PRINTED:	11/27/2018
FORM API	PROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FOR	MEDICARE & MEDI	CAID SERVICES			OM	B NO. 0938-039
	T OF DEFICIENCIES DF CORRECTION	CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> 157681 B. WING			(X3) DATE SURVEY COMPLETED 10/02/2018	
	ROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500 0	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT. (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	5110012	DATE
0000						
Bldg. 00	conducted by the I Health in accordar Home Health Ager recertification surv complaints.	eparedness Survey was ndiana State Department of ice with 42 CFR 484.22 for a ncy Federal and State rey and investigation of 2 9/21/18, 9/24/18 - 9/28/18,	E 0000			
	10/1/18-10/2/18 Facility # 013593					
	Federal# 157581					
	Medicaid #: 20128	4430				
		stantiated with findings stantiated with findings				
	12 Month Undupli	cated Census: 257				
	Home visits with r	ecord review: 3				
	Records reviewed	without home visit : 4				
	Total records revie	wed: 7				
	and Disabled Hom be in compliance v	Preparedness survey, Aging e Health Care LLC was found to vith Emergency Preparedness Medicare Participating Providers				
G 0000						
LABORATOR	Y DIRECTOR'S OR PRO) VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE		(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

PRINTED: 11/27/2018 FORM APPROVED

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157681	A. BU B. WI	IILDING NG	00	COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIEF	HEALTH CARE LLC		10500 C	DDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, APOLIS, IN 46256		
(X4) ID				ID	DROVIDED'S DI AN OF CODDEC	FION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPF	.D BE	COMPLETIO
TAG Bldg. 00	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	survey with investig Dates of survey: 9/ 10/1/18-10/2/18 Facility # 013593 Federal # 157581 Medicaid #: 201284 Complaints # IN 00243261: Subs IN 00220561: Subs 12 Month Unduplic Home visits with re Records reviewed w Total records review Aging and Disabled precluded form doin aide training and co for a period of 2 yea 10/02/2020 for bein Conditions of Partic Patient Rights, 484.	tantiated with findings tantiated with findings ated Census: 257 cord review: 3 vithout home visit : 4 ved: 7 I Home Health Care, LLC is ng it's own its own home health mpetency evaluation program ars beginning 10/02/2018 to ng out of compliance with the cipation for 42 CFR 484.50 60 Care Planning, Coorination,	G 0	000			
G 0406		4.80 Home Health Aide Service, ization and Administration of					
Bldg. 00							

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681		PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILE		AN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00			(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛTE	(X5) COMPLETIC DATE	
	failed to maintain of of Participation of failure to provide of patient's family have patient's rights (See all services outline were provided (See the patient in writh for HHA services of federally-funded p to investigate comp and not provided a (See Tag G 480), f and resolve complation The cumulative effi resulted in the hom provide quality hea	view and interview, the agency compliance with the Condition Patient Rights as evidenced by locumentation the patient or the d received written notice of e Tag G 422), failure to ensure d in the POC (Plan Of Care) we Tag G 436), failure to inform ng the extent to which payment may be expected from rograms (See Tag G 440), failure plaints of care that was needed s ordered on the plan of care ailure to document, investigate aints (See Tag G 484). Fect of these systemic problems ne health agency's inability to alth care in a safe environment of Participation at 42 CFR 484.36,	G 0	406	G 406 The Administrator or designee will immediately rev all active patient records for evidence that the patient and legal representative received notice of their rights in a langu and manner the individual understands during the initial evaluation, and if not obtained during this initial evaluation, w correct the deficiency by obta evidence that the deficiency h been corrected by obtaining a Home Health Admission Serv Agreement signed by patient or legal representative. The agency will immediately of accepting referrals without approval of the DON. The administrator or designee will immediately review all active clinical records for evidence th all services in the POC are be provided. If there is evidence the POC is not being followed DON will call the PCP for a ve order to update the plan of ca and the POC will be updated the clinical record and sent to PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON call the patient and offer to tra- them to an agency that can provide all services in the POC patient agrees to be transferre another agency the DON will facilitate a transfer to an agency the patients choice. The DON	or Jage J vill ining as new ice and do hat that the brbal re in the ov will unsfer C. If ed to cy of	11/30/20	

	MEDICARE & MEDI				OMB NO. 0938-03
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 10/02/2018
NAME OF PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD,	10/02/2010	
AGING &	DISABLED HOM	E HEALTH CARE LLC		NAPOLIS, IN 46256	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETIO DATE
				review all new referrals to ens	
				that before acceptance of refe	
				the agency can reasonably me	
				the needs of the patient before	
				acceptance of such referral. T	
				DON will sign off on all accept referrals as evidence that she	54
				reviewed the referral.	
				The administrator or designee	will
				immediately review all active	
				clinical records for evidence th	e
				patient or legal representative	was
				informed of the extent of paym	
				from federally funded program	
				no documentation exists in the	
				patients clinical record the RN case manager will review this	
				the patient and obtain evidence	
				obtaining a new Home Health	c by
				Admission Service Agreement	as
				evidence that this was reviewe	
				with the patient or the legal	
				representative.	
				The phone message system w	/ill
				be updated immediately to inc	
				the Administrators number in t	he
				event that a patient or family	la int
				member wishes to file a comp and all complaints will be	am
				forwarded to the Administrator	or
				designee and will be documen	
				investigated, with resolution a	
				logged in the complaint log bo	
				The DON or designee will edu	
				administration/management, a	
				clinicians on agency policy "Pl	an
				of Care," "Client/family	
				Complaint/grievance policy," " The Home Health Admission	

	R MEDICARE & MEDI					-	MB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	ì í	E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681		A. BU B. WI	ILDING	00		PLETED 2/2018	
		137081	D. WI			10/02	2/2018
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					CROSSPOINTE BLVD,		
AGING 6		E HEALTH CARE LLC		INDIAN	IAPOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	-	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG			DATE
					Service Agreement," " Patier Rights"	Its	
					Rights		
					To prevent this deficiency in	the	
					future, the Administrator or		
					designee will be responsible	for	
					active clinical record audits u	until	
					100% compliance is met the	n 10	
					% of all clinical records will b		
					audited quarterly for evidence	e after	
					100% compliance is met to		
					ensure that this deficiency w	ill not	
					reoccur.		
					Education completed on		
					11/08/2018.		
G 0422							
Bldg. 00							
Diag. 00			G 04	172			11/30/201
	Based on record re	eview and interview, the agency	0.0		G 422 The Administrator or		11/50/201
		ocumentation that the patient or			designee will immediately re	view	
	the patient's family	had received written notice of			all active patient records for		
	the patient's rights	for 1 of 1 patient's (Patient' # 5			evidence that the patient and	d or	
) in a sample of 7	clinical records reviewed.			legal representative received		
					notice of their rights in a lang	juage	
	Findings Include:				and manner the individual		
	An aconover 1	titled "Home Core Dill of			understands during the initia		
		titled, "Home Care Bill of ved and stated, "Clients will be			evaluation, and if not obtaine during this initial evaluation,		
	U U	ights as a consumers of home			correct the deficiency by obt		
		include the right to voice			evidence that the deficiency	-	
		uest changes without			been corrected by obtaining		
		orisal or unreasonable			Home Health Admission Ser		
		vices1. A designated			Agreement signed by patien		
	_	Therapist shall provide the			or legal representative and t		
		en notice of the Home Care Bill			documentation will be added		
	of Rights in advan	ce of furnishing care to the			the patients clinical record.		

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (2 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O client or during the treatment is initiate unable to make dee Rights shall be giv 2. The client/care and in writing or th Documentation of Bill of Rights will record" The clinical record care date of 6/19/1 12/141/6. The clin contain a copy of the The administrator 1:58 PM regarding produce copies of clinical record. Th	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> e initial evaluation visit before ed. In the event that the client is cision, the Home Care Bill of en to the client's legal guardian egiver shall be advised orally neir right to voice grievances the receipt of the Home Care be maintained in the clinical d of Patient # 5 with a start of 6 and a discharge date of ical record failed to evidence a he patient's rights. was interviewed on 10/1/18 at t the failure of the agency to the patient's rights in the e administrator was unable to rr documentation of the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The DON or designee will educa all clinicians on agency policy titled: Home Care Bill of Rights Home Health Admission Service Agreement To prevent this deficiency in the future, the DON will review each new admission with the RN that performed the initial comprehensive assessment to ensure all documentation of patient rights was reviewed verbally with the patient or legal representative and written documentation of this was obtained during this assessment, the Administrato or designee will be responsibl for all active clinical record audits until 100% compliance met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency wil not reoccur.	ate	
G 0434 Bldg. 00	failed to inform the disciplines and the	view and interview, the agency e patient in writing the frequency of the services to be c clincial record reviewed in a sample of 7.	G 0434	Education completed on 11/08/2018. G 434 The Administrator or designee will immediately review all active clinical records for documentation of Patients' Righ to be informed of all services		

	R MEDICARE & MEDI				-	IB NO. 0938-0
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,	CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681		IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	
		157681	B. WING		10/02	/2018
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COD		
				CROSSPOINTE BLVD,		
AGING 8		E HEALTH CARE LLC	INDIA	NAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	RIATE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				including disciplines involved		
	Findings Include:			care, frequency of visits, and		
				duration of care. If document	tation	
		cy titled, "Home Care Bill of		is not present in the clinical		
	-	ved and stated, "Clients will be		record, documentation of a r		
		ights as a consumers of home		Home Health Admission Ser		
		include the right to voice		Agreement acknowledging th		
		uest changes without		patients' rights were given to		
	· · ·	orisal or unreasonable		patient or legal representativ	e will	
		vices1. A designated		be obtained by the RN case	· f	
	-	Therapist shall provide the		manger to document correct	ion of	
		en notice of the Home Care Bill		this deficiency.		
		ce of furnishing care to the		The DON will educate	- 11	
	-	e initial evaluation visit before ed. In the event that the client is		administration/management,	all	
				clinicians on agency policy:	alata	
		cision, the Home Care Bill of en to the client's legal guardian		Home Care Bill of Rig Home Health Admiss	•	
		egiver shall be advised orally			ION	
		neir right to voice grievances		Service Agreement To prevent this deficiency in	the	
	-	the receipt of the Home Care		future, the DON will review e		
		be maintained in the clinical		new admission with the RN t		
	record"	be maintained in the enniear		performed the initial	Ilat	
				comprehensive assessment	to	
	2 The clinical reco	ord of Patient # 2 with a start of		ensure all documentation of		
		8 and a certification period of		patient rights was reviewed		
		was reviewed. The clinical		verbally with the patient or le	nal	
		document titled, Home Health		representative and written	941	
		e Agreement" dated 3/14/18.		documentation of this was		
		form to indicate services,		obtained during this assessn	nent.	
		ation was blank and not		the Administrator or designe		
	completed.			be responsible for all active		
				record audits until 100%		
	3. The clinical reco	ord of Patient # 5 with a start of		compliance is met then 10 %	of all	
		6 and a discharge date of		clinical records will be audite		
		ical record failed to evidence a		quarterly for evidence after 1		
	contain a copy of t			compliance is met to ensure		
	15			this deficiency will not reocci		
	4. The administrat	tor was interviewed on 9/26/18				
		ing the incomplete service		Education completed 11/08/2	2018.	
	-	s in the clinical record of				

