmacologic asures 10. Assess for oms of depression and ion symptoms on a 18 Patient oidance of environmental gentrow rugs, clutter, appropriate foot wear, ways, pets." Note Report dated Met section stated, "1. In will verbalize f instructions given re ulcer relief and ulcer Cardiac exacerbations omptly and interventions to minimize associated tient/caregiver				

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 381 of 518

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586		ILDING	NSTRUCTION 00	(X3) DATE COMPL 11/19/	ETED
	ROVIDER OR SUPPLIER			3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Changes in respiridentified and reprompt intervent associated risks. self management disease complete patient/caregiver stated understand fall preventions in hazards." The aevidence any car problems. M. The Goat 10/14/15 were represented on 10/21/15 visit and 18. The aphysician to remmodify/revise the N. The Visit 10/30/15 stated, Indicate patien The section titled "Integumentary/problems identified section stated," Inhealed." O. The visit	ported to physician for tion to minimize 8. Instruction regarding to f gastrointestinal ed this episode- 1 18. Patient/caregiver ding of instructions of related to environmental assessment notes failed to rediac and respiratory 1. Met previously on epeated as being and met again on ad listed as #'s 1, 2, 5, 7, agency failed to notify the love the Met Goals and the POC. 1. Note Report dated "Pain all of the time. ent Pain Scale Rating: 9."					
		isit Note Report dated					

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING		COMPLETED 11/19/2015		
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	10/30/15 stated, 1. Instruct patient changes/adaptive pressure detain pressure relieft for support, monprominences and least every 1-2 hapatient/caregiver pharmacological pain control mean observation, tead wound/deub care symptoms of infelevated temp, reincreased pain. requirements to printegrity and heat to discontinue unrelated to wound P. The Goal 10/21/15 were rereinstructed on a 10/30/15 visit and The agency faile to remove the Mamodify/revise the discontinue SN sincision was head. Q. During tel 11/18/15 at 10:00	"Instructions Provided. Int/caregiver in position e equipment to elevate ils/comments: instruct including using pillow itoring skin over bony position changes at ours 5. Instruct regarding and nonpharmacologic sures 18. Skilled ching and provision of as follows: signs and ection to report such as edness, swelling, I. Instruct in nutritional promote good skin ling." The agency failed innecessary teaching /decub instructions. Met previously on epeated as being and met again on d listed as #'s 1, 2, and 5. d to notify the physician et Goals and e POC, and failed to hervices once the cervical led. dephone interview on D AM, patient #10's					
	spouse stated the	steri-strips fell off of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
NAME OF I	DROVIDED OD GUDDI IEI		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		3115 S	WEBSTER ST		
	_AKES CARING			<u> </u>	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
PREFIX	`	ICY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO T		THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		on by the first or second					
	1	ould be approximately					
		atient's spouse stated the					
	nursing services	continued to be provided					
	after the steri str	ips fell off and the nurses					
	were touching or	n teaching about					
	depression and o	other self-care related					
	topics for the pa	tient.					
	R. During in	nterview on 11/11/18/15					
	at 10:30 AM, the Administrator stated if						
	the wound was healed and no other SN						
	was needed that	t would be an indication					
		m SN services and let					
	_	e and close out the case.					
		for stated the patient					
		•					
		discharged from SN on					
	11/4 or 11/10/15).					
	S. SN visits	s continued to be					
	provided on 11/4	4 and 11/11/15. The					
	Visit Note Repo	rt dated 11/4/15 stated,					
	"Pain all of	the time Indicate					
	Patient Pain Sca	le Rating: 8." The					
	section titled "In	itegumentary/Wounds"					
		lems identified."					
	l suite, and pass						
	T. The visit	t note repeated					
		rventions identified on					
		isit Note Report dated					
		Interventions Provided.					
		nt/caregiver in position					
	_	e equipment to elevate					
	pressure deta	ails/comments: instruct					

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 COMPLET 11/19/20					
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	in pressure relief for support, mon prominences and least every 1-2 h patient/caregiver pharmacological pain control mea observation, tead wound/deub care symptoms of infelevated temp, reincreased pain. requirements to pintegrity and heat to discontinue ur related to wound. U. The Goa 10/30/15 were rere-instructed on a visit and listed as ill verbalized und instructions give ulcer relief and uncertainty and integrity	Fincluding using pillow itoring skin over bony position changes at ours 5. Instruct regarding and nonpharmacologic sures 18. Skilled thing and provision of as follows: signs and ection to report such as edness, swelling, 17. Instruct in nutritional promote good skin ling." The agency failed mecessary teaching /decub instructions. Is Met previously on epeated as being and met again on 11/4/15 s: 1. Patient/caregiver derstanding of an related to pressure alcer prevention. 2. ations are identified erventions initiate hize associated risks aregiver demonstrate associated risks aregiver demonstrate anges in respiratory fied and reported to ompt intervention and to		TAG	DEFICIENCY)		DATE

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 385 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIEF			3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	are promptly ide implemented to 17. Patient/c ability to self mare requirements to integrity 19. understanding or preventions relat hazards. The agphysician to remmodify/revise the discontinue SN sincision was heat V. The Vis 11/11/15 stated, Indicate Patient W. The visit instructions/internative to the visit instructions/internative to the visit instructions and the visit in pressure in pressure relies for support, more prominences and least every 1-2 heatient/caregivery pharmacological pain control meating to self-the visit in pressure and least every 1-2 heatient/caregivery pharmacological pain control meating to self-the visit in pressure relies for support, more prominences and least every 1-2 heatient/caregivery pharmacological pain control meating to self-the visit in pressure relies for support, more prominences and least every 1-2 heatient/caregivery pharmacological pain control meating the visit in the visit	Patient/caregiver stated of instructions of fall sed to environmental ency failed to notify the ove the Met Goals and e POC, and failed to services once the cervical led. it Note Report dated "Pain all of the time. Pain Scale Rating: 8." it note repeated eventions identified on sit Note Report dated "Interventions Provided: int/caregiver in position e equipment to elevate tils/comments: instruct including using pillow intoring skin over bony it position changes at ours 5. Instruct					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			UILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED		
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
GREAT I	_AKES CARING				10, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤЕ	(X5) COMPLETION DATE	
		d healing." The Visit ed 10/30/15 evidenced d.						
	11/4/15 were representations of the status are identifications of are promptly ide implemented to 17. Patient/c ability to self mare quirements to integrity 18. understanding or preventions relains hazards." The aphysician to remmodify/revise th	and met again on 11/1/15 s: 1. Patient/caregiver iderstanding of in related to pressure ilicer prevention. 2. intions are identified iterventions initiate inize associated risks isaregiver demonstrate if pharmacological and iteric pain control measures anges in respiratory ited and reported to imput intervention and to intervention and to intervention and to intervention and to intervention and to intervention and to intervention and to intervention and to intervention and to interventions intified and interventions intimize risks to patient. intervention aregiver will demonstrate						
	discontinue biv	ser, rees offee the corvical						

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		I .	ILDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
GREAT I	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	was reviewed on care date was 5/2 Huntington's Che 8/30-10/28/15 co the week of 9/6/2 week, 1 every twe every 3 weeks for needed for cardia gastrourinary/gast mental, pain, skir and falls. SN for Evaluate patient care, observation effectiveness of regimen and skill pain management level to physicial -Observation/ass system to identify with exacerbation of complications - Obtain pulse on upon recertificate and times 3 as not breath, oxygen urobservation/ass system to identify with exacerbation of complications system to identify with exacerbation of complicationsSN for urinary in the system of t	ecord for patient # 13 11/19/15. The start of 2/15. Diagnosis of orea. The POC dated ontained orders for SN 15, 1 time a week for 1 to weeks for 4 weeks, 1 or 3 weeks, and 3 as ac/respiratory, strointestinal, endocrine, in, wound status changes, it and develop plan of a and assessment of pain, pain management and led teaching related to at, report increase in pain in; essment of cardiac by changes associated in for early intervention confirm baseline eeded shortness of se, activity intolerance; essment of respiratory by changes associated in for early intervention in the confirm baseline eeded shortness of se, activity intolerance; essment of respiratory by changes associated in for early intervention					

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
GREAT I	AKES CARING				MO, IN 46902		
		TATEMENT OF DEPLOYEDING S	1				(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		to urinary incontinence		1110			Ditte
	_	Say obtain urinalysis and					
	_ ~	•					
		itivity times 3 if indicated					
		mptoms of urinary tract					
	infection or reter						
		tion/assessment of					
	-	system to identify					
	_	ted with exacerbation of					
	*	ation of complications,					
	SN to provide sl	killed teaching regarding					
	measures to con	trol diarrhea/constipation					
	as well as preven	nting related					
	complications, S	SN for administration of					
	saline enema tin	nes 3 as needed, SN for					
	removal of fecal	impaction times 3 as					
	needed.						
	-SN to evaluate	and provide interventions					
		nce and reduce the risk of					
	falls.						
	-SN to instruct p	patient/caregiver on					
	_	ures to reduce pressure					
	ulcer risk.	on to the state of the state of					
		supports to minimize					
		zation, patient/primary					
	_	e instructed in emergency					
	_	spects of cardiovascular					
		•					
	_	ment to reduce avoidable					
	hospitalization.						
	_	nstructions related to					
		ing. Discharge summary					
	_	s available to physician					
	upon request.						
		ion of medication					
	regimen to ident	rify					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
GREAT L	AKES CARING				MO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	changes/complic	cations for early					
	intervention.						
	GOALS;						
	-Pulse oximetry	results obtained.					
	-Changes in resp	piratory status will be					
	_	ported to physician for					
		tion to minimize					
	associated risks;						
	-Improvement in	n urinary incontinence;					
	_	n management of urinary					
	incontinence;						
	· ·	of gastrointestinal disease					
	will be promptly	•					
		plemented to minimize					
	risks to patient.	p					
	-Patient/caregive	er verhalize and					
		lity to manage altered					
	bowel elimination						
		re bowel patency;					
		able to perform activities					
		1					
		nd individual activities of					
		decreased risk for falls;					
		er will demonstrate					
		es of pressure ulcer					
	prevention,	_					
		re appropriate agency					
		ent rehospitalization,					
	avoidable hospit	alizations will be					
	reduced;						
	-Patient's discha	rge instruction needs will					
	be met. Dischar	ge summary for all					
	disciplines avail	able to physician upon					
	request;						
	_	er will demonstrate					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			r í	JILDING	nstruction 00	(X3) DATE COMPL 11/19/	ETED
	ROVIDER OR SUPPLIER			3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	A. The SN V Narrative section "Patient seen for supervisory visit breathing. Bilate Active bowel sor Reports BM [bor morning. No ed Denies chest pair No new skin issuer remains intact. I meal time. Spass times due to Hur Patient reports medication as predication as predicated appointments with symptoms of hypothesis of breatfacial flushing. teaching: Ziac: of side effects understanding of today." B. The Visit 9/10/15 section to Provided," stated patient/caregiver changes/adaptive	risit Note Report In dated 9/10/15 stated, It RN visit and HHA It Denies difficulty It lung sounds clear. It lung stated, it lung sounds clear. It lung sounds clear. It lung stated, it lung stated,		IAU			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
		157586	B. W	B. WING			11/19/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEI	₹			WEBSTER ST			
GREAT L	_AKES CARING				MO, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	`	LISC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	pressure relief in	ncluding using pillows for						
	_	ring skin over bony						
		d position changes at						
	_	nours. Instruct in						
	1	ing schedule 4.						
		caregiver regarding pain						
	•	0 0.						
		ement principles						
		nt/caregiver regarding use						
	of pain scale							
		scale. Instructed						
		s of pain. Instructed						
	1 0 01	ples of pain management						
		or management of pain to						
	enhance healing	and ability to cope with						
	illness. Instructe	d patient/caregiver that						
	pain is best cont	rolled before it reaches						
	an unmanageabl	e level. Instructed						
	patient/caregiver	r to coordinate						
	administration o	f pain medication with						
	activities. 5. Ins	truct patient/caregiver						
	regarding pharm	-						
		gic pain control measures.						
	-	oximetry for shortness of						
	_	struct in nutritional						
		promote good skin						
	integrity and hea	_						
	integrity and nee	iiiig.						
	C The SN V	Visit Note Report dated						
		titled "Goals Met," stated,						
		giver will verbalize						
		f instructions given						
	_	re relief and ulcer						
	_	Cardiac exacerbations are						
	identified promp	tly and interventions						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			JILDING	<u>00</u>	COMPL 11/19/	ETED		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
GREAT L	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION	
TAG		to minimize associated	+	TAG	DEFICIENC!)		DATE	
	risks 5. Pati							
	demonstrate und	_						
		and nonpharmacologic						
	-	sures this visit. 6. Pulse						
	oximetry comple							
	Changes in respi	ratory status are						
	identified and rep	ported to physician for						
	prompt intervent	ion to minimize						
	associated risks.	8. Exacerbations of						
	gastrointestinal d	lisease are promptly						
	identified and int	terventions implemented						
	to minimize risks	s to patient. 9.						
	_	will demonstrate ability						
	_	utritional requirements to						
	-	in integrity 12.						
	_	stated understanding of						
		ll preventions related to						
		azards." The assessment						
	_	ratory stated, "Was						
		m assessed? Yes.						
	_	ory assessment findings:						
	•	ntified." The assessment						
	_	umentary/Wounds stated,						
	"No problems ide							
		on for Cardiovascular						
		nsion." The vital signs						
		temperature 98.7, pulse						
	68, respirations 1 118/78.	8, and blood pressure						
	110//0.							
	D The SN V	isit Note Report dated						
		itled "Interventions						
	Provided," stated							
	110,1404, 544104	.,						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	00	COMPLETED 11/19/2015				
NAME OF I	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
GREAT I	AKES CARING		KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	patient/caregiver changes/adaptive pressure. Details pressure relief in support, monitor prominences and every 1-2 hours. turning/positioning. Instruct patient/c and pain manage instructed patient of pain scale using Obtain pulse oxing breath 8. Instruction and pain manage instructed patient of pain scale using Obtain pulse oxing breath 8. Instruction and pain manage integrity and heat importance of for after discharge." E. The Goals 9/10/15 were represented on a visit and listed as exacerbations are interventions init minimize associated Patient/caregiver to self manage in promote good skulpton and promote good skulpton. The agency failed to remove the Momodify/revise the modify/revise the mod	in position e equipment to elevate s/comments: instruct in cluding using pillows for ing skin over bony position changes at least Instruct in ing schedule 4. aregiver regarding pain ment principles t/caregiver regarding use ing 0-10 pain scale 5. metry for shortness of struct in nutritional bromote good skin ling 12. Instruct llowing prescribed diet The assessment Met previously on eated as being and met again on 9/24/15 is: "1. Cardiac is identified promptly and iated quickly to inted risks. 4. will demonstrate ability attritional requirements to in integrity." ed to notify the physician						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A.			A. BUILDING 00 COMPLETED B. WING 11/19/2015				
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	10/6/15 section t	itled "Interventions					
	Provided," stated	l, "1. Instruct					
	patient/caregiver	in position					
	changes/adaptive	e equipment to elevate					
	pressure. Details	s/comments: instruct in					
	pressure relief in	cluding using pillows for					
	support, monitor	ing skin over bony					
	prominences and	position changes at least					
	every 1-2 hours.	Instruct in					
	turning/positioni	ng schedule 4.					
	Instruct patient/c	aregiver regarding pain					
	and pain manage	ment principles					
	instructed patient	t/caregiver regarding use					
	of pain scale usir	ng 0-10 pain scale.					
	-	ling causes of pain.					
	_	ling principles of pain					
	management incl						
	-	pain to enhance healing					
	-	be with illness. Instructed					
	patient/caregiver						
	controlled before	•					
	unmanageable le						
	patient/caregiver						
	-	f pain medication with					
		truct patient/caregiver					
	regarding pharma	-					
	0 0.	ic pain control measures.					
		tient/caregiver regarding					
	•	ce incidence of urinary					
	incontinence. 8.	_					
		regarding measures to					
		ng urinary incontinence-					
	_	osable underpads,					
	condom catheters						
	condom cameter	J.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		JILDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF I	PROVIDER OR SUPPLIER			NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING			10, IN 46902		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	10/6/15 section to previously on 9/2 being re-instructed 10/6/15 visit and Patient/caregiver understanding of related to pressur prevention. 2. Consideratified promptinitiated quickly risks 5. Pating demonstrate under pharmacological pain control mean Changes in respirate dentified and reprompt intervent associated risks. patient/caregiver reduce incidence 8. Instruction regiment interventions in particular interventions imprises to patient. Stated understanding fall preventions in hazards." The assessing responsible to the preventions in the prevention in the	Cinstructions given the relief and ulcer Cardiac exacerbations are tly and interventions to minimize associated ent/caregiver terstanding of and nonpharmacologic sures this visit. 6. ratory status are corted to physician for ion to minimize 7. Instruct regarding measures to of urinary incontinence. garding urinary inpleted for this episode. s of gastrointestinal ptly identified and colemented to minimize 19. Patient/caregiver ding of instructions of related to environmental ssessment section for d, "Was respiratory				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	00	COMPI		
		157586	B. W	ING		11/19	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
GREAT I	LAKES CARING			KOKOM	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	^	ied." The assessment					
		iovascular stated, "No					
problems identified." The agency failed to notify the physician for a need to							
remove met goals and update POC.							
	Temove met goar	is and update FOC.					
	H The SN R	ecertificaation Outcome					
	Assessment and						
	(OASIS)Visit Note Report dated						
		titled "Interventions					
	Provided," stated, "1. Instruct						
	patient/caregiver in position						
	changes/adaptive equipment to elevate						
	pressure. Details/comments: instruct in						
	pressure relief in	cluding using pillows for					
	support, monitor	ring skin over bony					
	prominences and	l position changes at least					
	every 1-2 hours.	Instruct in					
	turning/positioni	ng schedule 4.					
	Instruct patient/c	caregiver regarding pain					
	and pain manage	ement principles					
	instructed patien	t/caregiver regarding use					
	of pain scale using	ng 0-10 pain scale.					
	Instructed regard	ling causes of pain.					
	_	ling principles of pain					
	management inc	_					
	-	pain to enhance healing					
		pe with illness. Instructed					
	patient/caregiver	-					
	controlled before						
	unmanageable le						
	patient/caregiver						
		f pain medication with					
	activities. 5. Ins	truct patient/caregiver					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 397 of 518

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER	\ {		1	DDRESS, CITY, STATE, ZIP CODE		
GREATI	_AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID	1	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE.	DATE
	regarding pharm	_					
		gic pain control measures.					
		ssessment for urinary					
		UA [Urinalysis] and C					
	_	sensitivity] obtained. 8.					
Instruct patient/caregiver regarding							
causes and complication of							
constipation/diarrhea 10. Instruct in							
nutritional requirement to promote good							
	skin integrity and healing." The Visit Note Report section titled						
	_						
	"Integumentary/Wound" stated, "No problems identified."						
	problems identif	icu.					
	I. The SN R	ecertification OASIS					
	Visit Note Repor	rt dated 10/26/15 section					
	_	t," previously on 10/6/15					
	were repeated as	being re-instructed on					
	and met again or	n 10/26/15 visit and listed					
	as: stated, "1. Pa	atient/caregiver will					
	verbalize unders	tanding of instructions					
	given related to	pressure relief and ulcer					
		Cardiac exacerbations are					
	identified promp	tly and interventions					
		to minimize associated					
	risks 5. Pati						
	demonstrate und	· ·					
		and nonpharmacologic					
	-	sures this visit. 6.					
	Changes in respi	-					
		ported to physician for					
	prompt intervent						
		9. Exacerbations of					
	gastrointestinal of	lisease are promptly					

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	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BU	A. BUILDING 00 B. WING		COMPLETED 11/19/2015	
NAME OF I	PROVIDER OR SUPPLIER		-		DDRESS, CITY, STATE, ZIP CODE		
GREAT I	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAU	identified and into minimize risks assessment section. "Was respiratory Indicate respiratory	rerventions implemented is to patient." The confor Respiratory stated, system assessed? Yes. ory assessment findings: intified." The assessment ovascular stated, "No fied." The agency failed sician for a need to so and update POC. Recertification OASIS of the dated 10/26/15 stated, "Patient fiest nursing not need at the continue with PT at record failed to evidence ischarged from SN policy titled "Care reviewed March 2015 wing the initial re Plan shall be		IAG			DATE