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00			(X3) DATE SURVEY COMPLETED			
		157681	B. W		<u></u>	10/02/2	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	•	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETIO DATE
	what's wrong. I yel 5. The administrat at 1:58 PM regardi produce copies of t clinical record for was unable to prod	administrator stated, "I see led at them about this." or was interviewed on 10/1/18 ng the failure of the agency to he patient's rights in the Patient # 5. The administrator uce any further documentation tts in the clinical records.					
G 0436							
	agency failed to en POC (Plan Of Card (Patient #1) record SN (Skilled Nurse) 2, 4 and 5) record of HHA (Home Healt patients. Findings Include: 1. A policy titled, and stated, "Home under the supervisi physician. The plan comprehensive ass provided by the clii members The pl to ensure that clien updated as necessa days The plan of to include: c. Type visits/services k requirements or rest treatments, and pro-	view and interviews, the sure all services outlined in the e) was provided in 1 out of 4 I reviewed of patients receiving and 4 of 4 patient (Patients # 1, reviewed of patients receiving h Aide) in a sample of 7 "Plan of Care" was reviewed care services are furnished on and direction of the client's n of care is based on a essment and information ent/family and health team an will be consistently reviewed t needs are met and will be ry, but at least every sixty (60) f care shall be completed in full , frequency, and duration of all Specific dietary or nutritional strictions. Medications, becdures p. Treatment goals fication and recertification, a	G 0	436	G 436 The administrator or designee will immediately revie all active clinical records for evidence that all services in the POC are being provided. If the is evidence that the POC is not being provided as per POC, the DON will call the PCP for a ver order to update the plan of care and the POC will be updated in the clinical record and sent to th PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON w call the patient and offer to tran- them to an agency that can provide all services in the POC patient agrees to be transferred another agency the DON will facilitate a transfer to an agence the patients choice. The DON w make a communication note in clinical record of this conversat as evidence that the patient wa informed of their right to transfe another agency if A and D is unable to provide the services of	ew erre t bal e bal e he vill asfer c. If d to ey of will the cion as er to	11/30/201

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	157681	B. WING	<u> </u>	10/02/2018
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP COD	
		E HEALTH CARE LLC		0 CROSSPOINTE BLVD, ANAPOLIS, IN 46256	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE
TAG		DR LSC IDENTIFYING INFORMATION of the client's current status and	TAG		DATE
	-	provided are submitted with		patient needs. The DON or designee will e	ducate
	-	r review. The summary shall		administration/managemen	
	-	limited to: changes in clients		clinicians on policy:	t, an
		osocial condition, client		Plan of Care	
		ervices and outcome of care			
	-	ofessional staff shall promptly		To prevent this deficiency in	n the
		to any changes that suggest a		future, the DON will review	
	need to alter the pl	lan of care"		referrals to ensure that before	
				acceptance of referral the a	igency
		ord of patient # 1 with a SOC		can reasonably meet the ne	eeds of
		of 7/18/16 was reviewed with		the patient before acceptan	ce of
	the following find	ings:		such referral. The DON will	-
				on all accepted referrals as	
		ertification period of 7/18/16 to		evidence that she reviewed	
		orders for skilled nurse 5 times a		referral. The Administrator	
		(a tube in the stomach where		designee will be responsible	
		provided) feedings while the c and HHA services 6 times a		active clinical record audits 100% compliance is met the	
	-	ed to provide services until		% of all clinical records will	
		fter the SOC. The HHA provided		audited quarterly for eviden	
		week 1-2 and 3 times week 6 of		100% compliance is met to	
	the certification pe as ordered.	eriod and failed to conduct visits		ensure that this deficiency reoccur.	
	The POC for the a	ertification period of 9/16/16 to		Education on Plan of Care	was
		orders for SN 5 times a week for		completed on 11/08/2018.	
		while the parent was at work and			
		mes a week for assistance with			
		s. SN services were provided 4			
		6, 3 times during week 7, 0 times			
		d 2 times during week 9 of the			
	certification period ordered.	d and failed to be provided as			
	A communication	note dated 11/1/16 stated, "Due			
		ing difficulties with this patient,			
		assist the family in finding a			
		nother agency at this time family			
		offer. Currently, mother is			

	NT OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP C CROSSPOINTE BLVD, IAPOLIS, IN 46256	COD	
(X4) ID PREFIX		/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	RECTION HOULD BE	(X5) COMPLETIC
TAG	coming home at neutil nursing staff were provided 3 ti certification period ordered. The POC for the c 1/13/17 included of G-Tube feedings at assistance with IA conducted a total of the POC for the ce provide visits as of The POC for the c 3/14/17 included of G-tube feedings ea week for assistance SN conducted a total of the feedings ea week for assistance SN conducted a to period and failed t There were no ord A SN note 3/14/17 (caregiver) of SN intervention, but th not necessary whe administration of th agency office pro- The POC for the c 5/13/17 included of assessment and ins HHA 6 times a we and ADL's. The Si for the weeks 1-3 clinical record fail any HHA visits fo period.	ertification period of 1/14/17 to orders for SN 1 time a week for ach visit and HHA 6 times a e with IADL's and ADL's. The tal of 5 visits in the certification o provide visit as ordered. ers to change the POC. 7 stated, "Informed the cg visits weekly for skilled hat daily is not achievable and n available CG competent in feedings. Encourage to call	TAG			DATE
	The POC for the c	ertification period of 5/14/17 to				

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER		E HEALTH CARE LLC	STREET 10500 INDIAN	COD		
· ,		/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
7/12/17assessinweek forPOC faHHA sievidenciand 2. T4 visitsThe PC9/101/7G-tubedays a videADL's.and 5-9provideconductduring trailed toThe PC11/9/17tube G-days a videADL's.and 4-8week 9provideduring trailed toThe HHA SN nrequestmotherParent trailed tonot bee	r included c nent and HI or assistance iled to inclervices. The edocumer The HHA c during weak of for the c r included c feedings an week for as The SN pr of the cert s visits pe ted 3 visits week 2-9 o provide v OC for the c r included c tube feeding week for as The SN pr of the cert s visits du of the cert as ordered week for as The SN pr of the cert as ordered tube feeding week for as the SN pr of the cert as ordered week s 1-6, week 8 and IA failed to ote dated 9 daily SN to is at work. states at thi cover the o n a daily R	OR LSC IDENTIFYING INFORMATION orders for SN 1 time a week for HA 9 hours a day for 5 days a e with IADL's and ADL's. The ude the duration of the SN and e clinical record failed to tation of HHA visits for week 1 onducted 6 visits week 4-8 and ek 9 of the certification period. ertification period of 7/13/17 to orders for SN 5 times a week for nd HHA 9 hours a day for 5 sistance with IADL's and ovided 1 visit during weeks 2-3 ification period and failed to r week as ordered. The HHA during week 1 and 6 visits f the certification period and isits 5 times weekly as ordered. ertification period of 9/11/17 to orders for SN 5 times a week for ngs and HHA 9 hours a day for 5 sistance with IADL's and ovided 2 visits during weeks 1 uring week 2 and 1 visit during ification period. The SN failed to I. The HHA provided 6 visits 2 visits during week 7, 4 visits 19 of the certification period. oprovided visits as ordered. //11/17 stated, "continues to o cover	TAG			DATE

	R MEDICARE & MEDIC							
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	È É				TE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED		
		157681	B. V	VING		10/	02/2018	
IAME OF	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP (COD		
					ROSSPOINTE BLVD,			
AGING 8	& DISABLED HOME	HEALTH CARE LLC	INDIANAPOLI		APOLIS, IN 46256	OLIS, IN 46256		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO		(X5)	
REFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLET	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ers for SN 5 times a week for						
	-	s and HHA 9 hours a day for 5						
		istance with IADL's and						
		orders present to change the						
		visit during week 7 and 9 of the						
	· · ·	The SN failed to follow the						
	^	visits 2 times during weeks 2-6.						
		conducted during week 1 and 8.						
	^	1 visit week 1 of the						
	-	on 11/10/17, 6 visits during						
		7 to 1/6/18. The HHA failed to						
	provide visits as orc	lered.						
	The POC for the ce	rtification period of 1/9/18 to						
	3/9/18 included ord	ers for SN 5 times a week for						
	tube G-tube educati	on, monitoring and feedings						
	and HHA 9 hours a	day, 5 days a week for						
	assistance with IAD	DL's and ADL's. The SN						
	provided visits 1 tin	ne during week 1 and 2 times						
	during week 2-9 of	the certification period. The SN						
	failed to provide vis	sits as ordered. The HHA						
	provided visits 4 tin	nes a week from 1/9/18 to						
	1/12/18 with 14-hou	ur visits on 1/9/18 and 1/11/18.						
	The HHA provided	visits 5 times a week from						
	1/15/18 to 1/19/18	with 14-hour visits on 1/16/18						
	and 1/18/18. The H	HA provided visits 6 times a						
	week from 1/21/18	to 3/9/18. The HHA failed to						
	provide visits as or	lered.						
	The POC for the ce	rtification period of 3/10/18 to						
		ers for SN 2 times a week for						
	G-Tube education,	monitoring and feedings and						
		, 5 days a week for assistance						
		DL's. The SN provided 1 visit						
		e certification period and failed						
	-	ordered. The HHA provided 6						
	-	1, 2, 3, 4, 6, 8, and 3 visits						
		HHA failed to provide visits						
	as ordered.	-						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CC		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER 157681	A. BUILDING B. WING	00	COMPLETED 10/02/2018	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD,	I	
AGING 8	& DISABLED HOM	E HEALTH CARE LLC		APOLIS, IN 46256		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	ROPRIATE	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ertification period of 5/9/18 to				
		ders for SN 2 times a week for				
		, monitoring and feedings and				
		y, 5 days a week for assistance				
		ADL's. A 14-hour visit on 5/9/18				
		t 5/12/18. The HHA provided 4				
		1 5/13/18 to 5/16/18 and 6 visits				
	2	/18 to $7/7/18$, when the clinical				
		that the patient was in the $\frac{1}{12}$				
	hospital from 5/17	/18 to 6/1/18.				
	The POC for the c	ertification period of 7/8/18 to				
	9/5/18 included or	ders for SN 2 times a week for				
	G-Tube care and c	lressing changes and HHA 9				
	hours a day, 5 day	s a week for assistance with				
	IADL's and ADL's	s. The SN provided 1 visit during				
	week 9 of the cert	ification period and failed to				
	provide visits as o	rdered. The HHA provided 6				
	visits during week	s 1-8 and 3 visits during week 9				
		period. The HHA provided				
		7/8/18, 7/10/18, 7/12/18. The				
	HHA failed to pro	vide visits as ordered.				
	The POC for the c	ertification period of 9/6/18 to				
	11/4/18 included of	orders for SN 2 times a week for				
	G-Tube care and d	lressing changes and HHA 9				
	hours a day, 5 day	s a week for assistance with				
		s. The SN provided 1 visit during				
		ification period and failed to				
	-	rdered. The HHA provided 3				
		1 and 6 visits during weeks 2				
		ication period. The HHA				
	·	visits on 9/6/18, 9/11/8.9/13/18,				
	-	18 and 16-hour visits on 9/9/18				
		HHA failed to provide services				
	as ordered.					
		rization) was requested for				
	-	lministrator provided a PA for				
	the period of 8/8/1	8 to 2/6/19. The administrator				

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET 10500 INDIAN	DD		
(X4) ID SUMM		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF C DELETY (EACH CORRECTIVE ACTION		OULD BE	(X5) COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	DATE	
	record #1. The cur services were requ not 5 times weekly	ent any other PAs for clinical rent PA established the SN ested for 2 times weekly and 7. conducted with the Parent of				
	Patient # 1 on 9/24 reported that he/sh	HAA for the agency, the				
	patient's sibling ca in the role of a HH	n not administer tube feedings IA. Without a nurse to come to parent had to change the				
	reported when the	be feeding schedule. The parent patient had been admitted on ngs had been given in mid day				
	full-time nurse lef	gency. The parent reported the t the agency around November after the agency stopped				
	reported he/she wa	days a week. The parent as told that the agency was g a replacement nurse. The				
	parent reported he patient's nurses an	/she had reported to the d to the agency that he/she lays a week, but the staffing				
	concern had not be parent reported a r	een addressed or resolved. The nurse had told him/her that a				
	him/her that Medi	essary and another nurse told caid had denied the prior nurse 5 times a week.				
	sibling and full-tin	conducted with Patient # 1's ne HHA on 9/25/18 at 1:50 PM. ed the parent administered the				
	G-Tube feedings f for work. The tube	or Patient #1 before he/she left e feeding schedule had been ernoon when the parent came				
	home and then at l since he/she was v	bedtime. The sibling reported working as a HHA it was not be of practice to give the tube				
		eported they have not had a				

SUMMARY STAT ACH DEFICIENCY M GULATORY OR LSC for 2/1/2 years and y would get a nurse k. The sibling repo A visits for 5 times terview was condu- istrator on 9/24/18 istrator was asked igation regarding t 5 days a week for rent is at work. Th mplaints had not b mplaint log. The a e had not been mad d this service. The of the missed visit OC for SN and HH			10500	(EACH CORRE CROSS-REFERE	TE BLVD,	CTION ULD BE		(X5) PLETIO ATE
ACH DEFICIENCY M GULATORY OR LSC for 2/1/2 years and y would get a nurse k. The sibling repo A visits for 5 times terview was condu- istrator on 9/24/18 istrator was asked igation regarding t 5 days a week for rent is at work. Th mplaints had not b mplaint log. The a c had not been mad d this service. The of the missed visit OC for SN and HH ed there was no fur	IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION I have been told the the for the feedings 5 days orted she/he had been told a week had been denied. A week had been		PREFIX	(EACH CORRE CROSS-REFERE	ECTIVE ACTION SHOU ENCED TO THE APP	ULD BE		PLETIC
for 2/1/2 years and y would get a nurse k. The sibling repo A visits for 5 times terview was condu- istrator on 9/24/18 istrator was asked igation regarding t 5 days a week for rent is at work. Th mplaints had not b mplaint log. The a e had not been mad d this service. The of the missed visit DC for SN and HH ed there was no fur	d have been told the e for the feedings 5 days orted she/he had been told a week had been denied. a week had been denied. a teted with the 8 at 2:35 PM. The if there was a complaint the family's reported SN G-Tube feedings while the administrator reported been reported or logged in dministrator reported le aware the family still administrator was made ts and the failure to follow 'A visits. The administrator		TAG		DEFICIENCY		E	ATE
y would get a nurse k. The sibling report visits for 5 times terview was condu- istrator on 9/24/18 istrator was asked igation regarding t 5 days a week for rent is at work. The mplaints had not b mplaint log. The a c had not been mad d this service. The of the missed visit DC for SN and HH ed there was no fur	e for the feedings 5 days orted she/he had been told a week had been denied. A							
f 9/28/15 and a cer 1/18, with services days a week for as s was reviewed wi	Patient # 2 with a SOC rtification period of 7/14/18 s to include HHA 8 hours a ssistance with IADL's and ith the following findings:							
cation period rangi or a weekly total of	ing from 3 to 11 hours a f 46 hours. The HHA failed							
HA provided visit cation period rangi veekly total of 33 l m the visits as orde	ts 4 days in week 5 of the ing from 8-9 hours a day hours. The HHA failed to ered.							
ca or fc Ca vo	ation period rang a weekly total of orm the visits as of IA provided visit ation period rang eekly total of 33 n the visits as ord	IA provided visits 6 days in week 4 of the ation period ranging from 3 to 11 hours a a weekly total of 46 hours. The HHA failed orm the visits as ordered. IA provided visits 4 days in week 5 of the ation period ranging from 8-9 hours a day eekly total of 33 hours. The HHA failed to a the visits as ordered. IA provided visits 4 days in week 7 of the ation period ranging from 7-8 hours a day	ation period ranging from 3 to 11 hours a a weekly total of 46 hours. The HHA failed orm the visits as ordered. IA provided visits 4 days in week 5 of the ation period ranging from 8-9 hours a day eekly total of 33 hours. The HHA failed to a the visits as ordered. IA provided visits 4 days in week 7 of the ation period ranging from 7-8 hours a day	ation period ranging from 3 to 11 hours a a weekly total of 46 hours. The HHA failed orm the visits as ordered. IA provided visits 4 days in week 5 of the ation period ranging from 8-9 hours a day eekly total of 33 hours. The HHA failed to a the visits as ordered. IA provided visits 4 days in week 7 of the	ation period ranging from 3 to 11 hours a a weekly total of 46 hours. The HHA failed orm the visits as ordered. IA provided visits 4 days in week 5 of the ation period ranging from 8-9 hours a day eekly total of 33 hours. The HHA failed to in the visits as ordered. IA provided visits 4 days in week 7 of the	ation period ranging from 3 to 11 hours a a weekly total of 46 hours. The HHA failed orm the visits as ordered. IA provided visits 4 days in week 5 of the ation period ranging from 8-9 hours a day eekly total of 33 hours. The HHA failed to in the visits as ordered. IA provided visits 4 days in week 7 of the ation period ranging from 7-8 hours a day	ation period ranging from 3 to 11 hours a a weekly total of 46 hours. The HHA failed orm the visits as ordered. IA provided visits 4 days in week 5 of the ation period ranging from 8-9 hours a day eekly total of 33 hours. The HHA failed to in the visits as ordered. IA provided visits 4 days in week 7 of the	ation period ranging from 3 to 11 hours a a weekly total of 46 hours. The HHA failed orm the visits as ordered. IA provided visits 4 days in week 5 of the ation period ranging from 8-9 hours a day eekly total of 33 hours. The HHA failed to in the visits as ordered. IA provided visits 4 days in week 7 of the ation period ranging from 7-8 hours a day

PRINTED: 11/27/2018 FORM APPROVED OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES 00