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AND PLAN OF CORRECTION DENTIFICATION NUMBER: 157586 NAME OF PROVIDER OR SUPPLIER GREAT LAKES CARING STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and the effectiveness of the interventions in achieving progress toward goals. All changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans for implementation. d. Indicators for	STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	(3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER GREAT LAKES CARING (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and the effectiveness of the interventions in achieving progress toward goals. All changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 (X5) PREFIX TAG PROVIDERS PLAN OF CORRECTION (X5) COMPLETION DATE (X5) COMPLETION DATE	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
AME OF PROVIDER OR SUPPLIER GREAT LAKES CARING (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and the effectiveness of the interventions in achieving progress toward goals. All changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans 3115 S WEBSTER ST KOKOMO, IN 46902 (X5) PREFIX TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX TAG TAG PREFIX TAG TAG PREFIX TAG PREFIX TAG TAG PREFIX TAG TAG TAG PREFIX TAG TAG TAG TAG TAG TAG TAG TA			157586	B. W	ING		11/19/	2015	
AME OF PROVIDER OR SUPPLIER GREAT LAKES CARING (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and the effectiveness of the interventions in achieving progress toward goals. All changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans 3115 S WEBSTER ST KOKOMO, IN 46902 (X5) PREFIX TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX TAG TAG PREFIX TAG TAG PREFIX TAG PREFIX TAG TAG PREFIX TAG TAG TAG PREFIX TAG TAG TAG TAG TAG TAG TAG TA					STREET A	ADDRESS CITY STATE ZIP CODE			
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) and the effectiveness of the interventions in achieving progress toward goals. All changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans ID	NAME OF P	PROVIDER OR SUPPLIEF	R						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and the effectiveness of the interventions in achieving progress toward goals. All changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) PROVIDER'S PLAN OF CORRECTION (CS) PROVIDER'S PLAN OF CORRECTION (CS) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) COMPLETION TO ACCH CORRECTIVE ACTION SHOULD BE (COMPLETION (CS)) COMPLETION TO ACCH CORRECTIVE ACTION SHOULD BE (COMPLETION (CS)) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) COMPLETION TO ACCH CORRECTIVE ACTION SHOULD BE (CS) COMPLETION TO ACCH CORRECTIVE ACTION SHOULD BE (CS) COMPLETION TO ACCH CORRECTIVE ACTION SHOULD BE (CS) COMPLETION TO ACCH CORRECTIVE ACTION SHOULD BE (CS) COMPLETION TO ACCH CORRECTIVE ACTION SHOULD BE (COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) TO ACCH COMPLETION TAG PROVIDER'S PLAN OF CORRECTION (CS) TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLETION TO ACCH COMPLE	GREATI	AKES CARING							
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) and the effectiveness of the interventions in achieving progress toward goals. All changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans						10, 11 10002			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) and the effectiveness of the interventions in achieving progress toward goals. All changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans									
and the effectiveness of the interventions in achieving progress toward goals. All changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans		`				CROSS-REFERENCED TO THE APPROPRIA	TE		
in achieving progress toward goals. All changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans	TAG		· · · · · · · · · · · · · · · · · · ·		TAU	DEFICIENCE I		DATE	
changes will be communicated to the appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans									
appropriate staff members. 3. The Care Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans			_						
Plan shall include, but not be limited to: a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans		changes will be	communicated to the						
a. Problems and needs identified related to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans									
to diagnosis. b. Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans		Plan shall include, but not be limited to:							
and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans		a. Problems and needs identified related							
and realistic goals as determined by the assessment and client expectations. c. A list of specific interventions with plans		to diagnosis. b. Reasonable, measurable,							
assessment and client expectations. c. A list of specific interventions with plans		_							
list of specific interventions with plans		_	-						
			-						
for implementation. d. indicators for		-							
		measuring goals achievement and							
		identified time frames. 4. The physician							
Plan of Care may be used as a care plan if			_						
specific interventions are clearly		•	-						
identified for home care staff to address									
client care needs."		client care needs	s."						
4. The agency's policy titled		4. The agency's	policy titled						
"Coordination of Client Services," #		"Coordination of	f Client Services," #						
C-360, reviewed March 2015 stated,		C-360, reviewed	March 2015 stated,						
"Purpose To ensure appropriate,		"Purpose To	ensure appropriate,						
quality care is being provided to clients.		_							
To modify the plan to reflect needs or			C 1						
changed identified by members of the		_	-						
ream and avoid duplication of services.		_	-						
To identify needs to modify the plan of			-						
		1	• •						
care Special Instructions 2.		_							
Interdisciplinary care conferences shall be									
conducted as often as necessary to			-						
respond to changes in the client's needs,									
services, care, or goals. 3. After the			_						
initial assessment the admitting		initial assessmer	nt the admitting						
Registered Nurse/Therapist shall		Registered Nurse	e/Therapist shall						

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A. BUILDING B. WING		³ <u>0</u>	00 COMPLETE 11/19/20		ETED	
NAME OF F	PROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIP CODE BSTER ST		
GREAT L	AKES CARING				IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X CF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE	(X5) COMPLETION DATE
	communicate the visit with the Cliensure: a. Clarificare orders diskilled nursing caservices and/or resources 7. Manager or Clinicassume responsible updating/changing communicating diskilled nursing d	e findings of the initial nical Supervisor to fication of the plan of and an element of the fication of the plan of and an element of the first of t					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 401 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED					
THE TERM	or condition.	157586	B. WI		00	11/19/	
	ROVIDER OR SUPPLIER			3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
N 0537 Bldg. 00	the registered numembers of the treordination and changes or needs activities in the hinclude: observateaching and train Management and plan and routine procedures." 410 IAC 17-14-1(a Scope of Services Rule 1 Sec. 1(a) shall provide nursi	timely response to client 3. Skilled nursing ome care setting may tion and assessment, ning activities. I evaluation of the care and complex skilled					
	nurse in accordancere as follows: Based on record the agency failed staff provided trethe plan of care (reviewed. (# 3) Findings include	review, and interview, I to ensure the nursing eatments as ordered on POC) for 1 of 20 records	N 05	537	To ensure compliance with 410 IAC 17-14-1(a): Scope of Services the following interventions have been implemented: · All LPN and RN staff received education by 12/24/15, that included hands demonstration check offs in a skills lab by RN staff educators. The education included review PICC line procedures, physicial notification of abnormal assessment, documentation	N on S.	12/24/2015

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 402 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMP	LETED	
	9/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2445 O MEDICIER OF		
3115 S WEBSTER ST		
GREAT LAKES CARING KOKOMO, IN 46902		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE	
care (POC) dated 10/23/-12/21/15 with review, as well as return		
orders for Skilled Nursing (SN) 1 time a demonstration of skills including		
weak for 1 week 2 times a week for 9		
addit will be performed by the		
weeks, then 1 time a week for 1 week, with 3 as needed visits for cardiac, administrator or designee of 100% of all patients with a PICC		
line until 4000/ econtinues is meet		
for 4 consecutive weeks. After 4		
gastrourinary, neurologic, endocrine, consecutive weeks of		
mental, pain, skin/wound status changes, 100%compliance the audit will		
and falls. SN for: Instruct on decrease to 10% quarterly and		
lab/venipuncture procedure, obtain lab will be completed through the		
results and report to physician. SN to		
obtain Vancomycin trough week of (Exhibit 6)		
10/26/15 and BMP [basic metabolic		
profile] twice weekly until instructed		
otherwise SN to change PICC		
dressing using sterile technique every		
week and as needed times 3 for soiled or		
loose dressing.		
A. The start of care assessment form		
dated 10/23/15 by employee G,		
Registered Nurse (RN) stated, "Indicate		
length of exposed PICC catheter from		
insertion site to catheter hub in		
centimeters: 10.0."		
B. The SN Visit Note Report dated		
10/26/15 by employee U, Licensed		
Practical Nurse (LPN) stated, "PICC line		
dressing dislodged. PICC line dressing		
changed using aseptic technique Lab		
draw obtained via PICC line using		
aseptic technique." The record failed to		
evidence the LPN measured the PICC		

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		IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING			COMPLETED 11/19/2015	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ë	(X5) COMPLETION DATE
	,	o evidence the nurse used for the dressing change.					
	10/30/15 by emplength of exposed insertion site to contimeters: 11.4 evidence the phy	isit Report dated loyee G stated, "Indicate d PICC catheter from eatheter hub in 0." The record failed to esician was notified of longer measurement of					
	by employee E, I Nursing assessm [Vancomycin] pousing clean techn Coordination No by employee E s PICC line dressindue to dislodgem changed using st record failed to e	risit Note dated 11/3/15 LPN stated, "Skilled ent completed for Vanco eak draw from PICC line nique." A Care te Report dated 11/3/15 tated, "Patient requesting ng changed during visit nent. PICC line dressing erile technique." The evidence the PICC line uring the dressing					
	11/6/15 by employ PICC Catheter S Indicate length of from insertion sincentimeters: 11.1 evidence the phy	isit Note Report dated byee G stated, "Indicate ite Assessment: Red f exposed PICC catheter te to catheter hub in 0." The record failed to exician was notified of the PICC catheter site.					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 404 of 518

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			JILDING	00	COMPL 11/19/	ETED	
		157500	B. W		ADDRESS, CITY, STATE, ZIP CODE	11/19/	2015
NAME OF	PROVIDER OR SUPPLIEF	R			WEBSTER ST		
GREAT	LAKES CARING			KOKOM	1O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	"Indicate length catheter from inshub in centimeter failed to evidence notified of the 3 measurement. 2. During interve PM, the Adminited of the Adminited of the Adminited of the Adminited of the Adminited of the nurse that at 3 centimeters said she measured showing under in that the PICC line. 4. The agency's "Responding to Lines," # I-230 s Migration: It is central venous of another location Certain types of susceptible to cate Clients who are Response: Measured States of the Adminited States of the Administration of the	theter tip migration					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586			COMPLETED
	PROVIDER OR SUPPLIER LAKES CARING		3115 9	ADDRESS, CITY, STATE, ZIP CODE S WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	performed on all placed catheters.	-ray study should be long-term, centrally			
	"PICC Line Dresstated, "PICC linuse Strict Asepti Procedure 9. catheter exposed gloves Docu Document in the	Note length of l 11. Don sterile mentation Guidelines 1. clinical record: d. er visible at exit site. e.			
N 0541 Bldg. 00	services are limite purposes of practi setting, the registe following:	, , , , ,			
	Based on record the agency failed the plans of care reviewed, failed were notified of needing Skilled due to goals met reviewed (# 10 a	review, and interview, I to ensure nurses revised for 2 of 20 records to ensure physicians patients no longer Nursing (SN) services for 2 of 20 records and 13), and failed to to revise goals met and	N 0541	To ensure compliance with 41 IAC 17-14-1(a): Scope of Services the following interventions have been implemented: All clinical staff educate on policy C-360 Coordination Client services, C-660 Care Plans, and C200 Skilled Nursi Services. Education focus included the need to provide a	d of ng

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
		157586	B. W	ING		11/19/	2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹			WEBSTER ST			
CDEATI	_AKES CARING				MO, IN 46902			
	-ANLO CANING			KOKOK				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE	
		vised for pain for 1 of 20			disciplines indicated, detailed a timely physician orders, and	and		
	records reviewed	d (# 10).			updating the care plan and			
					patient goals change, physicia	n		
	Findings include	e:			notification of change in patien			
					status and discharge when go			
	1 The clinical r	record for patient # 10			met.			
		11/17/15. The start of						
					An audit will be performed by t			
	care date was 9/26/15. POC dated 9/26-11/24/15 contained diagnosis of				administrator/designee on 100	%		
		•			of all admissions and recertification visits to assure			
	Aftercare following Surgery, with orders				patient interventions match			
	for SN 1 time a week for 1 week, 2 times				diagnosis on the plan of care u	ıntil		
a week for 2 weeks, then 1 times a week				100% compliance is met for 4				
	for 7 weeks, 3 as needed for falls, pain,				consecutive weeks. After 4 we			
	gastrointestinal/gastrourinary, respiratory,				of 100% compliance, the audit			
	,	d skin integrity, diabetes,			decrease to 10% quarterly and	i		
		ecline. Need for skilled			will be completed through the			
		ervention related to			clinical record review process. (Exhibit 12)			
	_				(EXHIBIT 12)			
		cervical spine incision.			An audit will be performed by t	:he		
	-	dry. May leave open to			administrator/designee of 50%			
	air if no drainage				all skilled nursing visits for			
	-Observation and	d assessment of cardiac			updated goals when indicated			
	system to identif	fy changes associated			and physician notification of			
	with exacerbatio	on for early intervention			updated and patient specific goals until 100% compliance is	,		
	of complications	s; observation/assessment			met for 4 consecutive weeks.	·		
	_	al system to identify			After 4 consecutive weeks of			
	-	ted with exacerbation of			100% compliance the audit wil	I		
	_	tion of complications;			decrease to 10% quarterly and	t		
	I -	-			will be completed through the			
		t and develop plan of			clinical record review process.			
		er signed by physician;			(Exhibit 13) An audit will be performed by t	ho		
		sessment of respiratory			administrator/designee of 50%			
	1 -	fy changes associated			all skilled nursing visits for pair			
		on for early intervention			interventions and physician			
	of complications	3;			notification when indicated unt	il		
		tions related to discharge			100% compliance is met for 4			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	(X3) DATE COMPL		
		157586	B. Wl	ING		11/19/	/2015
	PROVIDER OR SUPPLIER		<u> </u>	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	planning. Disch disciplines avail request; =Assess anxiety patient for under management of perform Hamilton mini mental exary provide assess teaching/reinford depression inclustion management and identify characteristic depressive disorbit intervention, SN depression scale exam; -Provide teaching etiology of confiction, safety management; obtoin for pain, effective management and teaching related to report increas physician for prospective disorbit increas physician for prospective management and teaching related to report increas physician for prospective management and teaching self management and teaching related to report increas physician for prospective management and teaching self management and teaching self management and teaching self management times and the self-based of the self-b	arge summary for all able to physician upon and provide assistance to estanding and feelings. SN may on anxiety scale and/or m; nent and eement of management of ding disease process, agement, coping skills nges associated with ders for early may perform geriatric and/or mini mental g/reinforcement in usion or altered measures and home servation and assessment eness of pain d regimen and skilled to pain management, SN e in pain level to ompt intervention; g and training of plan, disease process anagement of ypertension disease;			consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly an will be completed through the clinical record review process (Exhibit 13)		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			A. BUILDING 00 COMPLE B. WING 11/19/2					
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST					
GREAT L	AKES CARING				10, IN 46902			
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE	
	-SN for instruction	on/reinforcement of						
	gastrointestinal s	ystem related teaching,						
	including diverti	culitis and irritable						
	bowel syndrome	(IBS);						
	-SN to provide sl	killed teaching regarding						
	measures to cont	rol diarrhea/constipation						
	as well as preven	nting related						
	complications; sl	killed teaching and						
	training of emerg	gency care plan, disease						
	process laminect	omy surgery including						
	self management	t of neurologic disease;						
	-SN to provide a	ssessment and						
	teaching/reinford	ement of management of						
	diabetes includin	g disease process,						
	medication mana	ngement, coping skills						
	and identify char	nges associated with						
	diabetes for early	intervention. SN may						
	perform blood gl	ucose level as needed						
	for signs and syn	nptoms of						
	hyper/hypoglyce	mia or for baseline						
	testing. SN ass f	Feet and reinforce						
	diabetes mellitus	foot care;						
	-SN observation	and reaching						
	integumentary st	atus to promote optimum						
	skin integrity;							
	-SN to instruct p	atient/caregiver on signs						
	and symptoms of	f infection related to						
	cervical spine su	tures to reduce						
	complications to	the wound;						
	-SN to establish	supports to minimize						
	risk of hospitaliz	ation patient/caregiver						
	will be instructed	d in emergency care plan,						
	and aspects of ce	ervical spine surgery						
	disease managen	nent to reduce avoidable						
							l	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	COMPL		
		157586	B. W	ING		11/19	/2015
	F PROVIDER OR SUPPLIEF				NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREA	T LAKES CARING			KOKON	1O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	regimen to ident changes/complicintervention; -SN to provide it balance and redu-SN to instruct preventive measured ulcer risk; and -Licensed professigns falling out established paration, Pulse < 50 > 29, Systolic blood provided by the pr	nterventions to improve ace the risk of falls; satient/caregiver on are to reduce pressure assional to report vital aside the following anteers: Temp < 96> > 116, Respirations < 12 ood pressure , 80 > 170, pressure < 50 > 90, gar < 60 > 300, oxygen aited risks; Patient's etion needs will be met, ary for all disciplines ary for all disciplines are identified and tiated to allow patient to get will astrate understanding the depression by the end of symptoms are identified maintain patient safety in					

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	/2015
		_	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		3115 S	WEBSTER ST		
	AKES CARING				1O, IN 46902		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG				TAG			DATE
	_	n pain interfering with					
	activity;	at level of 3 or less or at					
	a level acceptable to the patient; -Patient/caregiver demonstrate understanding of pharmacological and						
	_						
		gic pain control measures;					
		nonstrate ability to self					
	_	ascular hypertension					
	_	and reduce caregiver					
		ed with disease process;					
	pulse oximetry r						
	_	er will demonstrate					
	1	anage gastrointestinal					
	disease process;						
	-Patient/caregive						
		lity to manage altered					
	bowel elimination	on. Patient will have					
	bowel patency;						
	-Demonstrated a	ability to self manage					
	neurologic disea	se process and reduce					
	caregiver burder	n associated with disease					
	process, improv	ement in signs and					
	symptoms of ne	urologic disease;					
	-Patient/caregive	er will verbalize					
	demonstrate und	lerstanding the					
	management of	diabetes by the end of the					
	_	nptoms are identified and					
	-	ntain patient safely in the					
	home;	•					
	1	mprovement in existing					
		early identification and					
		additional compromises					
	in skin;						
	l '		1				I

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED		
		157586	B. W	B. WING			11/19/2015	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEI	R			WEBSTER ST			
GREAT I	AKES CARING				1O, IN 46902			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	-Wound complie							
	_	nentary status will						
	improve as evidenced by a decrease in size or healing of wound/decub by end							
	of cert period;							
		ve appropriate agency						
	supports to prev	ent rehospitalization,						
	avoidable hospit	talizations will be						
	reduced;							
	-Patient/caregive	er will demonstrate						
	ability to safely	manage medications;						
	patient will be a	ble to perform activities						
	of daily living a	nd individual activities of						
	daily living with	decreased risk for falls;						
	-Patient/caregive	er will demonstrate						
	proper technique	es of pressure ulcer						
	prevention.	•						
	•							
		failed to ensure the						
		otified of goals being met						
		able goals needing to be						
		plan of care; and failed to						
	coordinate with	nursing staff to ensure						
	instructions and	education on goals met						
	was not being co	ontinued.						
	A. The initia	al start of care was						
		lient Coordination Note						
		late entry for 9/26/15						
	_	of patient] states the						
		pain ever gets is a # 8 on						
		rently patient takes						
	_	grams tablets for pain."						
		_						
	I he agency faile	ed to ensure the goal of						