DEPARTMENT OF HEALTH AND HUMAN SERVICES CEN

NTERS FOR MED	ICARE & MED	DICAID SERVICES

	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIO DATE
	certification period weekly total of 42 perform the visits a The HHA provided certification period a weekly total of 22 perform the visits a An interview was of administrator on 9/ failure to provide H week as ordered. T I can say the chang doesn't look like th	l visits 3 days in week 9 of the ranging from 4 to 11 hours for 2 hours. The HHA failed to as ordered. conducted with the 26/18 at 2:45 PM regarding the IHA visits 8 hours/ 5 days a he administrator reported, " All es and hours are an error It e aide reported changes in ninistrator had no further					
	date of 3/13/18 and to 9/8/18 and 9/9/1 include SN monthl HHA 3 hours a day	rd of Patient # 4 with a SOC certification period of 7/11/18 8 to 11/7/18, with services to y for aide supervisory visit and r for 4 days a week for IADL's iewed with the following					
		onduct a supervisory visit in the 018. This exceeded the Agency					
	the HHA failed to evidenced by the for during week 1, 1 v	n period of 7/11/18 to 9/18/18, conduct visits as ordered as ollowing missed visits: 3 visits isit during week 2, 1 visit during ring week 5, 6, 7 and 2 visits					
	For the certification	n period of 9/9/18 to 11/17/18,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3. An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind." An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided. 5. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week for assistance with IADL's and ADL's was reviewed with the following findings: During the certification period of 6/19/16 to 8/17/16, the HHA failed to provide 2 hours of care during weeks 3 and 4, 10 hours of care during week 6, and 4 hours of care during weeks 8 and 9. During the certification period of 8/18/16 to 10/16/16, there were no HHA visit notes for weeks 1,2, 3, 4, 5, 6, week. Week 7, 8, and 9 all were missing with the exception of 2-hour notes on 9/29/16, 9/30/16, 10/3/16 and 10/13/16. During the certification period of 10/17/16 to 12/14/16 the HHA failed to provide 10 hours during week 1, 18 hours during week 2, 18 hours during week 3 and with the exception of a 2-hour visit on 12/6/18. There were no further HHA notes for the certification period. Event ID: 106K11 Facility ID: 013593 Page 17 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	DATE SURVEY COMPLETED 10/02/2018
	PROVIDER OR SUPPLIEI	R E HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0440 Bldg. 00	An interview was c Administrator on 1 absence of HHA no orders to change th reported he/she was during that time pe no additional inform Based on record re- failed to inform the which payment for from federally-fund record reviewed (P 7. Findings Include: 1. An agency polic Rights" was review informed of their ri care services. This grievances and requ discrimination, rep- interruption of serv Registered Nurse/T client with a writter		G 0440	G 440 The Administrator or designee will immediately review all active clinical records for evidence that the Patients' Rights including the disciplines to be provided, frequency, duration of services and the expected payment from federal-funded programs. If documentation is not present in the clinical record, documentation will be obtained to document correction of this deficiency. The DON or designee will educat administration/management, all clinicians on policy: Home Care Bill of Rights Home Health Admission Service Agreement To prevent this deficiency in the	11/30/2018
	client or during the treatment is initiate unable to make dec Rights shall be give 2. The client/care and in writing or th Documentation of the	initial evaluation visit before d. In the event that the client is cision, the Home Care Bill of en to the client's legal guardian giver shall be advised orally eir right to voice grievances the receipt of the Home Care be maintained in the clinical		future, the DON will review each new admission with the RN that performed the initial comprehensive assessment to ensure all documentation of patient rights was reviewed verbally with the patient or legal representative and written	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	È É	JILDING	ONSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		TTION JLD BE ROPRIATE	(X5) COMPLETION DATE	
G 0480	record" 2. The clinical rec care date of 9/28/1 7/14/18 to 9/11/18 record contained a Admission Service The "rates for servindicate payment of federally funded p and duration was th 3. The clinical recording care date of 6/19/1 12/14/16 was revie contain a copy of th The administrator 4:00 PM regarding agreement that wa Patient's # 2 . The what's wrong. I ye 4. The administration at 1:58 PM regarding produce copies of clinical record for was unable to proce	ord of Patient # 2 with a start of 8 and a certification period of was reviewed. The clinical document titled, "Home Health e Agreement" dated 3/14/18. ices" section of the form to expectation from the patient/ rograms, services, frequency, plank and not completed. ord of Patient # 5 with a start of 6 and a discharge date of ewed and failed to evidence a			documentation of this wa obtained during this asse the Administrator or desig be responsible for all acti record audits until 100% compliance is met then 1 clinical records will be au quarterly for evidence aft compliance is met to ens this deficiency will not red Education completed on 11/08/2018.	essment, gnee will ive clinical 0 % of all dited er 100% ure that		
Bldg. 00	failed to investigat regards to lack of o	eview and interview, the agency e complaints that were made in care being provided by the linical records reviewed. 15)	G 0	480	G 480 The phone mess system will be updated immediately to include th Administrators number in event that a patient or far member wishes to file a c or grievance and all com	e i the mily complaint	11/30/201	

R MEDICARE & MEDI					-	MB NO. 0938-03
NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 10/02/2018	
REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Findings Include: 1. An agency policy titled, "Client/Family Complaint /Grievance Policy" was reviewed and stated, " Definitions: Client Complaint: A complaint is defined as "any expression of dissatisfaction by a client/family regarding care or services that can be addressed at the time of complaint by staff present" Grievance: A		B. W	STREET . 10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) /grievances will be forwarded the Administrator or designe will be documented, investig, with resolution and logged in complaint log book, complair grievances will be processed according to agency policy. The Administrator will review	d to e and ated, the ht /	(X5) COMPLETIC DATE
complaint by staff grievance is any for expression of dissa that is expressed b solved at that time complaint that fits require a written re complaining Sp complaints will be complaint form an an administrative f above include treat documented on the receiving the comp forwarded as soon director for inves Grievance will be director or his/her the complainant w responsible person calendar days with All persons with a notice of the inves	present" Grievance: A prmal or informal written atisfaction with care or services y the client/family that is not by staff present Any the grievance definition will esponse to the person ecial Instructions 2. Client documented on a client d filed with the complaint log in file. 3. The grievance as defined tment, services will be e grievance form by the person plain/grievances e and as possible to the appropriate estigation action and trending. 4. addressed by the department designee and response made to ithin 7 calendar days and the a will report back within 30 a resolution of the grievance. grievance will receive a written tigators review7. Grievances mpleted when an approved			Client/Family complaint/griev policy. The Administrator or designee will educate administration/management, clinicians on policy: Client/Family complaint/grievance policy To prevent this deficiency in future, all complaints/grievan will be reviewed with the QA committee and Governing Be quarterly for trending of com / grievances. Any trends will investigated and QAPI comn will address any trends ident Education on Client/Family complaint / grievance policy completed 11/08/2018.	ance all the ces PI olaints be nittee	
letters sent are r Quality Designee : data" 2. The clinical reco	:the originally along with the eturned to the administrator or for tabulation and trending of ord of patient # 1 with a SOC of 7/18/16 was reviewed with					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018			
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTIN CROSS-REFERENCED TO T TAG DEFICIENCY		LD BE	(X5) COMPLETIC		
TAG	the following find	PR LSC IDENTIFYING INFORMATION	IAG			DATE		
	9/15/16 included of week for G-Tube (liquid nutrition is p parent was at work week. The SN fail 8/9/16 (21 days) a services 5 times a	ertification period of 7/18/16 to orders for skilled nurse 5 times a (a tube in the stomach where provided) feedings while the x and HHA services 6 times a ed to provide services until fter the SOC. The HHA provided week 1-2 and 3 times week 6 of eriod and failed to conduct visits						
	11/14/16 included G-Tube feedings w HHA services 6 tin IADL's and ADL's times during week during week 8, and	ertification period of 9/16/16 to orders for SN 5 times a week for while the parent was at work and mes a week for assistance with s. SN services were provided 4 6, 3 times during week 7, 0 times d 2 times during week 9 of the d and failed to be provided as						
	to nursing schedul we have offered to nursing care via ar has declined this o coming home at no until nursing staff were provided 3 ti	note dated 11/1/16 stated, "Due ing difficulties with this patient, assist the family in finding a nother agency at this time family ffer. Currently, mother is boon to feed daughter via G-Tube available." The HHA services mes during week 5 of the d and failed to be conducted as						
	1/13/17 included of G-Tube feedings a assistance with IA conducted a total of	ertification period of 11/15/16 to orders for SN 5 times a week for and HHA 6 times a week for DL's and ADL's. The SN of 4 of the 45 visits ordered on ortification period and failed to						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681 NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
		STREET A 10500 (INDIAN)			
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF	JLD BE COMPLETI	
TAG	REGULATORY C provide visits as of	R LSC IDENTIFYING INFORMATION rdered.	TAG	DEFICIENCY)	DATE	
	3/14/17 included of G-tube feedings ea week for assistanc SN conducted a to period and failed t There were no ord A SN note 3/14/17 (caregiver) of SN intervention, but th not necessary whe	ertification period of 1/14/17 to orders for SN 1 time a week for ach visit and HHA 6 times a e with IADL's and ADL's. The tal of 5 visits in the certification o provide visit as ordered. ers to change the POC. ' stated, "Informed the cg visits weekly for skilled nat daily is not achievable and n available CG competent in ceedings. Encourage to call (as needed)."				
	5/13/17 included of assessment and ins HHA 6 times a we and ADL's. The SI for the weeks 1-3 of clinical record fail	ertification period of 3/15/17 to orders for SN 1 time a week for struction to caregivers and ek for assistance with IADL'S N failed to provide 1 visit weekly of the certification period. The ed to evidence documentation of r weeks 4-9 of the certification				
	7/12/17 included c assessment and HI week for assistanc POC failed to incl- HHA services. The evidence document and 2. The HHA c	ertification period of 5/14/17 to orders for SN 1 time a week for HA 9 hours a day for 5 days a e with IADL's and ADL's. The ude the duration of the SN and e clinical record failed to tation of HHA visits for week 1 onducted 6 visits week 4-8 and ek 9 of the certification period.				
	9/101/7 included of	ertification period of 7/13/17 to orders for SN 5 times a week for nd HHA 9 hours a day for 5				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	COMPLETE	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP CO CROSSPOINTE BLVD, IAPOLIS, IN 46256	D		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE CO	(X5) OMPLETIC	
TAG	days a week for as ADL's. The SN pr and 5-9 of the cert provide 5 visits pe conducted 3 visits during week 2-9 o failed to provide v The POC for the c 11/9/17 included of tube G-tube feedin days a week for as ADL's. The SN pr and 4-8, 0 visits du week 9 of the certi provide as ordered during weeks 1-6, during week 8 and The HHA failed to A SN note dated 9 request daily SN to mother is at work. Parent states at thi able to cover the o not been a daily R The POC for the c 1/8/18 included or tube G-tube feedin days a week for as ADL's. There wer SN frequency to 1 certification period POC and provided No SN visits were The HHA provide certification period	ertification period of 11/10/17 to ders for SN 5 times a week for ags and HHA 9 hours a day for 5 sistance with IADL's and re orders present to change the visit during week 7 and 9 of the d. The SN failed to follow the l visits 2 times during weeks 2-6. conducted during week 1 and 8. d 1 visit week 1 of the d on 11/10/17, 6 visits during 17 to 1/6/18. The HHA failed to	TAG			DATE	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500 (ADDRESS, CITY, STATE, ZIP COI CROSSPOINTE BLVD, APOLIS, IN 46256)		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL NR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
	3/9/18 included or tube G-tube educa and HHA 9 hours assistance with IA provided visits 1 ti during week 2-9 o failed to provide v provided visits 4 ti 1/12/18 with 14-ho The HHA provide 1/15/18 to 1/19/18 and 1/18/18. The H week from 1/21/18 provide visits as or The POC for the c 5/8/18 included or G-Tube education, HHA 9 hours a da with IADL's and A during week 9 of t to provide visits as visits during week during week 9. Th as ordered. The POC for the c 7/7/18 included or G-Tube education, HHA 9 hours a da with IADL's and A during week 9. Th as ordered.	ertification period of 3/10/18 to ders for SN 2 times a week for , monitoring and feedings and y, 5 days a week for assistance ADL's. The SN provided 1 visit he certification period and failed s ordered. The HHA provided 6 s 1, 2, 3, 4, 6, 8, and 3 visits e HHA failed to provide visits ertification period of 5/9/18 to ders for SN 2 times a week for , monitoring and feedings and y, 5 days a week for assistance ADL's. A 14-hour visit on 5/9/18 t 5/12/18. The HHA provided 4 5/13/18 to 5/16/18 and 6 visits 18 to 7/7/18, when the clinical hat the patient was in the /18 to 6/1/18.					
	The POC for the c	ertification period of 7/8/18 to					