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 412 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
		at level of 3 or less or at le to the patient" was						
	dated 9/26/15 state Conditions prior regimen change the past 14 days. The Pain assessing the Pain assessing the Pain assessing the Pain assessing the Pain assessing the Pain assessing the Pain assessing the Pain assessing the Pain assessment (mandicate endocrassessment (mandicate endocrassessment (mandicate endocrassessment (mandicate endocrassessment (mandicate endocrassessment) the Pain and Pai	to medical treatment or inpatient stay within 3- Intractable Pain." ment section stated "Pain le Pain Scale Rating: ities make pain worse: en is neck pain least? How long does neck ant. Can neck pain be The section titled hatopoietic" stated ine/Hematopoietic k all that apply): d problems Is the sulin? No Is the antidiabetic agent? Yes. e blood sugars check? y often. What are the lood sugar readings?						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. WI	NG		11/19/	2015
NAME OF I	DROVIDED OD GUDDI IEI		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		3115 S	WEBSTER ST		
	_AKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		<u> </u>	+	TAG	DEFICIENCI)		DATE
		posed plan of care: No.					
	1	physician not contacted:					
		ends." The section titled					
		ted: "3. Patient/caregiver					
	verbalizes under	standing of basic					
	nutritional/hydra	ation requirements." The					
	visit note failed	to evidence the SN					
	provided teaching	ng/reinforcement of					
	management of	diabetes.					
	C. The Visit	Note Report dated					
	10/2/15 stated "I	Pain: All of the time					
	Pain Scale Ratin	g 9 Wound: no					
		fied Have the					
	-	ugars remind stable for					
	-	ek? Not Applicable-					
	_	not routinely checked."					
	_	ection stated "Pain never					
		a 6 Instructed on pain					
	_	e interventions." The					
	_	iterventions" stated, "3.					
		-					
		ess pain intensity and					
		physical assessment					
		arrative note stated, "Has					
	-	that is constant. Pain					
	_	rated a 9 on 1-10 scale.					
	_	ned 30 minutes before					
	SN arrival."						
	The record failed to evidence a pain						
		er than instruction was					
	provided; failed	to evidence the physician					
	was notified to c	change or revise the goal					
	of "Pain controll	led at level of 3 or less or					
	at a level accepta	able to the patient;" and					
	I						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			JILDING	<u>00</u>	COMPL 11/19/	ETED	
NAME OF P	ROVIDER OR SUPPLIER		_	1	DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		e the SN provided ement of management of					
	10/2/15 Intervent Instruct in cardic hypo/hypertension Details/Comment Low Sodium/low Nutritional Requipolate in The evidence educated diabetic diet, and with the physicial diet/nutritional infailed to notify the Met Goals are POC. E. The Visit 10/2/15 Goals Management Pocts of the Patient/caregiver understanding of the Post of	on disease process, ts: Dietary restrictions, v fat." The POC irements stated agency failed to on to the patient on I failed to clarify/verify an as to the eeds of the patient, and he physician to remove and modify/revise the Note Report dated et section stated, "1. v will verbalize Cinstructions given					
	prevention, 2. Cidentified prompinitiated quickly risks 4. Pair intervention compatient/caregiver understanding of	pleted this visit. 5. demonstrate pharmacological and					
	nonpharmacolog this visit. 6. Ins	ic pain control measures truction in					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 COM B. WING 11/2			COMPL 11/19/	ETED	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL AGG DESTERNING DEFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION) ypo/hypertension disease	+	TAG	DEFICIENC!)		DATE
	-	pisode- patient/primary					
		ndent. 7. Changes in					
		s are identified and					
	reported to physi						
		ninimize associated risks.					
	8. Instruction re	garding self management					
		al disease completed this					
	_	/primary caregiver					
		Instruction regarding					
	self management	t of altered bowel					
	elimination comp	pleted this episode-					
	patient/primary o	caregiver independent.					
	10. Exacerbation	s of gastrointestinal					
	disease are prom	ptly identified and					
	interventions imp	plemented to minimize					
	risks to patient.	Instruction regarding					
	self management	t of meds that manage					
	depression comp	eleted this episode-					
	patient/primary o	caregiver independent					
	18. Instructions	regarding ability to self					
	manage nutrition	nal requirements to					
	promote skin into	egrity completed this					
		primary caregiver					
	independent. 19	. Instructions regarding					
	ability to self ma	nage nutritional					
	_	alleviate pressure					
		pisode- patient/primary					
		ndent. 20. Instructions					
	regarding signs a						
		n breakdown completed					
	• •	ient/primary caregiver					
	independent						
	regarding wound	I management completed					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		157586	B. W	ING		11/19/	/2015
NAME OF I	DROVADED OD GUDDU IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			3115 S	WEBSTER ST		
	_AKES CARING				1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
IAG	this episode-pati	•		TAG			DATE
		8. Instruction regarding					
	-						
	avoiding wound complications completed this episode-patient/caregiver						
		•					
	_	29. Patient/caregiver					
		ding of instructions of					
		related to environmental					
	hazards."						
	F The Visit	Note Report dated					
		Pain: All of the time,"					
	and was rated at	,					
		atopoietic section stated,					
	"Have the patien	-					
	_	for the past two weeks?					
		on titled "Goals Met"					
		iac exacerbations are					
		otly and interventions					
		to minimize associated					
	risks 5. Pat						
	demonstrate und	_					
		l and nonpharmacologic					
	-	asures this visit. 6.					
	-	iratory status are					
	1	ported to physician for					
		tion to minimize					
		7. Exacerbations of					
		disease are promptly					
	_	iterventions implemented					
	to minimize risk	_					
		rding self management of					
		ise completed this					
	_	/primary caregiver					
	maepenaent. 9.	Assessment regarding					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 417 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER			3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	patient ability to completed this very Patient/caregiver instructions of far environmental hands of the environmental hands of th	self manage wound care isit 14. It stated understanding of all preventions related to azards." Note Report dated "Pain, daily but not dat 9. The section titled la, "No problems Narrative section stated, ran, dry and intact, infection or drainage, will continue to monitor." If "Interventions, "4. Instruct regarding pain la principles, 5. raregiver regarding and nonpharmacologic issures, 6. Instruct in reduction of risk for evement in environment la, 8. Instruct in ypo/hypertension disease Instruct regarding causes in of of thea, 22. Assess to self manage disease comments: diabetic diet, le, proper skin care, foot ion, medication		IAG			DATE
	_	26. Assess current t for effectiveness weekly					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	WEBSTER ST		
	AKES CARING				1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nts: assess wound					
	treatment for effectiveness and wound						
	progressing."						
	W. W. W. W. W. D. W. L. L.						
	H. The Visit	Note Report dated					
	10/14/15 Goals 1	Met section stated, "1.					
	Patient/caregive	r will verbalize					
	understanding of	f instructions given					
	related to pressu	re ulcer relief and ulcer					
	prevention. 2.	Cardiac exacerbations					
	are identified pro	omptly and interventions					
	initiated quickly to minimize associated						
	risks 5. Pat						
	demonstrate und	_					
		l and nonpharmacologic					
	1 -	asures this visit. 6.					
	1 ^	ding injury prevention					
	1	pisode- patient/caregiver					
	_						
	_	Instruction regarding					
	managing chang	•					
	_	pisode- patient/caregiver					
	independent. 8.						
		ypo/hypertension disease					
		pisode-patient/caregiver					
	_	10. Changes in					
		s are identified and					
	reported to phys						
	intervention to n	ninimize associated risks.					
	11. Instruction i	regarding self					
	management of	gastrointestinal disease					
	completed this e	pisode- patient/caregiver.					
	12. Instruction i						
		altered bowel elimination					
	_	pisode- patient/caregiver					
	Tompicioa mis o	product patronic care 51 voi				ļ	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			î í	ILDING	<u>00</u>	COMPL 11/19/	ETED
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	gastrointestinal didentified and into minimize risks. Instruction regard anxiety complete patient/caregiver Instruction regard depression completent/caregiver Instruction regard alleviate pressure patient/caregiver Instruction regard of infection and scompleted this epindependent regarding wound this episode- patient/caregiver Instruction regarding wound this episode- patient/caregiver patient/caregiver Patient/caregiver Patient/caregiver Instructions of farenvironmental has I. The Goals 10/6/15 were representative on a 10/14/15 visit and the series of the series o	independent 19. ding self management of leted this episode- independent 23. ding equipment to e completed this episode- independent. 25. ding sings and symptoms skin breakdown pisode- patient/caregiver 27. Instruction management completed tent/caregiver Instruction regarding complications completed tent/caregiver 31. Instruction in pleted for this episode- independent 35. estated understanding of ll preventions related to management management management. Met previously on eated as being					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 420 of 518

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	COMPI		
		157586	B. W	ING		11/19	/2015
NAME OF I	PROVIDER OR SUPPLIER	,		STREET A	DDRESS, CITY, STATE, ZIP CODE		
					WEBSTER ST		
GREATI	_AKES CARING			KOKON	1O, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	failed to notify t	he physician to remove					
	the Met Goals as	nd modify/revise the					
	POC.						
		Note Report dated					
	· · · · · · · · · · · · · · · · · · ·	"Indicate Patient Pain					
	_	" The section titled Wounds:" stated,					
		healing incision without					
		a." The Narrative section					
		an incision to posterior					
		tely 8 centimeters in					
		mpletely healed without					
	redness or edem	a. Incision is left [open					
	to air] OTA."						
	K. The visit	note repeated					
		rventions identified on					
		visit Note Report dated					
		"Instructions Provided.					
		nt/caregiver in position					
	-	e equipment to elevate					
		ails/comments: instruct					
	in pressure relie	f including using pillow					
	for support, mor	itoring skin over bony					
	_	l position changes at					
	1	ours 5. Instruct					
	patient/caregiver	•					
		and nonpharmacologic					
		isures 10. Assess for					
		oms of depression and					
	routine basis	ion symptoms on a					
		idance of environmental					
	misu ucicu iii avc	riganice of chynolinichtal					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 421 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPL	
		157586	B. WI	NG		11/19/	/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	£		3115 S	WEBSTER ST		
GREAT L	AKES CARING				1O, IN 46902		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	hazards includin	g throw rugs, clutter,					
		appropriate foot wear,					
	obstructed pathy	• • •					
	obstructed patriv	vays, pets.					
	I The Wield	Nata Danant data d					
	L. The Visit Note Report dated 10/21/15 Goals Met section stated, "1.						
	Patient/caregiver						
		f instructions given					
	_	re ulcer relief and ulcer					
		Cardiac exacerbations					
		omptly and interventions					
	initiated quickly	to minimize associated					
	risks 5. Pat	tient/caregiver					
	demonstrate und	lerstanding of					
	pharmacological	and nonpharmacologic					
	pain control mea	asures this visit 7.					
	Changes in respi	iratory status are					
		ported to physician for					
	prompt intervent						
		8. Instruction regarding					
		t of gastrointestinal					
	disease complete	•					
	_	r 18. Patient/caregiver					
		ding of instructions of					
		related to environmental					
	_	assessment notes failed to					
	· ·	rdiac and respiratory					
	problems.						
	M. Til G. i						
		s Met previously on					
	10/14/15 were re						
		and met again on					
		nd listed as #'s 1, 2, 5, 7,					
	8, and 18. The a	igency failed to notify the					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
NAME OF I	DROWNER OR GURRI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C		3115 S	WEBSTER ST		
	AKES CARING				лО, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		nove the Met Goals and	+	IAG			DATE
	modify/revise th						
	inouny/revise in	le roc.					
	N. The Wigit	Note Depart detad					
		Note Report dated					
		"Pain all of the time.					
	Indicate patient Pain Scale Rating: 9." The section titled "Integumentary/Wounds" stated, "No						
		-					
	problems identified." The Narrative						
	section stated, "Incision to posterior neck						
	healed."						
	O The wight	note reported					
	O. The visit	-					
		rventions identified on					
		Visit Note Report dated					
		"Instructions Provided.					
	_	nt/caregiver in position					
		e equipment to elevate					
	l ~	ails/comments: instruct					
	_	f including using pillow					
		nitoring skin over bony					
	_	d position changes at					
	1	ours 5. Instruct					
	patient/caregiver						
	1 -	l and nonpharmacologic					
		asures 18. Skilled					
		ching and provision of					
		e as follows: signs and					
		Pection to report such as					
	_	edness, swelling,					
	_	19. Instruct in nutritional					
	_	promote good skin					
	1	aling." The agency failed					
	to discontinue u	nnecessary teaching					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	F PROVIDER OR SUPPLIEF	2		3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	P. The Goal 10/21/15 were rere-instructed on 10/30/15 visit at The agency failed to remove the M modify/revise the discontinue SN sincision was heat Q. During te 11/18/15 at 10:0 spouse stated the the wound incision rursing visit [worder 10/6/15]. The proposition of the steries of the part of the wound was for the wound was for the wound was for the wound was for the administration of the proposition of the p	and met again on and listed as #'s 1, 2, and 5. Bed to notify the physician are POC, and failed to services once the cervical aled. Ilephone interview on 0 AM, patient #10's are steri-strips fell off of an are stored and buld be approximately attent's spouse stated the continued to be provided approximately attent's reaching about bother self-care related tient. Iterview on 11/11/18/15 are Administrator stated if the aled and no other SN at would be an indication and SN services and let are and close out the case. For stated the patient discharged from SN on					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		C			WEBSTER ST		
GREAT I	_AKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		continued to be provided		-			
		11/15. The Visit Note					
	Report dated 11	/4/15 stated, "Pain all					
	_	ndicate Patient Pain Scale					
	Rating: 8." The	e section titled					
	_	Wounds" stated, "No					
	problems identif	-					
	•						
	T. The visit	note repeated					
	instructions/inte	rventions identified on					
	10/30/15. The V	isit Note Report dated					
	11/4/15 stated, "	Interventions Provided.					
	1. Instruct patie	nt/caregiver in position					
	changes/adaptiv	e equipment to elevate					
	pressure deta	ails/comments: instruct					
	in pressure relie	f including using pillow					
	for support, mor	nitoring skin over bony					
	prominences and	d position changes at					
	least every 1-2 h	ours 5. Instruct					
	patient/caregiver	r regarding					
	pharmacologica	l and nonpharmacologic					
	_	asures 18. Skilled					
		ching and provision of					
		e as follows: signs and					
		Pection to report such as					
	-	edness, swelling,					
	_	17. Instruct in nutritional					
	•	promote good skin					
		aling." The agency failed					
		nnecessary teaching					
	related to wound	d/decub instructions.					
	II. The Good	a Mat praviously on					
	10/30/15 were re	s Met previously on					
	10/30/13 were re	epeated as being					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	00	COMPL	ETED
		157586	B. W	ING	_	11/19/	/2015
		_		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		3115 S	WEBSTER ST		
	AKES CARING		_		1O, IN 46902		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
		and met again on 11/4/15					
		s: 1. Patient/caregiver					
	ill verbalized un	-					
	1	en related to pressure					
		ulcer prevention. 2.					
	Cardiac exacerbations are identified						
	1	terventions initiate					
	* -	nize associated risks					
		caregiver demonstrate					
	_	f pharmacological and					
	nonpharmacolog	gic pain control measures					
	this visit. 6. Ch	nanges in respiratory					
	status are identif	fied and reported to					
	physician for pro	ompt intervention and to					
	minimize associ	ated risks. 7.					
	Exacerbations o	f gastrointestinal disease					
	are promptly ide	entified and interventions					
	implemented to	minimize risks to patient.					
	_	aregiver will demonstrate					
		anage nutritional					
	I -	promote good skin					
		. Patient/caregiver stated					
	1	f instructions of fall					
		ted to environmental					
	1 *	gency failed to notify the					
	1	nove the Met Goals and					
		ne POC, and failed to					
		services once the cervical					
	incision was hea						
	micision was nea	IICU.					
	W Than	Note Donout dated					
		Note Report dated					
	1	"Pain all of the time.					
	Indicate Patient	Pain Scale Rating: 8."					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
ODEATI	ALCEO CARINO				WEBSTER ST		
	_AKES CARING			KOKON	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	W. The visit	rventions identified on					
		sit Note Report dated					
	-	"Interventions Provided:					
	Instruct patient/caregiver in position changes/adaptive equipment to elevate						
	changes/adaptive equipment to elevate pressure details/comments: instruct						
	_	f including using pillow					
		nitoring skin over bony					
	prominences and position changes at						
	least every 1-2 hours 5. Instruct						
	patient/caregiver						
		and nonpharmacologic					
		asures 17. Instruct in					
	_	rements to promote good					
		d healing." The Visit					
	-	ed 10/30/15 evidenced					
	the wound heale	d.					
	X. The Goals	s Met previously on					
	11/4/15 were rep	peated as being					
	re-instructed on	and met again on 11/1/15					
	visit and listed a	s: 1. Patient/caregiver					
	will verbalize ur	nderstanding of					
	instructions give	n related to pressure					
	ulcer relief and u	alcer prevention. 2.					
	Cardiac exacerba	ations are identified					
	promptly and int	terventions initiate					
		nize associated risks					
		caregiver demonstrate					
		f pharmacological and					
	_	gic pain control measures					
		anges in respiratory					
		ried and reported to					
	I	-					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 427 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BU	A. BUILDING 00 B. WING			COMPLETED 11/19/2015	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
GREAT L	AKES CARING				WEBSTER ST 10, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	minimize associal Exacerbations of are promptly ide implemented to 1 17. Patient/ca ability to self marequirements to preventions related hazards." The agree physician to rememodify/revise the discontinue SN sincision was heat 2. The clinical rewas reviewed on care date was 5/2 Huntington's Che 8/30-10/28/15 controlled the week of 9/6/2 week, 1 every two every 3 weeks for needed for cardiagastrourinary/gasmental, pain, skin and falls. SN for Evaluate patient care, observation effectiveness of pregimen and skill	Egastrointestinal disease ntified and interventions minimize risks to patient. are giver will demonstrate mage nutritional promote good skin Patient/caregiver stated instructions of fall ed to environmental gency failed to notify the over the Met Goals and e POC, and failed to services once the cervical led on 10/30/15. Becord for patient # 13 Becord for patient						

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BU	A. BUILDING 00 B. WING			COMPLETED 11/19/2015	
NAME OF I	ROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	level to physicia -Observation/ass system to identify with exacerbation of complications - Obtain pulse or upon recertificat and times 3 as not breath, oxygen urobservation/ass system to identify with exacerbation of complications -SN for urinary if and intervention, teaching related management. More culture and sensified for signs and syrinfection or reterest -SN for observation gastrointestinal sechanges association or early intervention of the system of the	richanges associated in for early intervention in the confirm baseline eeded shortness of se, activity intolerance; wessment of respiratory by changes associated in for early intervention in for early intervention in for early intervention in the provide skilled it is urinary incontinence in the fay obtain urinally is and intivity times 3 if indicated in the provide in the provide skilled in the provide in t					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 429 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			WEBSTER ST		
GREAT L	AKES CARING				/IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	•	patient/caregiver on					
	•	ures to reduce pressure					
	ulcer risk.						
		supports to minimize					
	-	zation, patient/primary					
	caregiver will be instructed in emergency						
	care plan, and aspects of cardiovascular						
	disease manager	nent to reduce avoidable					
	hospitalization.						
	-SN to provide i	nstructions related to					
	discharge planni	ing. Discharge summary					
	for all discipline	es available to physician					
	upon request.	2 2					
		ion of medication					
	regimen to ident						
	changes/complic	•					
	intervention.	Twicing for Curry					
	GOALS;						
	-	results obtained.					
	-	piratory status will be					
		eported to physician for					
		tion to minimize					
	associated risks;						
	•	n urinary incontinence;					
	_	i management of urinary					
	*						
		plemented to minimize					
	•						
	_						
	demonstrate abil	lity to manage altered					
	bowel elimination	on.					
	-Patient will hav	ve bowel patency;					
	-Improvement in incontinence; -Exacerbations of will be promptly interventions im risks to patientPatient/caregive demonstrate ability bowel elimination.	of gastrointestinal disease videntified and plemented to minimize er verbalize and lity to manage altered on.					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00		COMPLETED	
		157586	B. WI	NG		11/19/	2015	
NAME OF I	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP CODE			
					WEBSTER ST			
GREAT I	_AKES CARING			KOKON	1O, IN 46902			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		able to perform activities						
	, ,	nd individual activities of						
		decreased risk for falls;						
	-Patient/caregiver will demonstrate							
	proper techniques of pressure ulcer							
	prevention,							
	-Patient will hav							
	supports to prev	ent rehospitalization,						
	avoidable hospit	calizations will be						
	reduced;							
	-Patient's discha	rge instruction needs will						
	be met. Dischar	ge summary for all						
	disciplines avail	able to physician upon						
	request;	• • •						
	-	er will demonstrate						
	_	manage medications.						
	A. The SN V	isit Note Report						
	Narrative section	n dated 9/10/15 stated,						
	"Patient seen for	RN visit and HHA						
	supervisory visit	t Denies difficulty						
	breathing. Bilat	eral lung sounds clear.						
	Active bowel so	unds x 4 quadrants.						
		wel movement] this						
	morning. No ed	ema noted. Denies falls.						
	Denies chest pai	n. Denies depression.						
	No new skin issi	ues present. Skin						
	remains intact.	Reports good appetite at						
		etic movement noted at						
	-	ntington's diagnosis.						
	Patient reports							
		escribed and feels much						
	_	arge teaching: Continue						
		. Keep all follow up						
	liious us ordered	. 1200p an Iono ii ap						

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 431 of 518

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 B. WING DO	
NAME OF PROVIDER OR SUPPLIER GREAT LAKES CARING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DATE APPOINTMENT OF COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DATE APPOINTMENT OF COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DATE APPOINTMENT OF COMPLETIC CROSS-REFERENCED TO THE APPROPRIATE DATE APPOINTMENT OF COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE APPOINTMENT OF COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) APPOINTMENT OF COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE APPOINT OF COMPLETION CROSS-REFERENCED TO THE APPOINT CROSS-REFERENCED TO THE APPROPRIATE DATE APPOINT OF COMPLETION CROSS-REFERENCED TO THE APPOINT CROSS-REFERENCED TO THE APPOINT CROSS-REFERENCED	
GREAT LAKES CARING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) appointments with physicians. Signs and 3115 S WEBSTER ST KOKOMO, IN 46902 (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE	
GREAT LAKES CARING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH DEFICIENCY) TAG (EACH DEFICIENCY) TAG (EACH DEFICIENCY) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG (DEFICIENCY)	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY appointments with physicians. Signs and	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Appointments with physicians. Signs and PREFIX PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETIC TAG Appointments with physicians. Signs and	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY DATE appointments with physicians. Signs and	
appointments with physicians. Signs and	ON
symptoms of hypertension: chest pain,	
shortness of breath, heart palpitations,	
facial flushing. Fall precautions. Med	
teaching: Ziac: effect, dose, frequency,	
side effects Patient voices	
understanding of all teaching completed	
today."	
B. The Visit Note Report dated	
9/10/15 section titled "Interventions	
Provided," stated, "1. Instruct	
patient/caregiver in position	
changes/adaptive equipment to elevate	
pressure. Details/comments: instruct in	
pressure relief including using pillows for	
support, monitoring skin over bony	
prominences and position changes at	
least every 1-2 hours. Instruct in	
turning/positioning schedule 4.	
Instruct patient/caregiver regarding pain	
and pain management principles	
instructed patient/caregiver	
regarding use of pain scale using 0-10	
pain scale. Instructed regarding causes of	
pain. Instructed regarding principles of	
pain management including need for	
management of pain to enhance healing	
and ability to cope with illness. Instructed	
patient/caregiver that pain is best	
controlled before it reaches an	
unmanageable level. Instructed	
patient/caregiver to coordinate	
administration of pain medication with	

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 432 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					WEBSTER ST		
GREAT	LAKES CARING			KOKOM	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		truct patient/caregiver					
	regarding pharm	•					
	nonpharmacologic pain control measures.						
	_	oximetry for shortness of					
	breath 9. In	struct in nutritional					
	requirements to	promote good skin					
	integrity and hea	lling."					
		Visit Note Report dated					
		titled "Goals Met," stated,					
	"1. Patient/careg	giver will verbalize					
	understanding of	f instructions given					
	related to pressu	re relief and ulcer					
	prevention. 2. (Cardiac exacerbations are					
	identified promp	tly and interventions					
	initiated quickly	to minimize associated					
	risks 5. Pati	ient/caregiver					
	demonstrate und						
		and nonpharmacologic					
	-	sures this visit. 6. Pulse					
	oximetry comple						
	Changes in respi						
		ported to physician for					
	prompt intervent						
		8. Exacerbations of					
		disease are promptly					
	~	terventions implemented					
	to minimize risk	•					
		r will demonstrate ability					
	_	utritional requirements to					
	_	in integrity 12.					
	*	r stated understanding of					
	_	all preventions related to					
		azards." The assessment					
	Chvironiniental II	azarus. The assessinent					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 433 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	00	COMPLETED 11/19/2015	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST	
GREAT I	AKES CARING			MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	section for Respirespiratory system. Indicate respiratory system. Indicate respirator No problems idea section for Integut "No problems idea assessment section stated, "Hypertent were recorded as 68, respirations 1 118/78. D. The SN V 9/24/15 section to Provided," stated patient/caregiver changes/adaptive pressure. Details pressure relief in support, monitoring prominences and every 1-2 hours. turning/positioning. Instruct patient/cand pain manage instructed patient of pain scale using Obtain pulse oxing breath 8. Instrequirements to pain tegrity and hear	ratory stated, "Was m assessed? Yes. ory assessment findings: ntified." The assessment amentary/Wounds stated, entified." The on for Cardiovascular asion." The vital signs temperature 98.7, pulse 8, and blood pressure Visit Note Report dated itled "Interventions I, "1. Instruct in position equipment to elevate s/comments: instruct in cluding using pillows for ing skin over bony position changes at least			

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 434 of 518

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	ľ í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED
	PROVIDER OR SUPPLIER LAKES CARING			3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	9/10/15 were representations are interventions in minimize associal Patient/caregiver to self manage in promote good skarthe agency fail to remove the Minodify/revise the F. The SN V 10/6/15 section to Provided," stated patient/caregiver changes/adaptive pressure. Detail pressure relief in support, monitor prominences and every 1-2 hours. turning/positioni Instruct patient/cand pain manage instructed patient of pain scale using Instructed regard management incomanagement of pains and pain management of pains and pain management incomanagement of pains and pain management of pains and pain management incomanagement of pains and p	and met again on 9/24/15 s: "1. Cardiac e identified promptly and tiated quickly to ated risks. 4. will demonstrate ability utritional requirements to in integrity." ed to notify the physician et Goals and e POC on 9/10/15. isit Note Report dated itled "Interventions I, "1. Instruct in position e equipment to elevate s/comments: instruct in cluding using pillows for ing skin over bony I position changes at least Instruct in ng schedule 4. earegiver regarding pain ement principles t/caregiver regarding use ng 0-10 pain scale. ling causes of pain. ling principles of pain					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 435 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/19/2015	
	F PROVIDER OR SUPPLIE	2		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREA	LAKES CARING			KOKON	1O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	controlled before unmanageable le patient/caregiver administration of activities. 5. Instruction of activities. 7. Instruct partient/caregiver assist in managinal adult briefs, displayed activities. G. The SN 10/6/15 section of previously on 9/being re-instruct 10/6/15 visit and Patient/caregiver understanding of related to pressure prevention. 2. Gidentified prompinitiated quickly risks 5. Patient demonstrate understanding of the partient of the partient of the partient of the partient of the partient of the partient of the partient of the partient of the partient of the partient of the partient of the partient of the patient of the pati	evel. Instructed r to coordinate f pain medication with truct patient/caregiver acological and gic pain control measures. atient/caregiver regarding ace incidence of urinary Instruct r regarding measures to ag urinary incontinence- acosable underpads, rs." Visit Note Report dated citled "Goals Met," 24/15 were repeated as ed on and met again on I listed as: stated, "1. r will verbalize f instructions given re relief and ulcer Cardiac exacerbations are only and interventions to minimize associated dient/caregiver derstanding of and nonpharmacologic distructions states distructions to minimize associated dient/caregiver derstanding of and nonpharmacologic distructions states distructions states dient/caregiver derstanding of and nonpharmacologic distructions states dient/caregiver derstanding of and nonpharmacologic distructions states dient/caregiver derstanding of and nonpharmacologic distructions states dient/caregiver derstanding of					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE		
GREAT I	_AKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	associated risks.	regarding measures to					
		of urinary incontinence.					
	8. Instruction re	-					
		npleted for this episode.					
		s of gastrointestinal					
		ptly identified and					
	interventions im	plemented to minimize					
	risks to patient.	19. Patient/caregiver					
	stated understand	ding of instructions of					
	_	related to environmental					
		ssessment section for					
		ed, "Was respiratory					
	system assessed						
		sment findings: No					
	_	ied." The assessment					
		ovascular stated, "No					
	_	ied." The agency failed sician for a need to					
	1	s and update POC.					
	Temove met goai	s and update 1 OC.					
	H. The SN R	ecertificaation Outcome					
	Assessment and	Information Set					
	(OASIS)Visit No	ote Report dated					
	10/26/15 section	titled "Interventions					
	Provided," stated	l, "1. Instruct					
	patient/caregiver	*					
		e equipment to elevate					
	_	s/comments: instruct in					
	_	cluding using pillows for					
		ring skin over bony					
	prominences and position changes at least						
	every 1-2 hours.						
	turning/positioni	ng schedule 4.					

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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586 A2) MULTIPL A. BUILDING B. WING		JILDING	<u>00</u>	COMPLETED 11/19/2015		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	and pain manage instructed patient of pain scale usir Instructed regard Instructed regard management incl management of pain ability to coppatient/caregiver controlled before unmanageable le patient/caregiver administration of activities. 5. Instregarding pharma nonpharmacolog 7. Perform as incontinence & S [culture and Instruct patient/c causes and comp constipation/diar nutritional requires skin integrity and Note Report sect "Integumentary/" problems identified. I. The SN Revisit Note Report titled "Goals Metwere repeated as	pain to enhance healing be with illness. Instructed that pain is best it reaches an vel. Instructed to coordinate ruct patient/caregiver acological and ic pain control measures. sessment for urinary UA [Urinalysis] and C sensitivity] obtained. 8. aregiver regarding lication of rhea 10. Instruct in ement to promote good I healing." The Visit ion titled Wound" stated, "No					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 438 of 518

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION	COMPI		
ANDILAN	OF CORRECTION	157586	B. W		00	11/19	
		137380	<i>B.</i> 11			11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
GREAT I	_AKES CARING				WEBSTER ST 1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· · · · · · · · · · · · · · · · · · ·	atient/caregiver will					
		tanding of instructions					
	given related to p	pressure relief and ulcer					
	prevention. 2. C	Cardiac exacerbations are					
	identified promp	tly and interventions					
	initiated quickly	to minimize associated					
	risks 5. Pati	ent/caregiver					
	demonstrate und	erstanding of					
	pharmacological	and nonpharmacologic					
	pain control mea	sures this visit. 6.					
	Changes in respi	ratory status are					
	identified and re	ported to physician for					
	prompt intervent						
		9. Exacerbations of					
	gastrointestinal d	lisease are promptly					
	1 -	terventions implemented					
	to minimize risks	•					
	- The assessme	-					
		d, "Was respiratory					
	system assessed?						
	1 -	sment findings: No					
		ied." The assessment					
	*	ovascular stated, "No					
		ied." The agency failed					
	_	sician for a need to					
		s and update POC.					
	Teme (t met gem	s and appeared to e.					
	J. The SN Re	ecertification OASIS					
	Visit Note Repor						
	narrative section						
		isit nursing not need at					
		to continue with PT at					
	_	record failed to evidence					
		lischarged from SN					
	The patient was u	instruction on					

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		IDENTIFICATION NUMBER: 157586	A. BUILDING 00 B. WING		COMPLETED 11/19/2015
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
GREAT L	AKES CARING			S WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
(X4) ID PREFIX	summary stream regulatory or services. 3. The agency's Plans," # C-660, stated, "1. Follow assessment, a Cardeveloped with the caregiver. The incorrespond to the services needed at the episode of carshall be reviewed (minimally every needed) based upstatus and/or envassessments, care and the effective in achieving progechanges will be cappropriate staff Plan shall include a. Problems and to diagnosis. b. and realistic goal assessment and collist of specific infor implementation measuring goals identified time from	policy titled "Care reviewed March 2015 wing the initial re Plan shall be he client and/or interventions shall re problems identified, and the client goals for re. 2. The Care Plan d, evaluated, and revised resixty (60) days and as soon the client's health ironment, ongoing client regiver support systems, mess of the interventions gress toward goals. All communicated to the members. 3. The Care re, but not be limited to: needs identified related Reasonable, measurable, is as determined by the client expectations. c. A terventions with plans on. d. Indicators for achievement and ames. 4. The physician of the bused as a care plan if	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
	•	ne care staff to address			

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 440 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER)	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIER	X			WEBSTER ST		
	LAKES CARING				1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
TAU	 	,		TAG			DATE
	4. The agency's	f Client Services," #					
	C-360, reviewed March 2015 stated, "Purpose To ensure appropriate,						
	_						
		eing provided to clients.					
	-	e plan to reflect needs or					
		ed by members of the					
		duplication of services.					
		s to modify the plan of					
	•	Instructions 2.					
	1 .	care conferences shall be					
		en as necessary to					
		ges in the client's needs,					
		goals. 3. After the					
	initial assessmen	· ·					
	Registered Nurse	-					
	communicate the	e findings of the initial					
	visit with the Cli	nical Supervisor to					
	ensure: a. Clari	fication of the plan of					
	care orders	d. Client's need for					
	skilled nursing c	are. e. Need for other					
	services and/or r	eferral to community					
	resources 7.	The Nurse Case					
	Manager or Clin	ical Supervisor will					
	assume responsi	bility for					
	updating/changing	ng the Care Plan and					
	communicating	changes to caregivers					
	within 24 hours	following the conference					
	or changes. The	physician will be					
	_	his/her approval for that					
		ary and to alert the					
	_	nges in client condition.					
		identify a communication					
		that all disciplines and					
	'	1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157586	B. WING		11/19/2015
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIE	R		WEBSTER ST	
GREAT	LAKES CARING			MO, IN 46902	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	I	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DATE
	departments are	informed of changes to			
	-	d for modification."			
	F				
	5. The agency's	policy titled "Skilled			
	1 .	es," # C-200, reviewed			
	_	ted, "1. The Registered			
		Regularly reevaluates the			
		d coordinates the			
	1	ces. c. Initiates the Plan			
		essary revisions and			
		lan of care and the care			
		es services requiring			
	^	sing skill e. Informs			
	_	nd other personnel of			
		elient condition and needs.			
	1	nsed Practical Nurse:			
		ings and observation to			
	-	urse, physician and other			
	members of the				
		d timely response to client			
		ls 3. Skilled nursing			
		home care setting may			
		ration and assessment,			
	teaching and tra				
	1	d evaluation of the care			
	_	e and complex skilled			
	procedures."	and complex skined			
	procedures.				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586				ILDING	00	COMPL 11/19/	ETED
GREAT LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
Bldg. 00 Bldg. 00 Ruse purse foll (C revenue Barton rein no the	rvices are limited rposes of practic ting, the registe lowing:) Initiate the plazisions. Insed on record research the administration of the ptify the physicine plan of care produced reviewed sure the andings include: The clinical reasons reviewed on the date was 9/2 26-11/24/15 confercare following results of the produced for the produced research of the produced for the pro	(1)(C) Except where d to therapy only, for the in the home health red nurse shall do the in of care and necessary review, the agency failed nitting nurse initiated lan of care, and failed to the ian of the need to alter the ian goal for 1 of 20 (# 10), and failed to	N 05	542	To ensure compliance with 410 IAC 17-14-1(a)(1)(c): Scope of Services the following interventions have been implemented: All RN's received educa on Policy C-200 Skilled nursing services with focus on the requirement of the RN to proviongoing assessment and updated of the plan of care. This include physician notification of goals a met, uncontrolled pain, or othe changes in patient condition. A interventions must be applicable to the plan of care. An audit will be performed by the administrator/designee of 50% all skilled nursing visits for updated goals when indicated and physician notification of updated and patient specific goals until 100% compliance is met for 4 consecutive weeks. After 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process.	tion g de ate des not ur all le of	12/24/2015

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	00	(X3) DATE COMPL		
		157586	B. W			11/19/	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	11,710,	2010
		X.			WEBSTER ST		
GREAT I	_AKES CARING			KOKOM	1O, IN 46902		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	-Observation and	d assessment of cardiac			(Exhibit 13)		
	system to identif	ry changes associated			An audit will be performed by	tho	
	with exacerbation for early intervention				administrator/designee of 50%		
	_	s; observation/assessment			all skilled nursing visits for pai		
		al system to identify			interventions and physician notification when indicated un	til	
	_	ed with exacerbation of			100% compliance is met for 4		
	1	tion of complications;			consecutive weeks. After 4		
	_	t and develop plan of er signed by physician;			consecutive weeks of 100% compliance the audit will		
		sessment of respiratory			decrease to 10% quarterly an	d	
					will be completed through the		
	system to identify changes associated with exacerbation for early intervention				clinical record review process (Exhibit 14)		
	of complications	•			(EXHIBIT 14)		
	_	tions related to discharge					
	planning. Disch	arge summary for all					
	disciplines availa	able to physician upon					
	request;						
	1	and provide assistance to					
	patient for under	•					
	_	feelings. SN may					
	-	on anxiety scale and/or					
	mini mental exam	<i>'</i>					
		cement of management of					
	_	ding disease process,					
	_	agement, coping skills					
		nges associated with					
	depressive disor	ders for early					
	intervention, SN	may perform geriatric					
	depression scale	and/or mini mental					
	exam;						
	-Provide teaching/reinforcement in						
	etiology of confi						
	cognition, safety	measures and home					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BU	A. BUILDING 00 B. WING		COMPLETED 11/19/2015				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE				
GREAT L	AKES CARING			3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE		
	management; ob	servation and assessment							
	of pain, effective	eness of pain							
	management and	l regimen and skilled							
	teaching related	to pain management, SN							
	to report increase	e in pain level to							
	physician for pro	ompt intervention;							
	-Skilled teaching	and training of							
	emergency care p	plan, disease process							
	including self ma	anagement of							
	cardiovascular h	ypertension disease;							
	-SN to obtain pu	le oximetry							
	measurement tim	nes 3 as needed for							
	shortness of brea	th, oxygen use, activity							
	intolerance;								
	-SN for instruction	on/reinforcement of							
	gastrointestinal s	ystem related teaching,							
	including diverti	culitis and irritable							
	bowel syndrome	(IBS);							
	-SN to provide sl	killed teaching regarding							
	measures to cont	rol diarrhea/constipation							
	as well as preven	nting related							
	complications; sl	killed teaching and							
	training of emerg	gency care plan, disease							
	process laminect	omy surgery including							
	self management	t of neurologic disease;							
	-SN to provide a	ssessment and							
	teaching/reinford	ement of management of							
	diabetes includin	ig disease process,							
	medication mana	agement, coping skills							
	and identify char	nges associated with							
	diabetes for early	v intervention. SN may							
	perform blood gl	ucose level as needed							
	for signs and syn	nptoms of							
	hyper/hypoglyce	mia or for baseline							
							l .		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/19/	ETED	
	OF PROVIDER OR SUPPLIER	2		3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	diabetes mellitus -SN observation integumentary s skin integrity; -SN to instruct p and symptoms of cervical spine su complications to -SN to establish risk of hospitalize will be instructe and aspects of co- disease manager hospitalization; -Skilled instruct regimen to ident changes/complice intervention; -SN to provide i balance and reduSN to instruct p preventive meas ulcer risk; and -Licensed profes signs falling out established para- 101, Pulse < 50 > 29, Systolic bl Diastolic blood fasting blood su saturation < 88. GOALS: Assoc	and reaching tatus to promote optimum ratient/caregiver on signs of infection related to atures to reduce of the wound; supports to minimize ration patient/caregiver d in emergency care plan, ervical spine surgery ment to reduce avoidable tion of medication ify					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			WEBSTER ST		
GREAT L	_AKES CARING				MO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DEFICIENCY)	
	discharge summ	ary for all disciplines					
	_	sician upon request;					
		xiety are identified and					
	interventions initiated to allow patient to						
	manage feelings	•					
	-Patient/caregive						
	_	nstrate understanding the					
		depression by the end of					
	_	symptoms are identified					
	_	maintain patient safety in					
	the home; Patier	-					
	· ·	lerstanding of etiology of					
		naintain patient safety in					
	the home;	1					
	· ·	n pain interfering with					
	activity;						
	•	at level of 3 or less or at					
	a level acceptab	le to the patient;					
	-Patient/caregive	er demonstrate					
	understanding o	f pharmacological and					
		gic pain control measures;					
	_	nonstrate ability to self					
		ascular hypertension					
		and reduce caregiver					
	•	ed with disease process;					
	pulse oximetry i						
	-	er will demonstrate					
	_	anage gastrointestinal					
	disease process;						
	-Patient/caregive						
	_	lity to manage altered					
		on. Patient will have					
	bowel patency;						
		ibility to self manage					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19	/2015
		_		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			WEBSTER ST		
	AKES CARING				1O, IN 46902		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		,	+	TAG			DATE
	_	se process and reduce					
	_	n associated with disease					
	process, improvement in signs and						
	1	urologic disease;					
	-Patient/caregive						
	demonstrate und						
		diabetes by the end of the					
	1 1	nptoms are identified and					
	managed to mai	ntain patient safely in the					
	home;						
	-Demonstrated improvement in existing						
	conditions and e	early identification and					
	intervention of a	additional compromises					
	in skin;						
	-Wound complie	cations avoided;					
	-Patient integum	nentary status will					
	_	enced by a decrease in					
	-	of wound/decub by end					
	of cert period;	,					
		e appropriate agency					
		ent rehospitalization,					
		talizations will be					
	reduced;	unizations will be					
		er will demonstrate					
	_	manage medications;					
	1 -	•					
	-	ble to perform activities					
		nd individual activities of					
		decreased risk for falls;					
	_	er will demonstrate					
		es of pressure ulcer					
	prevention.						
	A The initia	al start of care was					
	9/26/13. The Cl	lient Coordination Note					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	00	COMPLETED 11/19/2015	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST	
	AKES CARING			MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
PREFIX	REGULATORY OR REGULATORY OR Report dated as I stated "[Spouse of lowest patient's pain scale. Curred Dilaudid 2 milling The agency failed "Pain controlled a level acceptable revised; failed to was notified of gunobtainable goat on the plan of cate coordinate with minimate the plan of cate coordinate with minimate the plan of cate of the past 14 days. The Pain assessment All of the time 9 What active Movement. What Always in Pain. pain last? Constructions of the past 14 days.	ate entry for 9/26/15 of patient] states the patient takes grams tablets for pain." d to ensure the goal of at level of 3 or less or at e to the patient was ensure the physician coals being met and of als needing to be changed re; and failed to nursing staff to ensure education on goals met continued. of care assessment form ated "(M1018) to medical treatment for inpatient stay within 3- Intractable Pain." nent section stated "Pain e Pain Scale Rating: ities make pain worse: en is neck pain least? How long does neck ant. Can neck pain be	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
	"Indicate endocri assessment (marl	ine/Hematopoietick all that apply):			
	-	I problems Is the sulin? No Is the			
	-	antidiabetic agent? Yes.			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL			
		157586	B. W	ING		11/19/	2015	
	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		TE	(X5) COMPLETION DATE	
	Not checked ver	e blood sugars check? y often. What are the ood sugar readings?						
	Coordination" st communicated w involved in this d discipline did you Physician, Careg Supervisor. Indi- contacted: Was physician for app of care: No. Indi- not contacted: No. The section titled Patient/caregiver understanding of nutritional/hydra- visit note failed	cate reason physician not Contacted. Contacted proval of proposed plan icate reason physician Not in on weekends." d "Goals Met" stated: "3. r verbalizes f basic ution requirements." The to evidence the SN g/reinforcement of						
	Nursing Services March 2015 state Nurse: b. R client needs, and necessary servic of Care and nece updates to the pl plan. d. Provide	policy titled "Skilled s," # C-200, reviewed ed, "1. The Registered egularly reevaluates the coordinates the coordinates the es. c. Initiates the Plan essary revisions and an of care and the care es services requiring ang skill e. Informs						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			A. BUILDING B. WING	00	COMPLETED 11/19/2015	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
	AKES CARING		KOKON	10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	changes in the classical changes in the classical changes of the transfer of t	timely response to needs 3. Skilled in the home care setting servation and ning and training gement and evaluation of troutine and complex				
N 0546 Bidg. 00	services are limited purposes of practice setting, the register following: (G) Inform the physappropriate medicate the patient's conditional the patient and fan and related needs programs, and supprograms, and supprograms, and supprograms personnel. Based on record the agency failed notified the physical setting purposes are limited to the physical setting purposes.	(1)(G) Except where d to therapy only, for ce in the home health cred nurse shall do the vsician and other al personnel of changes in tion and needs, counsel nily in meeting nursing , participate in inservice pervise and teach other	N 0546	To ensure compliance with 41 IAC 17-14-1(a)(1)(G): Scope of Services the following interventions have been implemented:		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
NAME OF T	DOMDED OF CARRY			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C		3115 S	WEBSTER ST		
	AKES CARING		1		лО, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG			+	TAG	Dia relation,		DATE
		or 1 of 1 patient records			•aaaaaaa All skilled nursing		
	reviewed receiving PICC line care (# 3), and failed to measure wounds weekly for				staff received education on		
		-			documentation requirements f		
	•	eceiving wound care (#			wound care, as well as hands		
	4).				competency checks in a skills	lab	
					for wound care, and infection control with wound care, by ar	,	
	Findings include	:			RN preceptor by 12/24/15		
	1 The clinical =	coord of nations # 2 start			All LPN and RN staff		
		record of patient # 3, start			received hands on competence	:v	
		23/15, contained a plan of			check offs in a skills lab by RN	•	
	` ′	d 10/23/-12/21/15 with			staff educators, competency		
		d Nursing (SN) 1 time a			included review of PICC line		
		x, 2 times a week for 8			procedures and return		
	· ·	ne a week for 1 week,			demonstration of skills, documentation, measurement	of	
	with 3 as needed	l visits for cardiac,			PICC and physician notificatio		
	respiratory, gast	rointestinal,			abnormal assessment. To be	0.	
	gastrourinary, no	eurologic, endocrine,			completed by 12/24/15		
	mental, pain, ski	in/wound status changes,					
	and falls. SN fo	r: Instruct on			• □ □ □ □ □ PICC measuremer		
	lab/venipuncture	e procedure, obtain lab			service code created in HCHB	on	
	•	rt to physician. SN to			12/14/15.		
		cin trough week of			An audit will be performed by		
	_	MP [basic metabolic			administrator/designee of 100	%	
		eekly until instructed			of wound visits to ensure		
		N to change PICC			measurements q week, as we	ll as	
					detailed orders and complete documentation of wound care		
		terile technique every			provided until 100% compliand	ce	
		ded times 3 for soiled or			is met for 4 consecutive weeks		
	loose dressing.				After 4 weeks of 100%		
	A. The start of care assessment form dated 10/23/15 by employee G, Registered Nurse (RN) stated, "Indicate				compliance the audit will		
					decrease to 10% quarterly and	d	
					will be completed through the clinical record review process.		
					(Exhibit 11)		
	length of expose	ed PICC catheter from			(=XIIDIC 11)		
	insertion site to	catheter hub in			An audit will be performed by	the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		î ´	ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER		•	3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	B. The SN V 10/30/15 by emplength of expose insertion site to a centimeters: 11. evidence the phy the 1 centimeter the PICC line. 2. During interv AM, the Adminito the nurse that at 3 centimeters said she measure showing under nurse that the PICC line. 3. The clinical reviewed on 11/date was 9/20/15 9/20-11/18/15 county times a week for for 1 week, 2 times a week for the 1 time a week needed visits for respiratory/cardicomplications, no SN for teaching	Gisit Report dated bloyee G stated, "Indicate d PICC catheter from catheter hub in 0." The record failed to resician was notified of longer measurement of longer measurement of strator stated she talked measured the PICC line on 11/13 and the nurse and only what was eath the dressing, and he is sutured in place. Secord for patient # 4 was 17/15. The start of care of the POC dated ontained orders for SN 6 of 1 week, 7 times a week hees a week for 1 week, ek for 6 weeks, with 3 as pain, falls,		TAG	administrator or designee of 100% of all patients with a PIC line until 100% compliance is r for 4 consecutive weeks. After consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and will be completed through the clinical record review process. (Exhibit 6)	CC met r 4	DATE
	betadine and let	and cleanser, apply dry, every day. Area to cleanse with wound					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BU	A. BUILDING 00 B. WING			COMPLETED 11/19/2015	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	VE ACTION SHOULD BE CED TO THE APPROPRIATE	
	lightly moistened gauze. Area to r wound cleanser,	Santyl and cover with d gauze and dry and dry ight hip cleanse with apply Santyl cover with d gauze and cover with					
	A. The Wound Assessment Tool Report dated 9/27-11/3/15 failed to evidence the Upper Right Arm, Right Hip, and Left Ball of Foot wounds were measured the weeks of 9/27-10/3, 10/4-10/10, and 11/1-11/3.						
	4. During interview on 11/17/15 at 11:45 AM, the Administrator stated she did not see any documentation of wound measurements during those weeks.						
	"Responding to C Lines," # I-230 s Migration: It is central venous ca another location Certain types of susceptible to ca Clients who are Response: Meas external length of dressing change.	theter tip migration very active sure and document the of the catheter with each This will assist in early					
		long-term, centrally					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 454 of 518