TERS FU	R MEDICARE & MEDIC.						OMB NO. 0938-0
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	È É		ONSTRUCTION		DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING	00		OMPLETED
		157681	В.	WING		1	0/02/2018
JAME OF	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP	COD	
					CROSSPOINTE BLVD,		
AGING 8	& DISABLED HOME	HEALTH CARE LLC		INDIAN	APOLIS, IN 46256		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLET
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	9/5/18 included ord	ers for SN 2 times a week for					
		essing changes and HHA 9					
		a week for assistance with					
		The SN provided 1 visit during					
		cation period and failed to					
	*	lered. The HHA provided 6					
	-	1-8 and 3 visits during week 9					
	·	eriod. The HHA provided					
		8/18, 7/10/18, 7/12/18. The					
	HHA failed to prov	ide visits as ordered.					
	The POC for the cer	tification period of 9/6/18 to					
		ders for SN 2 times a week for					
		essing changes and HHA 9					
		a week for assistance with					
		The SN provided 1 visit during					
		ication period and failed to					
		lered. The HHA provided 3					
	-	and 6 visits during weeks 2					
	-	ation period. The HHA					
		sits on 9/6/18, 9/11/8.9/13/18,					
	· ·	8 and 16-hour visits on 9/9/18					
	and 9/16/18. The H	HA failed to provide services					
	as ordered.						
	A DA (prior outhori	zation) was requested for					
		ninistrator provided a PA for					
	-	to 2/6/19. The administrator					
	-	nt any other PAs for clinical					
	-	ent PA established the SN					
		sted for 2 times weekly and					
	not 5 times weekly.	sted for 2 times weekly and					
		onducted with the Parent of					
		18 at 10: 00 AM. The Parent					
		worked 5-6 days a week. The					
	-	HA for the agency, the					
		not administer tube feedings					
		A. Without a nurse to come to					
	the home daily the p	parent had to change the			1		

	R MEDICARE & MEDIONT OF DEFICIENCIES		CIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			(X3) DA	OMB NO. 0938-039 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	· /	BUILDING	<u>00</u>	· · ·	IL SORVEI IPLETED	
		157681		VING		_	02/2018	
NAX (5 07				STREET A	ADDRESS, CITY, STATE, ZIP C	COD		
		E HEALTH CARE LLC			CROSSPOINTE BLVD, APOLIS, IN 46256			
AGING		E HEALTH CARE ELC		INDIAN	AF 0L13, IN 40230			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		be feeding schedule. The parent						
	~	patient had been admitted on						
		ings had been given in mid day						
		gency. The parent reported the						
		t the agency around November						
		after the agency stopped						
		days a week. The parent						
	-	as told that the agency was						
		g a replacement nurse. The						
	· ·	/she had reported to the						
	· ·	d to the agency that he/she						
		ays a week, but the staffing						
		een addressed or resolved. The						
		urse had told him/her that a						
		essary and another nurse told						
		caid had denied the prior						
	authorization for a	nurse 5 times a week.						
		conducted with Patient # 1's						
	-	ne HHA on 9/25/18 at 1:50 PM.						
		ed the parent administered the						
	-	or Patient #1 before he/she left						
		e feeding schedule had been						
		ernoon when the parent came						
		bedtime. The sibling reported						
		vorking as a HHA it was not						
		be of practice to give the tube						
	-	eported they have not had a						
	-	ars and have been told the						
		a nurse for the feedings 5 days						
		g reported she/he had been told						
	the PA visits for 5	times a week had been denied.						
	An interview was	conducted with the						
	administrator on 9	/24/18 at 2:35 PM. The						
	administrator was	asked if there was a complaint						
	investigation regar	ding the family's reported SN						
	needs 5 days a wee	ek for G-Tube feedings while						
		rk. The administrator reported						
	the complaints had	I not been reported or logged in						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided. 3. The clinical record of Patient # 4 with an original SOC of 7/29/16, a recent readmission SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed with the following findings: The SN failed to conduct a supervisory visit in the month of August, 2018. This exceeded the Agency policy by 2 days. For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during weeks 5, 6, 7 and 2 visits during week 8. For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3. An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind." Event ID: 106K11 Facility ID: 013593 Page 27 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE An interview was conducted with the administrator on 10/1/18 at 4:30 PM regarding the missed visits for Patient #4. The complaint log failed to include any complaints regarding missed services for Patient # 4. The administrator reported he/she was not made aware of the missed visits or the complaints expressed to the staff by Patient # 4. The administrator reported there was no further documentation to be provided. 4. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week for assistance with IADL's and ADL's was reviewed with the following findings: A SN note for a HHA supervisory visit 9/23/16 was reviewed and stated, "Past Tuesday had no night time coverage. CG (caregiver) stated office knew about client not being covered. CG and patient highly satisfied with aides, C/O (complained of) poor office communication." The agency complaint log was reviewed on 10/1/18 and failed to include any documentation of a complaint from the family of Patient # 5 regarding missed visits and poor office communication. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes, orders to change the plan of care, patient rights and admission agreement. The administrator reported he/she could not locate the missing documents. In addition the Administrator was asked about the failure of the agency to document the complaint from the family of Patient # 5. The Administrator reported he/she was not working at the agency during 2016 and 106K11 Facility ID: 013593 Page 28 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

11/27/2018

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/27/2018 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, JAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION the complaint was not		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CON	(X5) MPLETION DATE
G 0484	documented or inv	-					
Bldg. 00	failed to document 7 patients record re a sample of 7. Findings Include: 1. An agency poli Complaint /Grieva stated, "Definition complaint is define dissatisfaction by a services that can b complaint by staff grievance is any fo expression of dissa that is expressed b solved at that time complaint that fits require a written re complaints will be complaint form an an administrative f above include treat documented on the receiving the comp forwarded as soon director for inve Grievance will be director or his/her the complainant w	eview and interview, the agency and resolve complaints for 3 of eviews. (Patients # 1, 4 and 5) in cy titled, "Client/Family nce Policy" was reviewed and s: Client Complaint: A ed as "any expression of a client/family regarding care or e addressed at the time of present" Grievance: A ormal or informal written tisfaction with care or services y the client/family that is not by staff present Any the grievance definition will esponse to the person ecial Instructions 2. Client documented on a client d filed with the complaint log in ile. 3. The grievance as defined tment, services will be e grievance form by the person olain/grievances e and as possible to the appropriate stigation action and trending. 4. addressed by the department designee and response made to ithin 7 calendar days and the will report back within 30	G 04	484	N 484 The Administrator or designed immediately review all clinical records for coordination of car between SN/HHA. Immediate RN case managers will be required to conference with the HHA weekly for patients they manage, and document this coordination of care through a communication note in the clin record. The DON or designee will edu administration/management, a clinicians on policy: Coordination of Client Services Home Health Aide Supervision Care Planning/ Coordina of Care Home health aides will be educated on: "What to Report to RN, Case Manager" Home Health Aide Documentation To prevent this deficiency in the future, the RN case managers be required to review all HHA documentation and perform weekly conference with HHA's	e will e case nical ucate all ation	/30/201