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	00	COMPLETED 11/19/2015	
	PROVIDER OR SUPPLIER		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION
	6. The agency's "PICC Line Dresstated, "PICC linuse Strict Aseption Procedure 9. catheter exposed gloves Document in the Length of catheter Any physician not a seem of Seem	undated policy titled ssing Change," # I-240 te dressing changes will to Technique Note length of 11. Don sterile tementation Guidelines 1. clinical record: d. ter visible at exit site. e. totification."			
N 0547 Bldg. 00	services are limite purposes of practi setting, the register following: (H) Accept and carchiropractor, podia optometrist orders Based on record the agency failed care (POC)contar wound care orders.	(1)(H) Except where d to therapy only, for ce in the home health ered nurse shall do the arry out physician, atrist, dentist and	N 0547	To ensure compliance with 4 IAC 17-14-1(a)(1)(H): Scope Services the following interventions have been implemented:	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COM			COMPL	ETED
		157586	B. W	ING		11/19/	2015
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
CDEATI	AKES CARING				MO, IN 46902		
					, 114 40902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
	`	and 11), and failed to			• and an All skilled nursing		
	ensure the POC included orders for				staff received education on	o.r	
	drawing labs fro	m the Peripherally			documentation requirements for wound care, as well as hands		
	Inserted Central	Catheter (PICC) for 1 of			competency checks in a skills		
	1 record review	of patients with PICC			for wound care, and infection		
	lines. (# 3)	1			control with wound care, by ar	1	
	111165. (11 5)				RN preceptor by 12/24/15.		
	Findings include	<u>.</u>	1		A 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	r manigs merade	•			· All LPN and RN staff	.,	
	1 771 1 1	1 6 4 4 4 2			received hands on competenc check offs in a skills lab by RN		
		record of patient # 3, start			staff educators, competency		
		23/15, contained a plan of			included review of PICC line		
	care (POC) dated	d 10/23/-12/21/15 with			procedures and return		
	orders for Skille	d Nursing (SN) 1 time a			demonstration of skills,		
	week for 1 week	z, 2 times a week for 8			documentation, measurement		
	weeks, then 1 tir	ne a week for 1 week,			PICC and physician notificatio	n of	
	•	l visits for cardiac,		abnormal assessment. To be completed by 12/24/15			
	respiratory, gast	•			Completed by 12/24/13		
		eurologic, endocrine,					
		in/wound status changes,			· PICC measurement		
					service code created in HCHB	on	
		r: Instruct on			12/14/15.		
	•	e procedure, obtain lab			A		
	_	rt to physician. SN to			An audit will be performed by administrator/designee of 100	0/2	
	obtain Vancomy	cin trough week of			of wound visits to ensure	/0	
	10/26/15 and BN	MP [basic metabolic			measurements q week, as wel	ll as	
	panel] twice wee	ekly until instructed			detailed orders and complete		
	otherwise Si	N to change PICC			documentation of wound care		
		terile technique every			provided until 100% compliand		
		ded times 3 for soiled or			is met for 4 consecutive weeks	3.	
	loose dressing.				After 4 weeks of 100% compliance the audit will		
	10030 diessing.				decrease to 10% quarterly and	1	
	A THE DOCUMENT				will be completed through the	-	
		failed to evidence the			clinical record review process.		
	,	orders to draw labs via			(Exhibit 11)		
	the PICC line.						

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	/2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			WEBSTER ST		
GREATI	AKES CARING				MO, IN 46902		
		TAMEN AND DEPOSIT OF D	1		,		(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIADE DEFICIENCY)	ΓE	DATE
1710		terview on 11/16/15 at		mo	An audit will be performed by t	he	DATE
	_				administrator or designee of		
		Iministrator indicated the			100% of all patients with a PIC	C	
	orders for lab draws via PICC line are on the infusion orders for the Vancomycin.				line until 100% compliance is r		
	the infusion orde	ers for the Vancomycin.			for 4 consecutive weeks. After	r 4	
					consecutive weeks of 100% compliance the audit will		
	C. The [Infusion Clinic] orders dated				decrease to 10% quarterly and	d	
		6 stated, "Physicians			will be completed through the		
		outine PICC Care." This			clinical record review process.		
		vidence the physician			(Exhibit 6)		
	ordered lab draw	vs via the PICC line.					
	2. The clinical r	record for patient # 4 was					
	reviewed on 11/	17/15. The start of care					
	date was 9/20/15	5. The POC dated					
	9/20-11/18/15 co	ontained orders for SN 6					
	times a week for	1 week, 7 times a week					
	for 1 week, 2 tin	nes a week for 1 week,					
		ek for 6 weeks, with 3 as					
	needed visits for						
	respiratory/cardi						
		nental status changes.					
	_	and intervention related					
	_	a to ball of left foot					
		und cleanser, apply					
		dry, every day. Area to					
		cleanse with wound					
		Santyl and cover with					
	~ -	d gauze and dry and dry					
	~	right hip cleanse with					
		apply Santyl cover with					
		d gauze and cover with					
	dry gauze.						
	-The wound	care orders for the right					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. B.		A. BU	a. BUILDING 00 3. WING			COMPLETED 11/19/2015	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		e right hip failed to ies for the wound care.					
	was reviewed on care date was 12 10/5-12/3/15 cortimes a week for for 1 week, 3 tim times a week for for 1 week, 4 tim times a week for week for 1 week for pain, falls, ca gastrointestinal/g wound complica teaching and into heel, and poor sk with wound clear	•					
		failed to contain a wound care orders.					
	11:25 AM, the A	derview on 11/18/15 at definition definition definition definition at the definition of the definition definit					
	Plans," # C-660,	policy titled "Care reviewed March 2015 Care Plan shall include,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. Bl	JILDING	00	COMPL		
		157586	B. W	ING		11/19/	/2015
NAME O	F PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREA1	LAKES CARING				10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	needs identified c. A list of spec plans for implen physician Plan of care plan if spec clearly identified address client ca Indiana Addend of care will cont and appropriate information, and activities." 5. The agency's "Venipuncture for Collection," # I- stated, "Blood D Venous Access 1. Review Phys sterile technique 6. The agency's "Coordination of C-360, reviewed After the initial a Registered Nurs communicate the visit with the Cliensure: a. Clari care orders	or Blood Specimen 140, revised 7/30/14 Praw from Central Devices Procedure: ician order. 2. Use strict" policy titled f Client Services," # I March 2015 stated, "3. assessment, the admitting					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BU	A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 11/19/2015		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
N 0553 Bldg. 00	practice in the hon licensed practical of following: (A) Provide service agency policies. Based on record the agency failed Practical Nurse (Peripherally Inse (PICC) Line polimeasuring and classes of the care. (# 3) Findings include 1. The clinical response for Skilled orders for Skilled orders for Skilled week for 1 week weeks, then 1 tim with 3 as needed respiratory, gastr gastrourinary, nemental, pain, skilland falls. SN for lab/venipuncture results and report	(2) For purposes of the health setting, the hurse shall do the les in accordance with review and interview, to ensure the Licensed LPN) followed red Central Catheter cies and procedures for hanging PICC dressings liewed receiving PICC dressings liewed receiving PICC lessons is less a week for 8 less a week for 8 less a week for 1 week, visits for cardiac, ointestinal, less a week lessons less a week less a week, wisits for cardiac, ointestinal, less a week, less a week, less a week, less a week, less a week less a week, less a week less a week,	NO	553	To ensure compliance with 41 IAC 17-14-1(a)(2)(A): Scope of Services the following interventions have been implemented: All LPN and RN staff received hands on competency check offs in a skills lab by RN staff educators, competency included review of PICC line procedures and return demonstration of skills, documentation, measurement PICC and physician notification abnormal assessment. To be completed by 12/24/15. PICC measurement service code created in HCHB 12/14/15. An audit will be performed by administrator or designee of 100% of all patients with a PIC line until 100% compliance is refor 4 consecutive weeks of 100% compliance the audit will decrease to 10% quarterly and	of of n of the CC met r 4	12/24/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		r í	ILDING	nstruction 00	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER	2		3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	profile] twice we otherwise S dressing using st week and as nee loose dressing.	MP [basic metabolic eekly until instructed N to change PICC terile technique every ded times 3 for soiled or of care assessment form			will be completed through the clinical record review process. (Exhibit 6)		
	dated 10/23/15 t Registered Nurs	by employee G, e (RN) stated, "Indicate ed PICC catheter from catheter hub in					
	10/26/15 by emp Practical Nurse of dressing dislodg changed using a draw obtained v aseptic technique evidence the LP line and failed to	Visit Note Report dated bloyee U, Licensed (LPN) stated, "PICC line ed. PICC line dressing septic technique Lab in PICC line using e." The record failed to N measured the PICC of evidence the nurse ssing using sterile					
	by employee E, Nursing assessm peak draw from technique." A C Report dated 11, stated, "Patient i	Visit Note dated 11/3/15 LPN stated, "Skilled ment completed for Vanco PICC line using clean Care Coordination Note (3/15 by employee E requesting PICC line d during visit due to					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	changed using st record failed to e was measured du change. D. The SN V	ICC line dressing erile technique." The evidence the PICC line uring the dressing Tisit Note Report dated loyee V, LPN stated,					
	catheter from ins	of exposed PICC ertion site to catheter rs: 3.0." The record e the physician was centimeter PICC					
	PM, the Adminis	iew on 11/16/15 at 3:00 strator stated PICC should be sterile.					
	AM, the Admini to the LPN that r at 3 centimeters said she measure showing under n	strator stated she talked measured the PICC line on 11/13 and the nurse of only what was eath the dressing, and e is sutured in place.					
	"Responding to C Lines," # I-230 s Migration: It is central venous ca	undated policy titled Complications of PICC tated, "Catheter Tip possible for any type of atheter to migrate to while in the body. clients are more					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	00	COMPLETED 11/19/2015	
	ROVIDER OR SUPPLIER AKES CARING		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	Clients who are a Response: Mease external length of dressing change. detection. Period verification by a performed on all placed catheters. 5. The agency's "PICC Line Dresstated, "PICC line use Strict Aseptimals Procedure 9. catheter exposed gloves Document in the	the catheter with each This will assist in early dic catheter tip -ray study should be long-term, centrally " undated policy titled ssing Change," # I-240 the dressing changes will to Technique Note length of 11. Don sterile timentation Guidelines 1. clinical record: d. er visible at exit site. e.			
N 0563 Bldg. 00	listed in subsection (2) review the plate severity of the patient at least every Based on record the agency failed	The appropriate therapist in (b) of this rule shall: in of care as often as the itent's condition requires, two (2) months; review, and interview, at the interview is a subject to ensure the in 1 of 20 records	N 0563	To ensure compliance with 4 IAC 17-14-1(c)(2): Scope of Services the following interventions have been implemented: •□□□□□□□□ All clinical staff	10 12/24/2015

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	ONSTRUCTION	COMPI		
ANDILAN	OF CORRECTION	157586	B. W		00	11/19	
		107 300				11/13/	2013
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	Findings included 1. The clinical rewas reviewed or care date was 7/dated 9/17-11/15 for recertification. A. The recert completed until recompleted undil recompleted undil recompleted until recompleted undil recompleted until recompleted until recompleted until recompleted until recompleted undil recompleted until	ecord for patient # 12 in 11/18/15. The start of 19/15. The POC was 5/15. The 5 day window in was 9/12-9/16/15. tification was not 9/22/15. ician Verbal Order dated Patient refused visit fication. Intervention: sed visit for Friday at Coordination Note 7/15 stated, "This nurse appointment with patient as informed that patient as informed that patient a other son to give regiver] respite and to done Monday or at apparently received a from Dr. and DIL] would like instructions Will notify PCP rysician] of delay along			educated on policy C-145 comprehensive client assessr and C-155 Client Recertification/Follow-up/and Resumption of Care. Education included the requirement to recertify within the five day window. An audit will be performed by administrator/designee of 100 of all recertification visits to verthat they were completed between day 56 and 60 until 100% compliance is met for 4 weeks. After 100% compliance met for 4 weeks the audit will decrease to 10% quarterly an will be completed through the clinical record review process (Exhibit 16)	the % erify ce is	
		/15 Reschedule					
	l		1				I

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		r í	UILDING ING	<u>00</u>	COMPLETED 11/19/2015		
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Medicare week."		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	E. The Visit 9/22/15 stated, "Supervisory" Timing: 1-Early status Patient that leaving hom contraindicated.' F. During int 1:50 PM, the Ad patient should hat the agency found able to schedule within the 5 day 2. The agency's "Comprehensive C-145, reviewed Reassessments a client needs, phy professional judg other regulatory 3. The agency's Recertification/F of Care," # C-15 stated, "5. Each will be responsible care/services at 1	Note Report dated Recertification Visit + "(M-0110) Episode ," "Homebound thas a condition such e is medically erview on 11/18/15 at ministrator stated the twe been discharged once dout they would not be the recertification visit window. policy titled Client Assessment," # March 2015 stated, "16. re conducted based on sician orders, gment and/or OASIS or requirement." policy titled "Client follow-Up/Resumption 5, reviewed March 2015 professional discipline ple for reassigning east every fifty-six to sy while the client is					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION		
N 0596 Bldg. 00	shall be responsibe to patient contact, furnish home heal behalf meet the reas follows: (1) The home hee (A) have success competency evaluaddresses each of subsection (h) of the Based on record the agency failed aide (HHA) skill included bathing Health Aide (HHN, and P); failed competencies into of motion (ROM reviewed (I and an arrangement of the acquired age services to 1 of 7 services listed on census (# 16). Findings included 1. During intervitors	The home health agency ble for ensuring that, prior the individuals who th aide services on its equirements of this section alth aide shall: sfully completed a ration program that if the subjects listed in his rule; and review, and interview, at to ensure home health is competency checks a patients for 4 of 5 Home IA) files reviewed (C, I, to ensure the filed skills cluded transfer and range I) for 2 of 5 files N); and failed to ensure or agreement existed for ancy to provide HHA I a patients with HHA in the South Bend branch	N 0596	To ensure compliance with 4 IAC 17-14-1(I)(A): Scope of Services the following interventions have been implemented: • • • • • Beginning September 21, 2015 the skil competency checks included bathing patient, transfer and range of motion as well as a other required skills. • • • On December 22 2015 the Competency Bases Skills Checklist for home her aides was revised to include and where the skill was performed that the skill was performed on a patient, the employee who observed the skills as well as the signature home health aide. The revise	lls d ll 2, d alth e how		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		ľ í	JILDING	onstruction 00	(X3) DATE : COMPL 11/19/	ETED		
	F PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	skill check offs the parent office on-boarding, and bed bath and a d sponge bathing, in the field with checked off. En preceptor gets a go into the field 2. During interve PM, employee The not have the confor bathing hand employees C, I, change of assess 3. During interve PM, employee I stated the agency official first patient conformation and supproximately a first patient contour date of hire. 4. During interve PM, the Administills competency of the parent of the paren	week, so they just say act date is 5 days after view on 11/19/15 at 2:30 strator stated the annual cies for the HHAs are with the mannequin for			Competency Based Skills Checklist will be used for all Home Health Aides hired on of after December 21, 2015. As of November 62, 2015, a contractual arrangement was secured between the age referred to as Great Lakes Carcon 157586 (agency) and the acquired agency of AC and Associates dba Great Lakes Caring (acquired agency) for the provision of Home Health Services such as PT, OT, SLF SN, MSW and HHA. An audit will be performed by administrator/designee of 100 of all new home health aides hired on or after December 21 2015 to ensure Competency Based Skills Checklist is completed prior to home health aide seeing patient independently. Audit will contuntil 100% compliance is maintained for 4 consecutive weeks. After 4 weeks of 100% compliance audit will decrease 10% quarterly and will be completed by Human Resource (Exhibit 5)	the continue		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		r í	JILDING	onstruction 00	(X3) DATE COMPL 11/19/	ETED		
	F PROVIDER OR SUPPLIE T LAKES CARING	t	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE	
	reviewed on 11/4/2/12, first pati The file contained Documentation Checklists," date titled "Where Of 1A Temperature Respiration, 2 B or Shower Bath, Shampoo at Sinl Care, 5B Skin C Hygiene, 7A Ur Transfer Techni Range of Motion Positioning, 10 D The checklist fa the skills were a on a patient. 6. Employee fil on 11/19/15. Da patient contact of contained a "Sur for Skills Demor date 10/16/12. T Observed" state Temperature, 1E Bed Bath, 3 Spo Bath, 4A Shamp at Sink or in Tul Care, 5C Backry Urinal, 7B Bedp	for Skills Demonstration & 4/4/12. The section observed" stated "Lab of 1B Pulse and ed Bath, 3 Sponge, Tub, 4A Shampoo in Bed, 4B or in Tub, 5A Nail are, 5C Backrub, 6 Oral inal, 7B Bedpan, 8A ques, 8B Ambulation, 9A in Exercises, 9B Make Occupied Bed." illed to evidence any of ssessed being performed are 1, a HHA, was reviewed atte of hire 10/15/12, first late 10/20/12. The file inmary Documentation instration Checklists," The section titled "Where id "Lab 1A B Pulse and Respiration, 2 inge, Tub, or Shower in Bed, 4B Shampoo in Bed, 4B Shampoo in Bed, 4B Shampoo in SA Nail Care, 5B Skin ib, 6 Oral Hygiene, 7A						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE S COMPLE 11/19/2	CTED
	PROVIDER OR SUPPLIER		3115 S	ADDRESS, CITY, STATE, ZIP CO WEBSTER ST MO, IN 46902	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Make Occupied failed to evidence	ises, 9B Positioning, 10 Bed." The checklist ee any of the skills were erformed on a patient.				
	A. The document of the second	ment titled "Competency entation Checklist for de (CHC)," stated "Day n field with RN National Home Care on Program" and the emonstrate/Observe" was ad stated, "Hand ing of equipment usage, Bag Technique, ations Kit Use, Vital ssure, pulse, respiration, ft, Meals Preparation, pplication of TED hose, Skills, Observation, cumentation of patient re or service furnished, of body functioning and				
	reported to a RN safe and healthy Recognizing em of emergency premotional and depatients, and Resprivacy and proprior of the architecture.	ergencies and knowledge ocedures, Physical, evelopmental needs of spect for the patient, perty." This checklist te bathing, transfer, and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPL	
		157586	B. W	ING		11/19/	/2015
NAME OF 1	PROVIDER OR SUPPLIER)		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIER	X			WEBSTER ST		
	LAKES CARING		ı	<u> </u>	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG	<u> </u>	<u> </u>		TAG	Diricilité 1 y		DATE
		le N, a HHA, was 19/15. Date of hire					
	-	tient contact date 5/17/14.					
		tled "Competency Based					
		n Checklist for Home					
	,	IC)," stated "Day 4 Will					
	•	with RN completing the:					
		Care Aide Certification					
	Program" and th						
		bserve" was dated					
		ed, "Hand Washing,					
		ipment between patient					
		nique, Universal					
		Use, Vital Signs (blood					
		respiration, temp), Hoyer					
	-	ets, Application of TED					
	hose, Communio						
	Observation, rep	•					
		of patient status and the					
		urnished, Basic elements					
	_	ing and changes in body					
		st be reported to a RN,					
		a clean, safe and healthy					
	•	ecognizing emergencies					
	and knowledge	of emergency procedures,					
		onal and developmental					
	needs of patients	s, and Respect for the					
	patient, privacy	and property." This					
	checklist failed t	to evidence bathing,					
	transfer, and RO	M.					
	8. Employee fil	le P, a HHA, was					
	reviewed on 11/	19/15. Date of hire					
	5/27/15, first pat	tient contact date 5/31/15.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	The document tit Assignment Deta "MET" for "Assist to Walker, Assist to Walker, Assist walker, Assist walker, Assist walker, Assist walker, Assist walker, Assist walker, Assist walker, Assist walker, Assist walker, Assist walker, Assist walker, Check Technique, Hoye Bed, Nail Care, Carendard Temperature, Por Respiration, Rand Hose, Transfer Patransport, Urinal and Shaving- Satisfailed to evidence in the field, and the field, and the teritory service was chosen from Deteriorating Walisted as having be South Bend brand the territory service agency. The pathospice on 5/8/1. A. On 11/16/Administrator stamaintains the characteristic stamaintaintaintaintaintaintaintaintaintaint	tled "Skills Checklist ail" dated 5/26/15 stated, ist patient in and out of c Chair, Assist with with Walking, Backrub, in/Fracture Pan, Blood Skin, Handwashing er Lift, Make Occupied Oral Hygiene, Oral sitioning, Pulse and ige of Motion, TED ratient to wheelchair and Care, Shaving-Electric, fety." This document e skills were performed only evidenced employee ecord for patient # 16 in 11/9 and 11/16/15 and in the OASIS list for ound Status and was had been a patient of the inch. Patient # 16 lived in iced by the acquired ient was discharged to					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 471 of 518

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
	PROVIDER OR SUPPLIER		;	3115 S \	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING		I	KOKOM	O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	12:05 PM, the A patient # 16 is m agency, and the some involvement in a second was provided HI acquired agency 4/6, 4/8, 4/10, 4/4/28, 5/5, and 5/1 by employ "Home Health A stated, "Job Qualling Must provide of successful constate-established Aide training provided the competency eval Otherwise, must Home health Aide the Aide training provides of successful constate-established Aide training provides of successful cons	of care dated th start of care date ed orders for Home HA) 2 times a week for 1 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 1 es a week for 2 weeks. Index evidenced patient # 16 es a week for 1 es a week for 2 weeks. Index evidenced patient # 16 es a week for 2 weeks. Index evidenced patient # 16 es a week for 1 es					

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIEF	2	•		ADDRESS, CITY, STATE, ZIP CODE	•	
GREAT L	AKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		s policy titled "Home		_			
	Health Aide Ser	vices," # C-220,					
	reviewed March	2015 stated, "All					
	individuals prov	ing home health aide					
	services will be	qualified through training					
	and/or competer	ncy evaluations					
	Purpose To abid	de by state/federal					
	guidelines and o	ffer guidelines to GLC					
	staff, physicians	, and community for the					
	appropriate utiliz	zation of Home Health					
	Aide Services. S	Special Instructions 1.					
	Home Health Ai	de services may include:					
	a. Providing per	rsonal care services					
	including bathin	g, dressing, feeding,					
	weighing. back 1	rubs, skin care and					
	shampoos as dir	ect by the care plan and					
	licensed professi	ional. b. Assisting with					
	client transfers,	ambulation and					
	protecting the cl	ient from falls g.					
	Making observa	tions of the client's					
	condition and re	porting the results to the					
	Registered Nurs	e/Therapist, h. Assisting					
	with range of mo						
	ر ت	s policy titled "Skilled					
	_	s," # C-200, reviewed					
		ed, "1. The registered					
		pervises and teaches					
		rsonnel and home health					
	aides as appropr	iate."					

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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 11/19/2015					
	PROVIDER OR SUPPLIER LAKES CARING	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG N 0606 Bldg. 00	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
Didg. 00	therapist in therapy only cases, shall make the initial visit to the patient's residence and 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. Based on record review, the agency failed to ensure the Registered Nurse (RN) supervised the Home Health Aides (HHA) every two weeks for 3 of 9 records reviewed receiving HHA services with a skilled service for longer than 2 weeks (# 12, 14 and 16), and failed to ensure the parent or branch provided HHA supervision every 2 weeks for 1 of 1 records reviewed receiving HHA services from the acquired agency (# 16). Findings include: 1. The clinical record for patient # 12 was reviewed on 11/18/15. The start of care date was 7/19/15. The POC dated 9/17-11/15/15 contained orders for HHA 1 visit a week for 3 weeks, and Skilled Nursing (SN)1 time a week for 2 weeks, 1 every 2 week for 6 weeks, and 3 as	N 0606	To ensure compliance with 41 IAC 17-14-1(n): Scope of Services the following interventions have been implemented: • • • • • • • • • • • • • • • • • • •	of de de de de de de de de de de de de de			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. JILDING	NSTRUCTION 00	COMPI		
		157586	B. W	ING	<u> </u>	11/19	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	{		3115 S	WEBSTER ST		
GREAT I	_AKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG	needed visits for	· · · · · · · · · · · · · · · · · · ·		TAG	,		DATE
	needed visits for	iuiis, eteeteia.					
	A. The recor	d evidenced a HHA					
	supervisory visit	t was conducted on					
	9/22/15, and not	again until 10/15/15,					
	then not again u	ntil 10/30/15. The record					
	failed to evidence	ee the supervisory visits					
	were conducted	every 2 weeks and within					
	the appropriate of						
		upervisory visit, the next					
		e been conducted on					
	10/6/15, 10/20/1	5, and 11/3/15.					
	2 The clinical r	record for patient # 14,					
		e 6/29/15 was reviewed					
		contained a POC dated					
		with orders for SN 1 time					
	a week for 1 wee	ek, 1 time every two					
	weeks for 8 wee	ks, and 3 as needed visits					
	for labs, safety,	and abnormal bleeding;					
	and HHA 1 time	e a week for 1 week, then					
	two times a week	k for 8 weeks.					
	A The recor	d evidenced a HHA					
		t was conducted on					
		ot again until 11/12/15.					
	· ·	d to evidence the					
		ts were conducted every 2					
		n the appropriate dates.					
	After the 10/22/	15 supervisory visit, the					
	next one should	have been conducted on					
	11/5/15.						
	R During in	terview on 11/19/15 at					
	J. During in	101 v 10 w 011 1 1 / 1 7 / 1 3 at					1

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 475 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIER	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					WEBSTER ST		
GREAT I	_AKES CARING			KOKON	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		Administrator stated the					
		visit should have been					
	conducted around 11/3/15.						
		record for patient # 16					
		n 11/9 and 11/16/15 and					
		n the OASIS list for					
		ound Status and was					
		had been a patient of the					
	South Bend brar	nch. Patient # 16 lived in					
	the territory serv	viced by the acquired					
	agency. The patient was discharged to						
	hospice on 5/8/1	5.					
	A. The plan	of care dated					
	3/23-5/21/15 wi	th start of care date					
	3/23/15, contain	ed orders for skilled					
		ime a week for 9 weeks					
		visits for pain, falls,					
	respiratory/cardi						
	gastrointestinal/	gastrourinary, and					
		omplications; HHA 2					
	1 -	1 week then 3 times a					
	week for 2 week						
	B. The reco	rd evidenced patient # 16					
		HA services from the					
	_	on 3/25, 3/27, 3/30, 4/1,					
		/15, 4/17, 4/21, 4/24,					
		8/15 by employee WW;					
	and 5/1 by empl						
	und 5/1 by chipi	о јо о ши.					
	C. The recor	d evidenced a HHA					
		t was conducted on					
	supervisory visit	was conducted on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	/2015
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	KOVIDER OR SUPPLIER			3115 S	WEBSTER ST		
	AKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		yee NN, and not again					
	until 4/24/15 by employee NN. The						
	record failed to evidence the HHA						
		ts were conducted by the					
	1	South Bend branch, and					
		ee the supervisory visits					
	were conducted	every 2 weeks and within					
	the appropriate of	lates. After the 4/7/15					
	supervisory visit	t, the next one should					
	have been condu	acted on 4/21/15.					
	D. On 11/16	5/15 at 11:35 AM, the					
	Administrator st	ated the acquired agency					
	maintains the ch	arts for all the patients					
	they provided se	ervices for and patient #					
	16 was provided	services by the acquired					
	agency.						
	E. During int	erview on 11/5/15 at					
	1:40 PM, the Ad	lministrator stated that					
	some of the curr	ent South Bend patients					
	were serviced by	y an agency in Warsaw					
	that had been ac	quired by the Great					
	Lakes Corporation	on. These patients were					
		ith Bend branch active					
	patient list and a	lso on the acquired					
	1 *	•					
		•					
	_						
	own provider nu	iiiioci.					
	F. During in	nterview on 11/6/15 at					
	1	Administrator stated there					
	patient list and a agency's active pacquired agency insurance plans. stated that the acown provider nu	also on the acquired patient list due to the did not accept the The Administrator equired agency had its amber.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W		<u>oo </u>	11/19/	
	PROVIDER OR SUPPLIEF	<u> </u>		3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902	<u> </u>	
	•	TATEL IENT OF DEPLOYENCIES		<u> </u>	10, 111 +0302		975
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ct or an agreement for					
		ncy to provide services to					
	the South Bend						
	Administrator st						
		nired the agency provider					
		th Bend branch provided					
		counties already serviced					
	by the acquired	agency.					
	G During is	nterview on 11/6/15 at					
	1	Administrator indicated					
	·	ncy had their own					
		hart, Administrator, and					
	_	sor, but she was also the					
	_	nistrator for the acquired					
		ministrator stated the					
	, ,	South Bend branch is					
		he day to day scheduling					
		seeing care provided for					
	the patients.	seeing care provided for					
	the patients.						
	4. The agency's	policy titled "Home					
		pervision," # C-340,					
	reviewed March						
		ts of Home Health Aides					
		ng to the following					
		When skilled nursing					
		g provided to a client, a					
	Registered Nurs						
	_	to the client's residence					
		days (either when the					
	I	de is present to observe					
		delivery, or when the					
		de is absent) to assess					
	l	•	- 1				ı

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	goals are being in Health Aide servindividual who is by GLC but undo will take responsing quality of care, proceeding to registraining and commet. 9. The aide by the Clinical Stassure services a according to the same services and according to the same services March 2015 state nurse: h. Supother nursing peraides as appropriates The agency's "Supervision of State addition to person Nurse will make client's residence weeks." 7. The agency's Supervision," # 62015 stated, "Poil stated,	policy titled "Skilled s," # C-200, reviewed ed, "1. The registered pervises and teaches rsonnel and home health ate."					

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹		3115 S	WEBSTER ST		
	AKES CARING			KOKOM	/IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
		vision of a Registered					
	_	ional Director/Clinical					
	_	available to provide					
		sion during the operating					
		Under no circumstances					
		trative or supervisory					
	_	be delegated to another					
		urpose To meet the					
	_	state/federal guidelines					
	and provide sup	ervision and direction to					
	all staff delivering	ng home health care					
	services. To ass	sure employee					
	performance is a	appropriately supervised,					
	that care is direc	ted toward the					
	achievement of	goals, and that services					
	are provided bas	sed on client need and in					
	accordance with	the physician's Plan of					
	Care Specia	l Instructions 1. The					
	Regional Direct	or/Clinical Manager shall					
	be responsible for	or the quality of care					
	_	pervision of all staff					
		peutic services, including					
		Ie/she will also be					
		organizing and directing					
	_	functions. 2. The					
		or/Clinical Manager shall					
	_	ay-to-day operation of					
		and work with the					
	Administrator.						
		participate with the					
	_	or/Clinical Manager in all					
	_	nt to the professional					
		ed. This includes the					
		qualification and the					
	acveropinent of	quantication and the					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 480 of 518

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE: A. BUILDING 00 COMPLETED B. WING 11/19/2015						
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) PERSONNEL "	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
N 0608 Bldg. 00	410 IAC 17-15-1(a Clinical Records Rule 15 Sec. 1(a) containing pertine findings in accorda professional stand for every patient a (1) The medical	a)(1-6) Clinical records nt past and current ance with accepted lards shall be maintained s follows: plan of care and						
	(3) Drug, dietary orders. (4) Signed and contributed to by a Clinical notes shall is rendered and in (14) days.	physician, dentist, atrist, or optometrist. In treatment, and activity Idated clinical notes If assigned personnel. If be written the day service corporated within fourteen Immary reports sent to the efor the medical patient's care.						
	Based on record the agency failed of clinical inform	review and interview, I to ensure the accuracy nation for 7 of 20 records 1, 10, 11, 12, 13, and 16)	N 0608	To ensure compliance with 41 IAC 17-15-1(a)(1-6): Clinical Records the following interventions have been implemented:	0 12/24/2015			
	of care date 10/2 care (POC) dated orders for Skilled week for 1 week weeks, then 1 tir	ecord of patient # 3, start 3/15, contained a plan of d 10/23/-12/21/15 with d Nursing (SN) 1 time a , 2 times a week for 8 ne a week for 1 week, visits for cardiac,		• All LPN and RN stareceived hands on competence check offs in a skills lab by RN staff educators, competency included review of PICC line procedures and return demonstration of skills, documentation, measurement PICC and physician notification abnormal assessment. To be completed by 12/24/15	of			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		157586	B. W	ING		11/19/	2015
				CTD FET A	ADDRESS CITY STATE ZIR CODE		
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
ODEATI	ALCEO OADINIO			3115 S WEBSTER ST KOKOMO, IN 46902			
GREAT	LAKES CARING			KOKON	10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	respiratory, gast	rointestinal,					
	gastrourinary, no	eurologic, endocrine,			•□□□□□□□ PICC measuremer	nt	
	"	in/wound status changes,			service code created in HCHB	on	
		r: Instruct on			12/14/15.		
	•	e procedure, obtain lab			•□□□□□□□ All skilled nursing		
	1	rt to physician. SN to			staff received education on documentation requirements for	_{or}	
	1	cin trough week of			wound care, as well as hands		
	10/26/15 and BN	MP [basic metabolic			competency checks in a skills		
	profile] twice we	eekly until instructed			for wound care, and infection		
	otherwise S	N to change PICC			control with wound care, by an	1	
	dressing using st	terile technique every			RN preceptor by 12/24/15.		
		eded times 3 for soiled or					
	loose dressing.	aca times 5 for some of			•□□□□□□□ All clinical staff		
	loose dressing.				educated on policy C-145	ont	
					comprehensive client assessmand C-155 Client	ierit	
		of care assessment form			Recertification/Follow-up/and		
	dated 10/23/15 b	by employee G,			Resumption of Care. Educatio	n l	
	Registered Nurs	e (RN) stated, "Indicate			included the requirement to		
	length of expose	ed PICC catheter from			recertify within the five day		
	insertion site to	catheter hub in			window.		
	centimeters: 10.	0 "					
					An audit will be performed by t	he	
	D. The CMA	isit Note Report dated			administrator or designee of 100% of all patients with a PIC		
		*			line until 100% compliance is r		
		ployee U, Licensed			for 4 consecutive weeks. After		
		(LPN) stated, "PICC line			consecutive weeks of 100%	•	
	dressing dislodg	ed. PICC line dressing			compliance the audit will		
	changed using a	septic technique Lab			decrease to 10% quarterly and	d	
	draw obtained v	ia PICC line using			will be completed through the		
		e." The record failed to			clinical record review process.		
		N measured the PICC			(Exhibit 6)		
		evidence the nurse			An audit will be performed by		
					administrator/designee of 100°	_%	
		ssing using sterile			of wound visits to ensure	, ~	
	technique.				measurements q week, as wel	l as	
					detailed orders and complete		
	C. The SN V	visit Note dated 11/3/15			documentation of wound care		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			3115 S	WEBSTER ST		
	AKES CARING			KOKOM	лО, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		LPN stated, "Skilled			provided until 100% compliand is met for 4 consecutive weeks		
	_	ent completed for Vanco			After 4 weeks of 100%	o.	
	peak draw from	PICC line using clean			compliance the audit will		
	technique." A C	are Coordination Note			decrease to 10% quarterly and	t	
	Report dated 11/	/3/15 by employee E			will be completed through the		
	stated, "Patient r	equesting PICC line			clinical record review process.		
	dressing change	d during visit due to			(Exhibit 11)		
		PICC line dressing			An audit will be performed by t	the	
	_	terile technique." The			administrator/designee of 100		
		evidence the PICC line			of all recertification visits to ve	rify	
		uring the dressing			that they were completed		
	change.				between day 56 and 60 until 100% compliance is met for 4		
	change.				weeks. After 100% compliance	e is	
	D The SN V	isit Note Report dated			met for 4 weeks the audit will		
		-			decrease to 10% quarterly and	t	
		bloyee V, LPN stated,			will be completed through the		
	_	of exposed PICC			clinical record review process.		
		sertion site to catheter			(Exhibit 16)		
		ers: 3.0." The record			An audit will be performed by t	the	
		te the physician was			administrator/designee of 50%		
	notified of the 3	centimeter PICC			all skilled nursing visits for		
	measurement.				updated goals when indicated		
					and physician notification of updated and patient specific		
	E. During in	terview on 11/16/15 at			goals until 100% compliance is	s I	
	3:00 PM, the Ad	lministrator stated PICC			met for 4 consecutive weeks.		
	dressing changes	s should be sterile.			After 4 consecutive weeks of		
		11/15/15			100% compliance the audit will decrease to 10% quarterly and		
		terview on 11/17/15 at			will be completed through the		
	10:05 AM, the Administrator stated she talked to the LPN that measured the PICC line at 3 centimeters on 11/13 and				clinical record review process.		
					(Exhibit 13)		
		e measured only what					
	was showing under neath the dressing,						
	and that the PIC	C line is sutured in place.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BU		A. BUILDING 00 COMPLETED B. WING 11/19/2015						
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GREAT I	_AKES CARING				WEBSTER ST 10, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	reviewed on 11/1 date was 9/20/15 9/20-11/18/15 cot times a week for for 1 week, 2 tim then 1 time a we needed visits for respiratory/cardicomplications, many solutions. Area cleanse with work betadine and let right upper arm of cleanser, apply solutions and cleanser, apply solutions are display moistened gauze. Area to many solutions are display moistened dry gauze. A. The wound cleanser, lightly moistened dry gauze. A. The wound right upper arm a contain frequence on 11/1 date was 9/26/15 9/26-11/24/15 cot Aftercare follow for SN 1 time a was a week for 2 week	ac, wound nental status changes. and intervention related a to ball of left foot and cleanser, apply dry, every day. Area to cleanse with wound santyl and cover with d gauze and dry and dry ight hip cleanse with apply Santyl cover with d gauze and cover with d gauze and cover with ed care orders for the and the right hip failed to ies for the wound care. ecord for patient # 10 was 17/15. The start of care						