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	x1) provider/supplier/clia identification number 157681	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	COMP	e survey leted 2/2018
NAME OF PROVIDER OR SUPPLI AGING & DISABLED HOM		10500	ADDRESS, CITY, STATE, ZIP CO CROSSPOINTE BLVD, IAPOLIS, IN 46256	D	
(X4) ID SUMMAR PREFIX (EACH DEFICIE) TAG REGULATORY O calendar days with All persons with a notice of the invest are considered contresponse has been client/complainantel letters sent are to Quality Designee data" 2. The clinical rect (start of care) data the following find: An interview was Patient # 1 on 9/2 reported that he/sl patient's full time patient's sibling cain the role of a HI the home daily the patient bolus G-tu reported when the (7/18/16) the feed by a nurse of the a full time nurse lef of 2016 and soon sending a nurse 5 reported he/she w working on gettin parent reported he patient's nurses ar needed a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent reported a nurse 5 concern had not b parent caported parent caported parent caported parent caported parent caported parent caported pa	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION in a resolution of the grievance. In grievance will receive a written stigators review7. Grievances impleted when an approved mailed to the tthe originally along with the returned to the administrator or for tabulation and trending of ord of patient # 1 with a SOC e of 7/18/16 was reviewed with ings: conducted with the Parent of 4/18 at 10: 00 AM. The Parent ne worked 5-6 days a week. The HHA for the agency, the an not administer tube feedings IA. Without a nurse to come to e parent had to change the be feeding schedule. The parent patient had been admitted on ings had been given in mid day agency. The parent reported the at the agency stopped days a week. The parent as told that the agency was g a replacement nurse. The //she had reported to the d to the agency that he/she lays a week, but the staffing een addressed or resolved. The nurse had told him/her that a essary and another nurse told caid had denied the prior	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) all the patients they case RN case manager will a the aide care plan with t assigned home health aide pri services to the patient a the home health aide ca with the home health aide ca with the home health aide every 60 days or when t change in the patients' of the Administrator or des be responsible for active record audits until 100% compliance is met then clinical records will be a quarterly for evidence at compliance is met to en this deficiency will not re	e manage. Iso review he ide prior to oviding nd review ire plan de at least there is a condition. ignee will e clinical 0 % of all udited fter 100% sure that	(X5) COMPLETIO DATE
	a nurse 5 times a week.				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/02/2018
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500 (ADDRESS, CITY, STATE, ZIP C CROSSPOINTE BLVD, IAPOLIS, IN 46256	OD
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TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	the HHA on 9/25/18 at 1:50 PM. End the parent administered the			
		or Patient #1 before he/she left			
	-	e feeding schedule had been			
		ernoon when the parent came			
	-	bedtime. The sibling reported			
	since he/she was w	vorking as a HHA it was not			
	within his/her scop	be of practice to give the tube			
	-	eported they have not had a			
	-	ars and have been told the			
		a nurse for the feedings 5 days			
	a week. The sibling reported she/he had been the PA visits for 5 times a week had been d				
	the PA visits for 5	umes a week had been demed.			
	An interview was	conducted with the			
		/24/18 at 2:35 PM. The			
		asked if there was a complaint			
		ding the family's reported SN			
	-	ek for G-Tube feedings while rk. The administrator reported			
	-	I not been reported or logged in			
	· ·	The administrator reported			
		n made aware the family still			
		e. The administrator was made			
	aware of the misse	d visits and the failure to follow			
		d HHA visits. The administrator			
	-	no further documentation to be			
	provided.				
	3. The clinical rec	ord of Patient # 4 with an			
	e e	29/16, a recent readmission SOC			
		d certification period of 7/11/18			
		8 to $11/7/18$, with services to			
		ly for aide supervisory visit and			
		y for 4 days a week for IADL's			
	and ADL's was rev findings:	viewed with the following			
		conducted with Patient # 4 on 1. The patient reported it had			
	An interview was	conducted with Patient # 4 on 1. The patient reported it had			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	1050	ET ADDRESS, CITY, STATE, ZIF 0 CROSSPOINTE BLVD ANAPOLIS, IN 46256		DD	
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	 than 1 day a week hit or miss I can't a I've told them at out of sight and out An interview was administrator on 1 missed visits for P failed to include at services for Patien reported he/she way visits or the comple Patient # 4. The act no further docume 4. The clinical recedate of 6/19/16 with days a week for 20 IADL's and ADL's following findings A SN note for a H was reviewed and night time coverage knew about client patient highly satistic (complained of) per the agency complexity of a complaint from regarding missed was administrator on a basence of HHA m of care, patient right of the second s	conducted with the 0/1/18 at 4:30 PM regarding the atient #4. The complaint log ny complaints regarding missed t # 4. The administrator as not made aware of the missed laints expressed to the staff by dministrator reported there was entation to be provided.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS. IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE locate the missing documents. In addition the Administrator was asked about the failure of the agency to document the complaint from the family of Patient # 5. The Administrator reported he/she was not working at the agency during 2016 and did not know why the complaint was not documented or investigated. G 0546 Bldg. 00 G 0546 N 546 11/30/2018 Based on record review and interview the agency The Administrator or designee will failed to complete the comprehensive assessment immediately review all clinical the last 5 days of every 60 days for 1 of 7 (Patient records for coordination of care #1) clinical records reviewed. with any patient receiving dialysis, wound care. If coordination of Findings Include: care has not been established the DON or RN case manager will An agency policy titled, "Client establish this coordination of care Reassessment/Update of Comprehensive by calling the dialysis center or Assessment" was reviewed and stated, "The wound care center and request Comprehensive Assessment will be updated and weekly updates on patients care. revised as often as the client's condition warrants The DON or designee will educate due to major decline or improvement in health administration/management, all status. Assessment will include OASIS data clinicians on policy: collection for all Medicare and Medicaid skilled clients ... Reassessments must be done at least: 1. Coordination of Client Every second calendar month beginning with start Services of care within the last five (5) days of the episode, including day sixty (60)" To prevent this deficiency in the future, the DON will audit these The clincial record of Patient #1 with a SOC (start clinical records weekly to ensure of care) date of 7/18/16 was reviewed. During the updates from these providers are certification period of 11/15/16 to 1/13/17, the present in the clinical record, if not clinical record evidenced an OASIS recertification present the DON will call the reassessment that was completed on 1/18/17. The provider for an update and notify OASIS recertification reassessment failed to be the RN case Manager of the completed within the last 5 days of the update so the RN can update the certification period (between 1/9/17 to 1/13/17). POC if needed.

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

Event ID: 1

106K11 Facility

Facility ID: 013593

If continuation sheet

Page 33 of 206

11/27/2018

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681		ILDING	ONSTRUCTION 00	СОМ	e survey pleted 2/2018
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TON D BE OPRIATE	(X5) COMPLETION DATE
	2:50 PM regarding complete the OAS administrator repo the assessment had	was interviewed on 9/27/18 at the failure of the nurse to IS assessment timely. The rted he/she did not know why I been conducted late and er documentation to be			The Administrator or designed be responsible for active of record audits until 100% compliance is met then 10 clinical records will be aud quarterly for evidence after compliance is met to ensu- this deficiency does nor re- Education completed on 11/11/2018.	clinical) % of all lited er 100% ire that	
G 0570 Bldg. 00							
	failed to ensure the expectation that the needs for 1 out of 4 Nurse) and 4 of 4 p services (Patients a ensure all services Care) was provide accurately complet frequency and dura the nutritional requ treatments and me failed to ensure con nephrologist caring Dialysis) patient re G 602), and failed included document the SN (skilled nur aide) regarding a condition that prog 3 pressure ulcer (S		G 05	570	G 570 The agency will immediately do away with practice of accepting refer without approval of the DC administrator or designee immediately review all act clinical records for eviden all services in the POC ar provided. If there is evide the POC is not being follo DON will call the PCP for order to update the plan of and the POC will be updat the clinical record and ser PCP for signature. If failut follow the POC is due to a shortage on staffing the D call the patient and offer to them to an agency that can provide all services in the patient agrees to be trans another agency the DON facilitate a transfer to an a	rals DN. The will ive ce that e being nce that wed the a verbal f care ted in at to the re to a ON will o transfer in POC. If ferred to will	11/30/2018
		fect of these systemic problems ne health agency's inability to			the patients choice. The Administrator or design	gnee will	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	00	3) DATE SURVEY COMPLETED 10/02/2018
	PROVIDER OR SUPPLIE & DISABLED HOMI	R E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O provide quality hea	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION alth care in a safe environment of Participation at 42 CFR 484.60:	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) educate administration/management, all	(X5) COMPLETION DATE
	Coordination of Ca	are.), findings include:		clinicians on policy: Admission Policy Client Admission Process	
	and stated, "Home under the supervise physician. The pla comprehensive ass provided by the cli members The pl to ensure that clier updated as necessa days The plan o to include: c. Type visits/services k requirements or rea treatments, and pro At the time of cert written summary of the services being the plan of care for include but is not I physical or psycho response to care/se and services Pro alert the physician need to alter the plan	"Plan of Care" was reviewed care services are furnished ion and direction of the client's n of care is based on a sessment and information ient/family and health team lan will be consistently reviewed at needs are met and will be try, but at least every sixty (60) f care shall be completed in full e, frequency, and duration of all . Specific dietary or nutritional strictions. Medications, becedures p. Treatment goals ification and recertification, a of the client's current status and provided are submitted with r review. The summary shall imited to: changes in clients spocial condition, client ervices and outcome of care ofessional staff shall promptly to any changes that suggest a an of care"		Comprehensive Client Assessment Plan of Care Coordination of Client Car Service Agreement Skilled Nursing Services Client/Caregiver Education Client Discharge Policy Therapy Services To prevent this deficiency in the future, the DON will review all ne referrals to ensure that before acceptance of referral the agenc can reasonably meet the needs the patient before acceptance of such referral. The DON will sign on all accepted referrals as evidence that she reviewed the referral. The Administrator or designee will review all referrals weekly with the DON.	n ew ey of
	(start of care) date agency failed to m evidenced by the f	of 7/18/16 was reviewed. The eet the patient's needs as			
	9/15/16 included o week for G-Tube (a tube in the stomach where provided) feedings while the			

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

Event ID:

106K11 Facility ID: 013593

If continuation sheet Page 35 of 206

PRINTED: 11/27/2018 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	СОМ	e survey pleted 2/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP CO CROSSPOINTE BLVD, NAPOLIS, IN 46256	D	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	 week. The SN fail 8/9/16 (21 days) a services 5 times a the certification period as ordered. The POC for the certification period G-Tube feedings with the services 6 till ADL's and ADL's times during week 8, an certification period ordered. A communication to nursing schedul we have offered to nursing care via at has declined this of coming home at nuntil nursing staff were provided 3 till certification period ordered. The POC for the certification period ordered. 	c and HHA services 6 times a ed to provide services until fter the SOC. The HHA provided week 1- 2 and 3 times week 6 of eriod and failed to conduct visits ertification period of 9/16/16 to orders for SN 5 times a week for while the parent was at work and mes a week for assistance with s. SN services were provided 4 a 6, 3 times during week 7, 0 times d 2 times during week 9 of the d and failed to be provided as note dated 11/1/16 stated, "Due ing difficulties with this patient, o assist the family in finding a nother agency at this time family offer. Currently, mother is oon to feed daughter via G-Tube available." The HHA services mes during week 5 of the d and failed to be conducted as ertification period of 11/15/16 to orders for SN 5 times a week for und HHA 6 times a week for DL's and ADL's. The SN of 4 of the 45 visits ordered on ertification period of 1/14/17 to orders for SN 1 time a week for ach visit and HHA 6 times a				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CC A. BUILDING B. WING	<u></u>		(X3) DATE SURVEY COMPLETED 10/02/2018	
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)	D BE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE	DATE	
	SN conducted a to period and failed t	tal of 5 visits in the certification o provide visit as ordered. ers to change the POC.					
	(caregiver) of SN	7 stated, "Informed the cg visits weekly for skilled hat daily is not achievable and					
	not necessary whe	n available CG competent in feedings. Encourage to call					
	5/13/17 included of assessment and ins HHA 6 times a we and ADL's. The S2 for the weeks 1-3 clinical record fail	ertification period of 3/15/17 to orders for SN 1 time a week for struction to caregivers and eek for assistance with IADL'S N failed to provide 1 visit weekly of the certification period. The ed to evidence documentation of r weeks 4-9 of the certification					
	7/12/17 included of assessment and HI week for assistance POC failed to incl HHA services. The evidence documer and 2. The HHA of	ertification period of 5/14/17 to orders for SN 1 time a week for HA 9 hours a day for 5 days a e with IADL's and ADL's. The ude the duration of the SN and e clinical record failed to nation of HHA visits for week 1 onducted 6 visits week 4-8 and ek 9 of the certification period.					
	9/101/7 included of G-tube feedings and days a week for as ADL's. The SN pr and 5-9 of the cert provide 5 visits per conducted 3 visits	ertification period of 7/13/17 to orders for SN 5 times a week for nd HHA 9 hours a day for 5 sistance with IADL's and ovided 1 visit during weeks 2-3 ification period and failed to r week as ordered. The HHA during week 1 and 6 visits f the certification period and					