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

STREET LANGES, CITY, STATE, JP CODE. 3115 SWEBSTER ST KOKOMO, IN 46902 SUMMARY STATEMENT OF DEFICIENCIES BEREIN GREAT DEFICINCY MUST BE PRECEDED BY FULL GRACH DEFECIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG gastrointestinal gastrourinary, respiratory, cardiac, impaired skin integrity, diabetes, and functional decline. Need for skilled teaching and intervention related to wound incision corrected spine incision. Keep clean and dry. May leave open to air if no drainage noted. SN for: -Observation and assessment of cardiac system to identify changes associated with exacerbation for early intervention of complications; observation/assessment of gastrointestinal system to identify changes associated with exacerbation of or eraly intervention of corplications; -Evaluate patient and develop plan of care to be counter signed by physician; -Observation/assessment of respiratory system to identify changes associated with exacerbation for early intervention of complications; -Provide instructions related to discharge planning. Discharge summary for all disciplines available to physician upon request; -Assess anxiety and provide assistance to patient for understanding and management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills and identify changes associated with	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			JILDING	<u>00</u>	COMPL 11/19/	ETED		
CX3 D SUMMARY STATEMENT OF DEFICIENCIES TAG PROCEEDING THE PRECEDED BY FULL PREFIX CARCIFORMACT MOST BE PRECEDED BY FULL PREFIX CARCIFORMACT MOST BE PRECEDED BY FULL PREFIX CARCIFORMACT MOST DES PRECEDED BY FULL PREFIX TAG PROCEEDING ACT THE APPROXIMATE COMPLETION CARCIFORMACT MOST DES PRECEDED BY FULL PREFIX TAG PROCEEDING ACT THE APPROXIMATE COMPLETION CARCIFORMACT MOST DES PRECEDED BY FULL PREFIX TAG PROCEEDING ACT THE APPROXIMATE COMPLETION CARCIFORMACT MOST DES PRECEDED BY FULL PREFIX TAG PROCEEDING ACT THE APPROXIMATE COMPLETION CARCIFORMACT MOST DES PRECEDED BY FULL PREFIX TAG PROCEEDING ACT THE APPROXIMATE COMPLETION CARCIFORMACT MOST DES PRECEDED BY FULL PREFIX TAG PROCEDED BY FULL PREFIX TAG PROCEEDING ACT THE APPROXIMATE COMPLETION CARCIFORMACT MOST DESCRIPTION CARCIFORMACT MOST DESC	NAME OF P	ROVIDER OR SUPPLIER							
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-Observation/assessment of respiratory system to identify changes associated with exacerbation for early intervention of complications; -Provide instructions related to discharge planning. Discharge summary for all disciplines available to physician upon request; =Assess anxiety and provide assistance to patient for understanding and management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		•	• •						
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with exacerbation for early intervention of complications; -Provide instructions related to discharge planning. Discharge summary for all disciplines available to physician upon request; =Assess anxiety and provide assistance to patient for understanding and management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills									
of complications; -Provide instructions related to discharge planning. Discharge summary for all disciplines available to physician upon request; =Assess anxiety and provide assistance to patient for understanding and management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		system to identif	y changes associated						
-Provide instructions related to discharge planning. Discharge summary for all disciplines available to physician upon request; =Assess anxiety and provide assistance to patient for understanding and management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		with exacerbation	n for early intervention						
planning. Discharge summary for all disciplines available to physician upon request; =Assess anxiety and provide assistance to patient for understanding and management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		of complications	•						
disciplines available to physician upon request; =Assess anxiety and provide assistance to patient for understanding and management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		-Provide instruct	ions related to discharge						
request; =Assess anxiety and provide assistance to patient for understanding and management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		planning. Discha	arge summary for all						
=Assess anxiety and provide assistance to patient for understanding and management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		disciplines availa	able to physician upon						
patient for understanding and management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		request;							
management of feelings. SN may perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		=Assess anxiety	and provide assistance to						
perform Hamilton anxiety scale and/or mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		patient for under	standing and						
mini mental exam; -Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		management of f	Feelings. SN may						
-Provide assessment and teaching/reinforcement of management of depression including disease process, medication management, coping skills		perform Hamilto	n anxiety scale and/or						
teaching/reinforcement of management of depression including disease process, medication management, coping skills		mini mental exar	n;						
depression including disease process, medication management, coping skills		-Provide assessm	nent and						
medication management, coping skills		teaching/reinford	cement of management of						
and identify changes associated with		medication mana	gement, coping skills						
		and identify char	nges associated with						

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING	_	11/19/	/2015
en on r				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	· ·		3115 S	WEBSTER ST		
	AKES CARING				1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		· · · · · · · · · · · · · · · · · · ·	+	TAG	DEFICIENCY)		DATE
	depressive disor						
		may perform geriatric					
	_	and/or mini mental					
	exam;						
		g/reinforcement in					
	etiology of confi						
	"	measures and home					
		eservation and assessment					
	of pain, effective	•					
	management and	d regimen and skilled					
	teaching related	to pain management, SN					
	to report increas	e in pain level to					
	physician for pro	ompt intervention;					
	-Skilled teaching	g and training of					
	emergency care	plan, disease process					
	including self m	-					
	cardiovascular h	ypertension disease;					
	-SN to obtain pu						
		nes 3 as needed for					
		ath, oxygen use, activity					
	intolerance;	,, 8,					
	· ·	on/reinforcement of					
		system related teaching,					
	-	iculitis and irritable					
	bowel syndrome						
		killed teaching regarding					
	_	trol diarrhea/constipation					
		•					
	as well as preven	_					
	_	killed teaching and					
		gency care plan, disease					
	1 ^	tomy surgery including					
	1	t of neurologic disease;					
	-SN to provide a						
	teaching/reinfor	cement of management of					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 486 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	COMPL		
		157586	B. W	ING		11/19	/2015
NAME OF I	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE		
GREAT I	AKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		ng disease process,		TAG	DLI ICILI (CT)		DATE
		agement, coping skills					
		nges associated with					
	1	y intervention. SN may					
	·	lucose level as needed					
	for signs and syr						
	hyper/hypoglyce	emia or for baseline					
	testing. SN ass	feet and reinforce					
	diabetes mellitus	s foot care;					
	-SN observation	and reaching					
	integumentary st	tatus to promote optimum					
	skin integrity;						
	_	atient/caregiver on signs					
		f infection related to					
	cervical spine su						
	complications to						
		supports to minimize					
	_	ration patient/caregiver					
		d in emergency care plan,					
	_	ervical spine surgery					
		ment to reduce avoidable					
	hospitalization;	C 1' <i>t</i> '					
		ion of medication					
	regimen to ident changes/complic	•					
	intervention;	ations for earry					
	· ·	nterventions to improve					
		ace the risk of falls;					
		atient/caregiver on					
		ures to reduce pressure					
	ulcer risk; and	area to reduce pressure					
		ssional to report vital					
	_	side the following					
		meters: Temp < 96>					
		_					l

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 487 of 518

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION	COMPI			
AND PLAN	OF CORRECTION		B. W		00	COMPI		
		157586	D. W		_	11/19	/2015	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE					
CDEATI	AKES CADING		3115 S WEBSTER ST KOKOMO, IN 46902					
	_AKES CARING			<u> </u>	10, 111 40902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION DATE	
TAG		> 116, Respirations < 12		TAG			DATE	
	l '	ood pressure, $80 > 170$,						
	' •	oressure $< 50 > 90$,						
		gar < 60 > 300, oxygen						
	saturation < 88.	gai < 00 > 300, 0xygeii						
		isted misks. Detiontly						
		iated risks; Patient's						
		ction needs will be met, ary for all disciplines						
		sician upon request;						
	* *	xiety are identified and						
		tiated to allow patient to						
	manage feelings							
	-Patient/caregive							
		strate understanding the						
	_	depression by the end of						
		symptoms are identified						
	_	maintain patient safety in						
	the home; Patien	•						
		erstanding of etiology of						
		aintain patient safety in						
	the home;	and the total Control (14)						
		pain interfering with						
	activity;	at layed of 2 on loss+						
		at level of 3 or less or at						
	a level acceptabl	-						
	-Patient/caregive							
	1	f pharmacological and						
		gic pain control measures;						
		nonstrate ability to self						
	_	ascular hypertension						
		and reduce caregiver						
		d with disease process;						
	pulse oximetry r							
	-Patient/caregive	er will demonstrate						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586			JILDING	<u>00</u>	COMPL 11/19/	ETED		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
GREAT I	_AKES CARING				WEBSTER ST IO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	ability to self madisease process; -Patient/caregived demonstrate ability bowel elimination bowel patency; -Demonstrated a neurologic disease caregiver burden process, improved symptoms of neurologic disease caregiver burden process, improved demonstrate und management of depisode and symmanaged to main home; -Demonstrated in conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions and easing the conditions are easing the co	repropriate agency ent rehospitalization,						

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 489 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER			3115 S	WEBSTER ST			
GREAT LAKES CARING			<u> </u>	1O, IN 46902			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	<u> </u>	· · · · · · · · · · · · · · · · · · ·		TAG			DATE
		decreased risk for falls; er will demonstrate					
	_						
		es of pressure ulcer					
	prevention.						
	The agency faile	ed to ensure the physician					
	was notified of g	goals being met and of					
	unobtainable go	als needing to be changed					
	on the plan of ca	are; and failed to					
	coordinate with	nursing staff to ensure					
	instructions and	education on goals met					
	was not being co	_					
	A. The initia	l start of care was					
		ient Coordination Note					
		late entry for 9/26/15					
	_	of patient] states the					
		pain ever gets is a # 8 on					
		rently patient takes					
	-	grams tablets for pain."					
		ed to ensure the goal of					
		at level of 3 or less or at					
		le to the patient" was					
	revised.	ie to the patient was					
	TOVISOU.						
	B. The start	of care Outcome					
	Assessment and	Information Set					
	assessment form	dated 9/26/15 stated					
		itions prior to medical					
		en change or inpatient					
	_	past 14 days 3-					
		" The Pain assessment					
		Pain All of the time					
	Fam Scale Ratin	g: 9 What activities					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157586	(X2) MULTIPLE (A. BUILDING B. WING	OONSTRUCTION OO	(X3) DATE SURV COMPLETEI 11/19/201	D		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	СО	(X5) OMPLETION DATE		
	neck pain least? long does neck pain be relititled "Endocrine" "Indicate endocrassessment (mar Diabetes, thyroid patient taking in patient taking and How frequent ar Not checked ver patient's usual by Below 130." The section titl stated "Indicate with other discipcase: YES. Who communicate with communicate with Caregiver(s), Cl. Indicate reason particular to the communicate of propagation of	inical Supervisor. chysician not contacted: Contacted physician for cosed plan of care: No. chysician not contacted: mds." The section titled ted: "3. Patient/caregiver estanding of basic ation requirements." The to evidence the SN ag/reinforcement of						

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 491 of 518

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	NSTRUCTION 00	COMPL			
		157586	B. W	ING	<u> </u>	11/19/		
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
GREAT I	AKES CARING		3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION) 1. The POC dated		TAG	DEFICIENCY)		DATE	
		ntained orders for SN 3						
		1 week, 4 times a week						
		nes a week for 1 week, 4						
	· ·	1 week, 3 times a week						
		nes a week for 1 week, 3						
	times a week for	2 weeks, then 2 times a						
	week for 1 week	, with 3 as needed visits						
	for pain, falls, ca	ardiac/respiratory,						
	gastrointestinal/g	gastrourinary, diabetic, or						
	_	tions. Need for skilled						
		ervention related to left						
		kin integrity. Cleanse						
		nser, apply collagen,						
		dressing. Wrap bilateral						
	lower extremitie							
	compression wra	aps.						
	A. The POC	failed to contain a						
	frequency of the	wound care orders.						
	B. During in	terview on 11/18/15 at						
		Administrator stated there						
	should be a freque	uency on the wound care						
	orders.	-						
	5 The clinical r	ecord for patient # 12						
		11/18/15. The start of						
		19/15. The POC was						
		5/15. The 5 day window						
		n was 9/12-9/16/15.						
	A. The recer	tification was not						
	completed until	9/22/15.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI TAG DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	9/16/15 stated, "Itoday for recertification Reschedule miss 9/18.15." C. The Clien Report dated 9/1 called to set up a for recert and was staying with primary CG [carvisit. Could be a Tuesday. Patien new Glucometer [daughter in law] on how to use it. [primary care ph with clinical sup D. The Physidated 9/18/15 stated you have a proper outside of E. The Visit 9/22/15 stated, "Itography in the state of the primary care in t	t apparently received a from Dr. and DIL] would like instructions Will notify PCP ysician] of delay along ervisor." cian Verbal Order form ated, "Patient unavailable 15 Reschedule Medicare week." Note Report dated Recertification Visit + "(M-0110) Episode t," "Homebound t has a condition such e is medically					
			1				

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 493 of 518

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION G 00	COMP	E SURVEY PLETED 9/2015		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPE	LD BE	(X5) COMPLETION DATE	
	1:50 PM, the Adpatient should had the agency found	terview on 11/18/15 at Iministrator stated the ave been discharged once d out they would not be the recertification visit window.					
	6. The clinical r was reviewed or care date was 5/2 Huntington's Ch 8/30-10/28/15 co the week of 9/6/week, 1 every tweety 3 weeks for needed for carding gastrourinary/gamental, pain, ski and falls. SN for-Evaluate patien care, observation effectiveness of regimen and skill	ecord for patient # 13 a 11/19/15. The start of 2/15. Diagnosis of orea. The POC dated ontained orders for SN 15, 1 time a week for 1 wo weeks for 4 weeks, 1 or 3 weeks, and 3 as ac/respiratory, strointestinal, endocrine, n, wound status changes,					
	level to physicia -Observation/ass system to identif with exacerbatio of complications - Obtain pulse or upon recertificat and times 3 as no breath, oxygen u	n; sessment of cardiac by changes associated on for early intervention					

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PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			WEBSTER ST		
GREAT L	AKES CARING			KOKOM	/IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	*	fy changes associated					
		on for early intervention					
	of complications						
	1	incontinence screening					
	and intervention; SN to provide skilled						
	teaching related to urinary incontinence						
	management. May obtain urinalysis and						
	culture and sensitivity times 3 if indicated						
	for signs and syr	nptoms of urinary tract					
	infection or retention.						
	-SN for observation/assessment of						
	gastrointestinal system to identify						
	changes associated with exacerbation of						
	or early interven	tion of complications,					
	SN to provide sl	cilled teaching regarding					
	_	trol diarrhea/constipation					
	as well as preven	•					
	_	SN for administration of					
	_	nes 3 as needed, SN for					
		impaction times 3 as					
	needed.	imputation times 3 us					
		and provide interventions					
		nce and reduce the risk of					
	falls.	ioo and roduce the fish of					
		patient/caregiver on					
	_	ures to reduce pressure					
	ulcer risk.	ures to reduce pressure					
		auma anta ta mainii					
		supports to minimize					
	_	zation, patient/primary					
		e instructed in emergency					
	_	spects of cardiovascular					
	1	ment to reduce avoidable					
	hospitalization.						
	-SN to provide i	nstructions related to					

State Form Event ID: YJL511 Facility ID: 011284 If continuation sheet Page 495 of 518

PRINTED: 12/29/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W	ING		11/19/	2015
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹			WEBSTER ST		
GREAT L	AKES CARING				ло, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	discharge planni	ng. Discharge summary					
	for all discipline	s available to physician					
	upon request.						
	-Skilled instruction of medication						
	regimen to identify						
	changes/complications for early						
	intervention.						
	GOALS;						
	1	results obtained.					
	1	piratory status will be					
	identified and reported to physician for						
	prompt intervention to minimize						
	associated risks;						
	_	n urinary incontinence;					
	-	n management of urinary					
	incontinence;						
		of gastrointestinal disease					
	will be promptly	identified and					
	interventions im	plemented to minimize					
	risks to patient.						
	-Patient/caregive	er verbalize and					
	demonstrate abil	lity to manage altered					
	bowel elimination	-					
	-Patient will hav	re bowel patency;					
		able to perform activities					
		nd individual activities of					
		decreased risk for falls;					
		er will demonstrate					
	1	es of pressure ulcer					
	proper technique prevention,	23 of pressure uncer					
		re appropriate agency					
		ent rehospitalization,					
	-	alizations will be					
	reduced;						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		r í	JILDING	nstruction 00	(X3) DATE COMPL 11/19/	ETED	
	PROVIDER OR SUPPLIER			3115 S	NDDRESS, CITY, STATE, ZIP CODE WEBSTER ST 10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	-Patient's dischabe met. Dischardisciplines availarequest; -Patient/caregive ability to safely: A. The SN R Assessment and (OASIS)Visit National Section Assessment Scalare considered to developing presson the score, the is: LOW." The "Interventions Patient patient of changes adaptive pressure relief in support, monitor prominences and least every 1-2 h turning/positional Instruct in nutrit promote good skeeps. The Visit titled "Integume "No problems in the same and the score and the sco	rge instruction needs will ge summary for all able to physician upon er will demonstrate manage medications. eccertification Outcome Information Set ote Report dated titled "Braden Risk te" stated, "Total Score total score of 12 or less to be at high risk of sure ulcers): 18. Based risk level for this patient section titled rovided," stated, "1. caregiver in position te equipment to alleviate ss/comments: instruct in acluding using pillows for ring skin over bony d position changes at ours. Instruct in ng schedule 10. ional requirement to cin integrity and healing." Note Report section intary/Wound" stated, entified," and failed to		IAU			DATE
	-	ient needed skin integrity void pressure ulcer risks					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015		
	F PROVIDER OR SUPPLIEI	3	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE	
	and nutritional e	education to promote				
	Visit Note Repotitled "Goals Metale and met again of as: stated," 1. Possible unders given related to prevention. 2. Gidentified prompinitiated quickly risks 5. Patalemonstrate under pharmacological pain control metale Changes in respidentified and responsible to minimize risks. In the meds of the assessment data. D. The SN For Visit Note Reponsible to the reception of the section recertified this visit was a strong titled to the section reception of the section reception rec	lerstanding of l and nonpharmacologic asures this visit. 6. iratory status are eported to physician for tion to minimize 9. Exacerbations of disease are promptly atterventions implemented as to patient." The Goals idence the reflective of patient per the recorded. Recertification OASIS at dated 10/26/15 a stated, "Patient risit nursing not need at				
	D. The SN F Visit Note Repo narrative section recertified this v	recorded. Recertification OASIS rt dated 10/26/15 n stated, "Patient				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING B. WING	00	COMPLETED 11/19/2015	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST	
	AKES CARING			лО, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		ecord failed to evidence ischarged from SN			
	was reviewed on care date was 7/1 dated 9/17-11/15	ecord for patient # 12 11/18/15. The start of 9/15. The POC was /15. The 5 day window h was 9/12-9/16/15.			
	completed until 9	ification was not 0/22/15. The agency ge the patient and left the 11/15/15.			
	9/16/15 stated, "I today for recertif	cian Verbal Order dated Patient refused visit ication. Intervention: ed visit for Friday			
	Report dated 9/1 called to set up a for recert and wa was staying with primary CG [carvisit. Could be of Tuesday. Patien new Glucometer [daughter in law] on how to use it.	t apparently received a from Dr. and DIL would like instructions Will notify PCP ysician] of delay along			