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	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		10500 (ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256		
	1					(1/5)
(X4) ID PREFIX		(STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETIO
TAG		DR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPE DEFICIENCY)	ROPRIATE	DATE
		isits 5 times weekly as ordered.				
	11/9/17 included of tube G-tube feedin days a week for as ADL's. The SN pr and 4-8, 0 visits du week 9 of the certi provide as ordered during weeks 1-6, during weeks 1-6, during week 8 and The HHA failed to A SN note dated 9 request daily SN to mother is at work. Parent states at thi able to cover the o	ertification period of 9/11/17 to orders for SN 5 times a week for hgs and HHA 9 hours a day for 5 sistance with IADL's and ovided 2 visits during weeks 1 uring week 2 and 1 visit during ification period. The SN failed to 1. The HHA provided 6 visits 2 visits during week 7, 4 visits 19 of the certification period. b provided visits as ordered. //11/17 stated, "continues to to cover G-Tube feedings while Will discuss with leadership. s time his/her family has been ther days of the week there has N."				
	not been a daily RN." The POC for the certification period of 11/10/17 to 1/8/18 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. There were orders present to change the SN frequency to 1 visit during week 7 and 9 of the certification period. The SN failed to follow the POC and provided visits 2 times during weeks 2-6. No SN visits were conducted during week 1 and 8. The HHA provided 1 visit week 1 of the certification period on 11/10/17, 6 visits during weekly from 12/3/17 to 1/6/18. The HHA failed to provide visits as ordered. The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week for tube G-tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN					

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	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP C CROSSPOINTE BLVD, NAPOLIS, IN 46256	COD		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	during week 2-9 o failed to provide v provided visits 4 t 1/12/18 with 14-hd The HHA provide 1/15/18 to 1/19/18 and 1/18/18. The I week from 1/21/18 provide visits as o The POC for the c 5/8/18 included or G-Tube education HHA 9 hours a da with IADL's and A during week 9 of t to provide visits as visits during week during week 9. Th as ordered. The POC for the c 7/7/18 included or G-Tube education HHA 9 hours a da with IADL's and A during week 9. Th as ordered. The POC for the c 7/7/18 included or G-Tube education HHA 9 hours a da with IADL's and A and a 10-hour visi visits a week from weekly from 5/17/ record evidenced t hospital from 5/17 The POC for the c 9/5/18 included or G-Tube care and c hours a day, 5 day IADL's and ADL's week 9 of the certi	ertification period of 3/10/18 to ders for SN 2 times a week for , monitoring and feedings and y, 5 days a week for assistance ADL's. The SN provided 1 visit he certification period and failed s ordered. The HHA provided 6 s 1, 2, 3, 4, 6, 8, and 3 visits e HHA failed to provide visits ertification period of 5/9/18 to ders for SN 2 times a week for , monitoring and feedings and y, 5 days a week for assistance ADL's. A 14-hour visit on 5/9/18 t 5/12/18. The HHA provided 4 5/13/18 to 5/16/18 and 6 visits '18 to 7/7/18, when the clinical hat the patient was in the					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018	
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		10500 (ADDRESS, CITY, STATE, ZIP CO CROSSPOINTE BLVD, IAPOLIS, IN 46256)D	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLET	
	of the verification 14-hour visits on 7 HHA failed to pro The POC for the c 11/4/18 included c G-Tube care and d hours a day, 5 day IADL's and ADL's week 1 of the certifi provide visits as o visits during week and 3 of the certifi provided 14-hour 9/18/18, and 9/20/ and 9/16/18. The H as ordered.	s 1-8 and 3 visits during week 9 period. The HHA provided //8/18, 7/10/18, 7/12/18. The vide visits as ordered. ertification period of 9/6/18 to orders for SN 2 times a week for ressing changes and HHA 9 s a week for assistance with b. The SN provided 1 visit during fication period and failed to rdered. The HHA provided 3 1 and 6 visits during weeks 2 cation period. The HHA visits on 9/6/18, 9/11/8.9/13/18, 18 and 16-hour visits on 9/9/18 HHA failed to provide services				
	the period of 8/8/1 was unable to pres record #1. The cur services were requ not 5 times weekly An interview was	Iministrator provided a PA for 8 to 2/6/19. The administrator ent any other PAs for clinical rent PA established the SN ested for 2 times weekly and 7. conducted with the Parent of H/18 at 10: 00 AM. The Parent				
	reported that he/sh patient's full-time patient's sibling ca in the role of a HH the home daily the patient bolus G-tul reported when the (7/18/16) the feedi by a nurse of the a full-time nurse left	e worked 5-6 days a week. The HHA for the agency, the n not administer tube feedings (A. Without a nurse to come to parent had to change the be feeding schedule. The parent patient had been admitted on ngs had been given in mid day gency. The parent reported the t the agency around November after the agency stopped				

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION NUM 157681		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		СОМ	(X3) DATE SURVEY COMPLETED 10/02/2018	
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLETIC	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	sending a nurse 5	days a week. The parent					
	reported he/she wa	as told that the agency was					
	working on getting	g a replacement nurse. The					
	parent reported he	/she had reported to the					
	patient's nurses an	d to the agency that he/she					
		lays a week, but the staffing					
		een addressed or resolved. The					
		nurse had told him/her that a					
		essary and another nurse told					
		caid had denied the prior					
	authorization for a	nurse 5 times a week.					
	An interview was	conducted with Patient # 1's					
	-	ne HHA on 9/25/18 at 1:50 PM.					
		ed the parent administered the					
	-	for Patient #1 before he/she left					
		e feeding schedule had been					
		ernoon when the parent came					
		bedtime. The sibling reported					
		vorking as a HHA it was not					
	-	be of practice to give the tube					
		eported they have not had a					
	-	ars and have been told the					
		a nurse for the feedings 5 days					
		g reported she/he had been told					
	the PA visits for 5	times a week had been denied.					
		conducted with the					
		/24/18 at 2:35 PM. The					
		asked if there was a complaint					
		rding the family's reported SN					
		ek for G-Tube feedings while					
	-	rk. The administrator reported					
		l not been reported or logged in					
		The administrator reported					
		n made aware the family still e. The administrator was made					
		ed visits and the failure to follow					
		ad HHA visits. The administrator					
	reported there was	no further documentation to be		1		1	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	DISTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018			
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		10500 (STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETIC DATE		
1110	provided.					DATE		
	date of 9/28/15 an to 9/11/18, with se day 5 days a week ADL's was review the patient's needs findings: The HHA provide	ord of Patient # 2 with a SOC d a certification period of 7/14/18 ervices to include HHA 8 hours a for assistance with IADL's and ed. The agency failed to meet as evidenced by the following d visits 6 days in week 4 of the d ranging from 3 to 11 hours a						
		otal of 46 hours. The HHA failed						
	certification perio	d visits 4 days in week 5 of the d ranging from 8-9 hours a day of 33 hours. The HHA failed to as ordered.						
	certification perio	d visits 4 days in week 7 of the d ranging from 7-8 hours a day of 31 hours. The HHA failed to as ordered.						
	certification perio	d visits 6 days in week 8 of the d ranging for 7 hours daily for a hours. The HHA failed to as ordered.						
	certification perio	d visits 3 days in week 9 of the d ranging from 4 to 11 hours for 2 hours. The HHA failed to as ordered.						
	administrator on 9 failure to provide week as ordered. T	conducted with the /26/18 at 2:45 PM regarding the HHA visits 8 hours/ 5 days a The administrator reported, " All ges and hours are an error It						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE doesn't look like the aide reported changes in schedule." The administrator had no further documentation to be provided. 4. The clinical record of Patient # 4 with a SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed. The agency failed to meet the patient's needs as evidenced by the following findings: The SN failed to conduct a supervisory visit in the month of August 2018. This exceeded the Agency policy by 2 days. For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during week 5, 6, 7 and 2 visits during week 8. For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3. An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind." An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be Event ID: 106K11 Facility ID: 013593 Page 43 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018	
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION	
IAU	provided.	R LSC IDENTIFTING INFORMATION	IAU		DATE	
	date of 6/19/16 wir days a week for 20 IADL's and ADL's failed to meet the p the following findi During the certific 8/17/16, the HHA during weeks 3 and week 6, and 4 hour During the certific 10/16/16, there we 1,2, 3, 4, 5, 6, wea missing with the e 9/29/16, 9/30/16, 1 During the certific 12/14/16, the HHA during week 1, 18 during week 3 and visit on 12/6/18. T notes for the certific An interview was Administrator on 1 absence of HHA n orders to change th reported he/she wa during that time pe	ation period of 6/19/16 to failed to provide 2 hours of care d 4, 10 hours of care during rs of care during weeks 8 and 9. ation period of 8/18/16 to re no HHA visit notes for weeks ek. Week 7, 8, and 9 all were exception of 2-hour notes on .0/3/16 and 10/13/16. ation period of 10/17/16 to A failed to provide 10 hours hours during week 2, 18 hours with the exception of a 2-hour There were no further HHA				
G 0572						
Bldg. 00		view and interviews, the sure all services outlined in the	G 0572	G 572 The Administrator or designee will immediately re	11/30/201	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	157681	B. WING	<u></u>		/2018
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
AGING a	& DISABLED HOMI	E HEALTH CARE LLC		CROSSPOINTE BLVD, NAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	<u>`</u>	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE ROPRIATE	COMPLETI
TAG	1	R LSC IDENTIFYING INFORMATION	TAG			DATE
		e) was provided in 1 out of 4		all clinical records with SI		
		d reviewed of patients receiving		services are being provid		
) and 4 of 4 patient (Patients # 1,		there is evidence that the		
		reviewed of patients receiving		not being followed the DC		
		th Aide) in a sample of 7		call the PCP for a verbal		
	patients.			update the plan of care a		
				POC will be updated in the		
	Findings Include:			record and sent to the PC		
				signature. If failure to foll		
				POC is due to a shortage		
		"Plan of Care" was reviewed		staffing the DON will call		
		care services are furnished		patient and offer to transf		
	_	ion and direction of the client's		to an agency that can pro		
		n of care is based on a		services in the POC. If p		
	-	essment and information		agrees to be transferred t		
		ent/family and health team		agency the DON will facil		
	-	an will be consistently reviewed		transfer to an agency of t	ne	
		t needs are met and will be		patients choice and		
	-	ry, but at least every sixty (60)		documentation of convers		
		f care shall be completed in full		with patient will be record	led in the	
		, frequency, and duration of all		patients clinical record.		
		Specific dietary or nutritional				
		strictions. Medications, becedures p. Treatment goals		The Administrator or desi	gnee will	
	-	ification and recertification, a		educate	ant all	
		f the client's current status and		administration/manageme		
	-	provided are submitted with			les on	
	-	review. The summary shall		policy:		
	· ·	imited to: changes in clients		Plan of Care		
		social condition, client		Flation Care		
		rvices and outcome of care		To provent this deficiency	in the	
		fessional staff shall promptly		To prevent this deficiency future, the DON will moni		
		to any changes that suggest a		services of all clients wee		
	need to alter the pl			through audits of services		
				and any trends will be ad	-	
	2 The clinical reco	ord of patient # 1 with a SOC		weekly with the administr		
		of $7/18/16$ was reviewed with		The Administrator or desi		
	the following findi			also do clinical records a	-	
				100% compliance is met,		
	The POC for the c	ertification period of 7/18/16 to		10% of clinical records th		