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	COMPL	
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIEF	!			DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT I	AKES CARING				10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	dated 9/18/15 sta for visit on 9/18/ recert outside of	ician Verbal Order form ated, "Patient unavailable /15 Reschedule 'Medicare week."					
	Supervisory" Timing: 1-Early	-					
	1:50 PM, the Adpatient should hat the agency found	terview on 11/18/15 at Iministrator stated the ave been discharged once d out they would not be the recertification visit window.					
	was reviewed on was chosen from Deteriorating W listed as having South Bend bran the territory serv	ecord for patient # 16 in 11/9 and 11/16/15 and in the OASIS list for ound Status and was had been a patient of the inch. Patient # 16 lived in riced by the acquired itent was discharged to 5.					
	Administrator st	/15 at 11:35 AM, the ated the acquired agency arts for all the patients					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		157586	B. W	ING	<u></u>	11/19/	
	PROVIDER OR SUPPLIEF	<u> </u>	<u> </u>	3115 S	DDRESS, CITY, STATE, ZIP CODE WEBSTER ST IO, IN 46902	<u> </u>	
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ilE	DATE
	they provided se	rvices for and patient #					
	16 was provided	most services by the					
	acquired agency	•					
	B. The plan						
	3/23-5/21/15 with start of care date						
	3/23/15, contained orders for skilled						
	nursing (SN) 1 time a week for 9 weeks						
	and 3 as needed visits for pain, falls, respiratory/cardiac, diabetic,						
	gastrointestinal/gastrourinary, and						
	integumentary complications; Physical						
	Therapy (PT) 1 time for 1 week then 2						
		4 weeks; Occupational					
		time for 1 week then 2					
		3 weeks then 1 time for					
		Social Worker 1 time					
	•	1 visit every 2 weeks for					
		Health Aide (HHA) 2					
	· ·	1 week then 3 times a					
	week for 2 week	CS.					
		ord evidenced patient #					
	•	SN services from the					
		on 3/23, 4/14, 5/1, and					
		yee QQ; 3/30, 4/3, 4/7,					
		4/21, 4/24, 5/6, and					
	J 1	yee NN; and 4/28/15 by					
	employee PP.						
	D The reco	ord evidenced patient #					
		HHA services from the					
	•	on 3/25, 3/27, 3/30, 4/1,					
	1 0 3	15, 4/17, 4/21, 4/24,					
	l ' ' '		1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/19/2015	
	PROVIDER OR SUPPLIEF	2	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	4/28, 5/5, and 5/ and 5/1 by empl	8/15 by employee WW; oyee LL.			
	was provided P7 acquired agency	ord evidenced patient # 16 T services from the on 3/26/15 by employee , 4/10, 4/13, 4/17, 4/20, mployee UU.			
	F. The record evidenced patient # 16 was provided TO services from the acquired agency on 4/2 by employee CC.				
	12:40 PM, the A OASIS submissi nurses or clinicia	terview on 11/13/15 at administrator stated the ions are done by the ans, and the Corporate an submits the data to the			
	10:30 AM, the A agency does not	terview on 11/16/15 at Administrator stated the have and agreement or reporate office to submit the State agency.			
	And Reporting (reviewed March electronically re collect in accord regulations. GL behalf of GLC v	policy titled "Encoding DASIS Data," # B-250, 2015 stated, "GLC will port all OASIS data ance with federal C and agents acting on will ensure confidentiality ific information in the			

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				COMPLETED 11/19/2015			
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING				WEBSTER ST O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION DATE
	clinical record."						
	10. The agency's Necessary Discled Health Information March 2015 state recurring discloss information 1. Odisclosures of he makes on a routing that are not related has determined to heath information achieve the purpon Non-routine disconformation The agency's an individual's enful fillment of any justification for statement for any justification for statement of agency's 11. The agency's 11. The agency's 12.	ures of health GLC has identified alth information it ne and recurring basis ed to treatment. 2. GLC he minimum amount of n that is needed to ose of these requests losures of health 3. GLC relies on hat the information minimum a mount request if from a public care provider, a health nal providing service to ss associate, or a provides appropriate Disclosures of entire GLC does not disclose ntire medical record in y request not related to y reason unless a such a disclosure is					
	"Client/Family R Responsibilities,	tights & " # C-390, reviewed					

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	A) PROVIDENSUPPLIENCLIA A) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: 157586 B. WING			COMPLETED 11/19/2015			
NAME OF	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
GREAT	LAKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAG	March 2015 state Security- You had Confidentiality of electronic protect including your minformation about financial circumstakes place in your Indiana Addendor patient or the patterpresentative had informed of the perfective means home health age promote the exert shall do the follow documentation swith the requirer (E) Confidential maintained by the The home health patient of the age procedures regard clinical records.' 12. The agency' "Management of B-435, reviewed Physical Security limit access to an computer network with a confirmed Data Security Potential Security Poten	ed, "Privacy and ave the right to: of written, verbal and ted health information nedical records, at your health, social and stances or about what ur home State of am: Sec. 3. (a) The cient's legal as the right to be patient's rights through of communication. The next must protect and recise of these rights and awing: (2) Maintain showing it has complied ments of this section tity of the clinical records the home health agency. The agency shall advise the ency's policies and ding disclosure of		IAG	DEFICIENCE		DATE

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l é l		r í		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		157586	B. W	ING		11/19/	2015
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					WEBSTER ST		
GREAT I	LAKES CARING			KOKON	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	or created by en						
	jurisdiction of GLC. This includes but is						
	· ·	ata maintained within: 1.					
	Branches suppor	rted by GLC information					
		nent Basic Code of					
	Computer Secur	ity Ethics 1. Every					
	effort will be ma	ade to restrict access to					
	data and facilitie	es to those people with a					
	need-to-know."						
	13. The agency'	s undated policy titled					
	"Responding to	Complications of PICC					
		stated, "Measure and					
	*	ternal length of the					
		ch dressing change."					
		en er essemb enumber					
	14. The agency'	s undated policy titled					
		ssing Change," # I-240					
		entation Guidelines 1.					
	•	e clinical record: d.					
		er visible at exit site. e.					
	Any physician n						
	This physician in	ourieuren.					
	15. The agency'	's policy titled "Care					
		reviewed March 2015					
	•	Care Plan shall include,					
	•	ed to: a. Problems and					
		related to diagnosis					
	-	ific interventions with					
		nentation 4. The					
	1 2	of Care may be used as a					
		ific interventions are					
	-	d for home care staff to					
	address client ca	re needs State of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W.	ING		11/19/	/2015
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			WEBSTER ST		
GREATI	AKES CARING				10, IN 46902		
					10, 11 10002		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCY)		DATE
		um: The nursing plan					
		tain: 1. A plan of care					
	and appropriate	patient identifying					
	information, 5. Medications, diet, and acclivities."						
	16. The agency	16. The agency's policy titled					
	"Venipuncture for Blood Specimen						
		140, revised 7/30/14					
	· ·	Oraw from Central					
	· · · · · · · · · · · · · · · · · · ·						
	Venous Access Devices Procedure:						
	1. Review Physician order. 2. Use strict						
	sterile technique	e."					
	17. The agency	's policy titled					
	"Coordination o	f Client Services," #					
	C-360, reviewed	d March 2015 stated, "3.					
	After the initial	assessment, the admitting					
		e/Therapist shall					
	•	e findings of the initial					
		inical Supervisor to					
		ification of the plan of					
		e. Need for other					
		referral to community					
	resources."						
	18. The agency	's policy titled "Encoding					
	and Reporting C	OASIS Data," # B-250,					
		2015 stated, "2. Data					
		at status at time of					
	assessment."	at time of					
	ussessificit.						
	10 The agency	la policy titled					
	19. The agency						
	"Comprehensive	e Client Assessment," #					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING			COMPLETED 11/19/2015		
NAME OF F	PROVIDER OR SUPPLIER	-			DDRESS, CITY, STATE, ZIP CODE WEBSTER ST		
GREAT L	AKES CARING				10, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	C-145, reviewed Reassessments a client needs, phy professional judg other regulatory 20. The agency's Recertification/F of Care," # C-15 stated, "5. Each will be responsible care/services at 1 sixty (56-60) day receiving skilled 21. The agency's Documentation, March 2015 state that there is an asservices provide ongoing need for conformance with modifications to interdisciplinary 22. The agency's Record Confider reviewed March Authorized users b. Staff members	March 2015 stated, "16. re conducted based on sician orders, gment and/or OASIS or requirement." s policy titled "Client follow-Up/Resumption 5, reviewed March 2015 professional discipline ple for reassigning east every fifty-six to ys while the client is services." s policy titled "Clinical "# C-680, reviewed ed, "Purpose To ensure eccurate record of the d, client response and recare. To document the Plan of Care, the plan, and involvement." s policy titled "Clinical extraction of the dintiality," # C-880,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING 00 COMPLETED B. WING 11/19/2015			ETED	
		157586	B. W.		ADDRESS, CITY, STATE, ZIP CODE	11/19/	2015
NAME OF F	PROVIDER OR SUPPLIER				WEBSTER ST		
GREAT L	AKES CARING			KOKOM	/IO, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
TAG N 0614 Bldg. 00	410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) information shall be loss or unauthorize procedures shall grecords and condition information. Patient be required for releauthorized by law be maintained at the from which the set the patient is disched Closed files may be parent or branch or returned to the off hours. Closed files if the service. Based on record the agency failed confidentiality of allowing an acquiservices to 26 of on both the Sout patient list and the active patient list active patient list and the active patient list and the active patient list and the active	Clinical record be safeguarded against ed use. Written govern use and removal of tions for release of nt's written consent shall ease of information not Current service files shall he parent or branch office rvices are provided until harged from service. be stored away from the office provided they can be dice within seventy-two (72) do not become current patient is readmitted to review and interview, If to ensure the f medical records by hired agency to provide for active patients listed the Bend branch active the acquired agency's to (# 16, 26, 27, 28, 29, 4, 35, 36, 37, 38, 39, 40, 5, 46, 47, 48, 49, 50, and cord reviewed chosen the agency's Outcome Information Set (OASIS) do failed to ensure an the agreement was in place office in Michigan to atta to the State agency	NO		To ensure compliance with 41 IAC 17-15-1(c): Clinical Reconthe following interventions have been implemented: As of November 6th 2015, a contractarrangement was secured between the agency referred to as Great Lakes Caring CCN 157586 (agency) and the acquired agency of AC and Associates dba Great Lakes Caring (acquired agency) for the provision of Home Health Services such as PT, OT, SLP SN, MSW and HHA. As of November 6th 2015, a contractarrangement was secured between the Great Lakes Caring Corporate office and the agency to submit OASIS data to the state. As of December 3rd 2015-All agency South Bend branch patients were assigned.	0 ds e tual o	DATE 12/23/2015

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		A. BUILDING 00 B. WING		COMPLETED 11/19/2015		
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		
GREAT L	AKES CARING			5 S WEBSTER ST KOMO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION DATE
	Findings include 1. During interv PM, the Administ of the current So serviced by an ag been acquired by Corporation. The on the South Berlist and also on the active patient list agency did not acplans. The Administrator acquired agency number. 2. During interv AM, the Admining a contract or acquired agency South Bend patients stated the acquired stated the acquired agency South Bend patients accorporation acquired agency acquired agency South Bend patients accorporation acquired acq	iew on 11/5/15 at 1:40 strator stated that some uth Bend patients were gency in Warsaw that had the Great Lakes ese patients were listed and branch active patient the acquired agency's the due to the acquired accept the insurance inistrator stated that the had its own provider iew on 11/6/15 at 10:15 strator stated there was an agreement for the to provide services to the ents. The Administrator ed agency staff were ployees. The lated when the agency provider the Bend branch provided counties already serviced		the correct South Bend RN Clinical Supervisor. · As of November 15th, 2015 – no ne patients were accepted to set for the agency that would normally be admitted to the acquired agency's provider number. · As of 12/23/15 – A 'acquired agency's' patients were discharged from the agency. audit will be performed by the administrator/designee of 100 of all new South Bend admiss with a SOC date on or after November 15th for a period of weeks. After 8 weeks of 1009 compliance, the audit will decrease to 10% quarterly ar will be completed through the clinical record review process (Exhibit 1)	ew rvice An e D% sions of 8	
		n them, but the acquired				

	OF CORRECTION	IDENTIFICATION NUMBER: 157586	A. BUILDING B. WING	00	COMI	PLETED 9/2015
	PROVIDER OR SUPPLIER LAKES CARING		3115 S	ADDRESS, CITY, STATE, ZIP C WEBSTER ST MO, IN 46902	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Administrator st acquired agency medical records provide services patients were als Bend branch ros A. The South B compared with the	ot bill the patients. The ated the staff at the did have access to the of the patients they for, even though the o listed on the South ter. end active roster was he acquired agency's oss referenced on 11/5				
	and 11/6/15. Pa	tients listed on the South er and also the acquired				
	# 26, start of 10/27/15 # 27, SOC 10 # 28, SOC 10 # 29, SOC 7/ # 30, SOC 9/2 # 31, SOC 8/ # 32, SOC 9/2 # 33, SOC 10 # 35, SOC 9/2 # 36, SOC 10 # 37, SOC 10 # 38, SOC 9/2 # 40, SOC 10 # 41, SOC 10 # 42, SOC 8/ # 43, SOC 11	0/18/15 18/15 26/15 14/15 26/15 0/26/15 0/3/15 22/15 0/27/15 0/24/15 10/15 11/15 0/3/15				

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		r í		NSTRUCTION	(X3) DATE SU		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLET	ΓED
		157586	B. W	ING		11/19/2	015
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	KOVIDER OR SUPPLIER			3115 S	WEBSTER ST		
GREAT I	AKES CARING			KOKOM	1O, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE '	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	# 44, SOC 10						
	# 45, SOC 10						
	# 46, SOC 3/24/15						
	# 47, SOC 9/						
	# 48, SOC 9/2						
	# 49, SOC 9/2						
	# 50, SOC 7/5	,					
	# 51, SOC 9/2	26/15.					
	B. During interview on 11/6/15 at						
		Administrator provided					
	the South Bend	•					
		ated this roster was only					
		whom South Bend					
	_	This roster failed to					
	evidence patient						
	punton	J = 0 01.					
	3. During interv	view on 11/6/15 at 11:12					
	AM, the Admini	strator indicated the					
	acquired agency	had their own					
	Administrator ar	nd Clinical Supervisor,					
	but she was also	the Alternate					
	Administrator fo	or the acquired agency.					
	4. During interv	view on 11/6/15 at 11:30					
	AM, the Admini	strator stated since the					
	staff at the acqui	red agency were all					
	Great Lakes emp	oloyees, there was not a					
		fidentiality of medical					
		lministrator stated the					
		nch was approved for					
		efore other provider					
		uired. The Administrator					
	_	es acquired the Warsaw					

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i i		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU B. W		00		
		157586	D. W			11/19/	2015
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CDEATI	_AKES CARING				WEBSTER ST 10, IN 46902		
			-	<u> </u>	10, 111 40302		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	 	er number in October,					
	2014.	or manneer in October,					
	5. The clinical record for patient # 16						
		n 11/9 and 11/16/15 and					
		n the OASIS list for					
		ound Status and was					
	1	had been a patient of the					
	_	nch. Patient # 16 lived in					
	the territory serv	viced by the acquired					
	agency. The patient was discharged to						
	hospice on 5/8/15.						
	A. On 11/16	/15 at 11:35 AM, the					
	Administrator st	ated the acquired agency					
	maintains the ch	arts for all the patients					
	they provided se	ervices for and patient #					
	16 was provided	most services by the					
	acquired agency						
	B. During in	nterview on 11/16/15 at					
	12:05 PM, the A	Administrator stated					
	_	nanaged by the acquired					
		South Bend branch had					
	no involvement	in the care.					
	g	0 1 . 1					
	C. The plan						
		th start of care date					
		ed orders for skilled					
		ime a week for 9 weeks					
		visits for pain, falls,					
	respiratory/cardi						
		gastrourinary, and					
	integumentary c	omplications; Physical					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157586		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	COM	(X3) DATE SURVEY COMPLETED 11/19/2015			
	OF PROVIDER OR SUPPLIED	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION DATE		
	times a week for Therapy (OT) 1 times a week for 1 week; Medica for 1 week; Medica for 1 weeks; Home times a week for week for 2 weeks. D. The reco was provided Sn acquired agency 5/5/15 by employee PP. E. The reco was provided H acquired agency 4/6, 4/8, 4/10, 4/13, 4/10, 4/18, 5/5, and 5/1 by employee PP. F. The reco was provided Pracquired agency 4/6, 4/3, 4/6 and 5/1/15 by employee PP. G. The reco was provided Pracquired agency SS; 4/1, 4/3, 4/6 and 5/1/15 by employee PP.	rd evidenced patient # 16 N services from the on 3/23, 4/14, 5/1, and oyee QQ; 3/30, 4/3, 4/7, o, 4/21, 4/24, 5/6, and oyee NN; and 4/28/15 by rd evidenced patient # 16 HA services from the on 3/25, 3/27, 3/30, 4/1, o/15, 4/17, 4/21, 4/24, oyee LL. rd evidenced patient # 16 T services from the on 3/26/15 by employee						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		157586	B. W.	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	ROVIDER OR SULTER	X.		3115 S	WEBSTER ST		
GREAT L	AKES CARING			KOKOM	1O, IN 46902		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	Berielewery		DATE
	(D : : :	. 11/12/15 . 12 10					
	_	view on 11/13/15 at 12:40					
	PM, the Administrator stated the OASIS						
		done by the nurses or					
		he Corporate office in					
	Michigan submi	ts the data to the State					
	agency.						
	7 During intern	view on 11/16/15 at 10:30					
	_	istrator stated the agency					
	· ·	0 ,					
		nd agreement or contract					
		office to submit OASIS					
	data to the State	agency.					
	Q The agency's	policy titled "Encoding					
	"	OASIS Data," # B-250,					
		2015 stated, "GLC will					
	_	port all OASIS data					
		lance with federal					
	_	C and agents acting on					
		vill ensure confidentiality					
		eific information in the					
	clinical record."						
	9 The agency's	policy titled "Minimum					
	"	osures of Protected					
	1						
		ion," # C-385, reviewed					
		red, "Routine and					
	recurring disclos						
		GLC has identified					
		ealth information it					
	makes on a routine and recurring basis						
		ted to treatment. 2. GLC					
	has determined t	the minimum amount of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		157586	B. WING		11/19/2015	
	PROVIDER OR SUPPLIE	R	3115 S	ADDRESS, CITY, STATE, ZIP CODE WEBSTER ST MO, IN 46902	ı	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
IAG	heath information achieve the purp Non-routine disinformation representations requested is the necessary if the official, a health plan, a profession GLC as a busing researcher (who documentation) medical records an individual's of fulfillment of art treatment for an justification for documented." 10. The agency Record Confider reviewed March Authorized user b. Staff member providing and state of the providing and sta	on that is needed to cose of these requests closures of health 3. GLC relies on that the information minimum a mount request if from a public n care provider, a health conal providing service to cess associate, or a co provides appropriate Disclosures of entire GLC does not disclose centire medical record in my request not related to my reason unless a such a disclosure is "s policy titled "Clinical mitality," # C-880, n 2015 stated, "1. "s will be identified as: "ers and contract staff upervising client care."	IAG	DEPLIENCY	DATE	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	COMPL		
		157586	B. W	ING		11/19/	/2015
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP CODE	•	
GREAT I	AKES CARING				WEBSTER ST IO, IN 46902		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ut your health, social and		IAG			DATE
		stances or about what					
	takes place in yo	our home State of					
	Indiana Addenda	um: Sec. 3. (a) The					
	patient or the par	tient's legal					
	representative ha	as the right to be					
	informed of the	patient's rights through					
	effective means	of communication. The					
		ncy must protect and					
	1 *	rcise of these rights and					
		owing: (2) Maintain					
		howing it has complied					
	_	nents of this section					
	` '	lity of the clinical records					
		ne home health agency.					
		agency shall advise the					
		ency's policies and					
		ding disclosure of					
	clinical records.'	'					
	12. The agency'	s policy titled					
	_	f electronic Data," #					
	1	March 2015 stated, "4.					
		y These procedures					
		reas, which contain					
	-	rk equipment to those					
		d "need to know" 2.					
	_	olicy a. Scope. i.					
		es to all data maintained					
	or created by ent						
	l "	LC. This includes but is					
	· ·	ata maintained within: 1.					
		ted by GLC information					
	systems departm	ent Basic Code of					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		(X3) DATE SURVEY COMPLETED			
		157586	B. W	ING		11/19/	/2015	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE					
GREAT LAKES CARING			3115 S WEBSTER ST KOKOMO, IN 46902					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE	
		Computer Security Ethics 1. Every						
	effort will be made to restrict access to							
	data and facilities to those people with a							
	need-to-know."							
	13. The agency's policy titled "Clinical							
	Supervision," # C-300, reviewed March							
	2015 stated, "Policy Skilled nursing and							
	other therapeutic	e services are provided						
	under the supervision of a Registered							
	Nurse. The Regional Director/Clinical							
	Manager will be available to provide							
	ongoing supervision during the operating							
		Under no circumstances						
	will the administrative or supervisory							
	responsibilities be delegated to another							
	organization. Purpose To meet the							
		tate/federal guidelines						
		ervision and direction to						
		ng home health care						
	services. To ass							
	1 ^	ppropriately supervised,						
	that care is direc	goals, and that services						
	l '	ed on client need and in						
		the physician's Plan of						
		l Instructions 1. The						
	1	or/Clinical Manager shall						
	~	or the quality of care						
	_	pervision of all staff						
	1 ^	eutic services, including						
		le/she will also be						
		organizing and directing						
	GLC's ongoing functions. 2. The							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED		
		157586	B. WING			11/19/2015	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e	3115 S WEBSTER ST				
GREAT LAKES CARING			KOKOMO, IN 46902				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE COMPLETI COMPLETI DEFICIENCY) DATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	Regional Director/Clinical Manager shall						
	coordinate the day-to-day operation of						
	the organization	and work with the					
	Administrator. 3. The Clinical						
	Supervisor will participate with the						
	Regional Director/Clinical Manager in all						
	activities relevant to the professional						
	services furnished. This includes the						
	development of qualification and the						
	assignment of personnel."						

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