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018		
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		1	TREET A 0500 C NDIAN	-		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION D BE DPRIATE	(X5) COMPLETIC DATE
	 9/15/16 included of week for G-Tube (liquid nutrition is parent was at work week. The SN faile 8/9/16 (21 days) at services 5 times a the certification peas ordered. The POC for the c 11/14/16 included G-Tube feedings w HHA services 6 the IADL's and ADL's times during week 8, and certification period ordered. A communication to nursing schedul we have offered to nursing care via ar has declined this o coming home at neutil nursing staff were provided 3 the certification period ordered. The POC for the c 1/13/17 included c G-Tube feedings and communication to nursing schedul were for the communication to nursing staff were provided 3 the certification period ordered. 	rders for skilled nurse 5 times a a tube in the stomach where provided) feedings while the a and HHA services 6 times a ed to provide services until fter the SOC. The HHA provided week 1- 2 and 3 times week 6 of riod and failed to conduct visits ertification period of 9/16/16 to orders for SN 5 times a week for while the parent was at work and mes a week for assistance with 5. SN services were provided 4 6, 3 times during week 7, 0 times 12 times during week 9 of the 14 and failed to be provided as note dated 11/1/16 stated, "Due ing difficulties with this patient, assist the family in finding a nother agency at this time family ffer. Currently, mother is poon to feed daughter via G-Tube available." The HHA services mes during week 5 of the 14 and failed to be conducted as ertification period of 11/15/16 to rrders for SN 5 times a week for nd HHA 6 times a week for			quarterly to ensure deficie does not reoccur. Education on Plan of Care completed 11/08/2018.	·	
	conducted a total of	DL's and ADL's. The SN of 4 of the 45 visits ordered on rtification period and failed to rdered.					
	The POC for the c	ertification period of 1/14/17 to					

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 157681	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/02/2018			
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256					
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIC		
TAG	3/14/17 included of G-tube feedings ea week for assistanc SN conducted a to period and failed t There were no ord A SN note 3/14/17 (caregiver) of SN intervention, but th not necessary whe administration of f agency office prote The POC for the c 5/13/17 included of assessment and ins HHA 6 times a we and ADL's. The SI for the weeks 1-3 of clinical record fail any HHA visits fo period. The POC for the c 7/12/17 included of assessment and HI week for assistanc POC failed to incli HHA services. The evidence document and 2. The HHA c 4 visits during weat The POC for the c 9/101/7 included of adays a week for assistanc	R LSC IDENTIFYING INFORMATION rders for SN 1 time a week for ach visit and HHA 6 times a e with IADL's and ADL's. The tal of 5 visits in the certification o provide visit as ordered. ers to change the POC. ' stated, "Informed the cg visits weekly for skilled hat daily is not achievable and in available CG competent in eedings. Encourage to call (as needed)." ertification period of 3/15/17 to orders for SN 1 time a week for struction to caregivers and ek for assistance with IADL'S N failed to provide 1 visit weekly of the certification period. The ed to evidence documentation of r weeks 4-9 of the certification ertification period of 5/14/17 to rders for SN 1 time a week for the certification period. The ed to evidence documentation of r weeks 4-9 of the certification ertification period of 5/14/17 to rders for SN 1 time a week for IA 9 hours a day for 5 days a e with IADL's and ADL's. The ude the duration of the SN and e clinical record failed to tation of HHA visits for week 1 onducted 6 visits week 4-8 and ek 9 of the certification period.	TAG			DATE		

AND PLAN OF CORRECTION IDENTIF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018		
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE COMPLETIC		
	conducted 3 visits during week 2-9 o failed to provide v The POC for the c 11/9/17 included of tube G-tube feedin days a week for as ADL's. The SN pr and 4-8, 0 visits du week 9 of the certi provide as ordered during weeks 1-6, during weeks 1-6, during weeks 8 and The HHA failed to A SN note dated 9 request daily SN tu mother is at work. Parent states at thi able to cover the o not been a daily R The POC for the c 1/8/18 included or tube G-tube feedin days a week for as ADL's. There wen SN frequency to 1 certification perioo POC and provided No SN visits were The HHA provide certification perioo	r week as ordered. The HHA during week 1 and 6 visits f the certification period and isits 5 times weekly as ordered. ertification period of 9/11/17 to orders for SN 5 times a week for ags and HHA 9 hours a day for 5 sistance with IADL's and ovided 2 visits during weeks 1 uring week 2 and 1 visit during fication period. The SN failed to 1. The HHA provided 6 visits 2 visits during week 7, 4 visits 9 of the certification period. provided visits as ordered. /11/17 stated, "continues to provided visits as ordered. /11/17 to 1/0/17, 6 visits during '17 to 1/6/18. The HHA failed to					
		rdered. ertification period of 1/9/18 to ders for SN 5 times a week for					

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
	and HHA 9 hours assistance with IA provided visits 1 ti during week 2-9 o failed to provide v provided visits 4 ti 1/12/18 with 14-hd The HHA provide 1/15/18 to 1/19/18 and 1/18/18. The H week from 1/21/18 provide visits as of The POC for the c 5/8/18 included or G-Tube education, HHA 9 hours a da with IADL's and A during week 9 of t to provide visits as visits during week during week 9. Th as ordered. The POC for the c 7/7/18 included or G-Tube education, HHA 9 hours a da with IADL's and A and a 10-hour visit visits a week from weekly from 5/17/ The POC for the c 9/5/18 included or G-Tube care and d	ertification period of 3/10/18 to ders for SN 2 times a week for , monitoring and feedings and y, 5 days a week for assistance ADL's. The SN provided 1 visit he certification period and failed s ordered. The HHA provided 6 s 1, 2, 3, 4, 6, 8, and 3 visits e HHA failed to provide visits ertification period of 5/9/18 to ders for SN 2 times a week for , monitoring and feedings and y, 5 days a week for assistance ADL's. A 14-hour visit on 5/9/18 t 5/12/18. The HHA provided 4 .5/13/18 to 5/16/18 and 6 visits '18 to 7/7/18, when the clinical hat the patient was in the					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	СОМ	e survey pleted 2/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
	IADL's and ADL's week 9 of the cert provide visits as o visits during week of the verification 14-hour visits on 7 HHA failed to pro The POC for the c 11/4/18 included c G-Tube care and c hours a day, 5 day IADL's and ADL's week 1 of the cert provide visits as o visits during week and 3 of the certifi provided 14-hour 9/18/18, and 9/20/	s. The SN provided 1 visit during ification period and failed to rdered. The HHA provided 6 s 1-8 and 3 visits during week 9 period. The HHA provided 7/8/18, 7/10/18, 7/12/18. The vide visits as ordered. ertification period of 9/6/18 to orders for SN 2 times a week for dressing changes and HHA 9 s a week for assistance with s. The SN provided 1 visit during ification period and failed to rdered. The HHA provided 3 : 1 and 6 visits during weeks 2 tection period. The HHA visits on 9/6/18, 9/11/8,9/13/18, '18 and 16-hour visits on 9/9/18 HHA failed to provide services				
	patient # 1. The act the period of 8/8/1 was unable to press record #1. The cur services were requined not 5 times weekly An interview was Patient # 1 on 9/24 reported that he/sh patient's full-time patient's sibling ca in the role of a HH the home daily the patient bolus G-tur reported when the	rization) was requested for Iministrator provided a PA for 8 to 2/6/19. The administrator sent any other PAs for clinical rent PA established the SN rested for 2 times weekly and y. conducted with the Parent of 4/18 at 10: 00 AM. The Parent he worked 5-6 days a week. The HHA for the agency, the in not administer tube feedings IA. Without a nurse to come to be parent had to change the be feeding schedule. The parent patient had been admitted on ings had been given in mid day				

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DA	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	ì í	UILDING	00	r í	MPLETED	
AND FLAN	OF CORRECTION	157681		VING	00		/02/2018	
				STREET A	DDRESS, CITY, STATE, ZIP			
NAME OF	PROVIDER OR SUPPLIEF	ł.			ROSSPOINTE BLVD,			
AGING a	& DISABLED HOME	HEALTH CARE LLC		INDIANA	APOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETI	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	by a nurse of the ag	ency. The parent reported the						
	full-time nurse left	the agency around November						
	of 2016 and soon at	fter the agency stopped						
	sending a nurse 5 d	ays a week. The parent						
	reported he/she was	s told that the agency was						
	working on getting	a replacement nurse. The						
	parent reported he/s	she had reported to the						
	patient's nurses and	to the agency that he/she						
	needed a nurse 5 da	ys a week, but the staffing						
	concern had not bee	en addressed or resolved. The						
	parent reported a nu	urse had told him/her that a						
		ssary and another nurse told						
	him/her that Medica	aid had denied the prior						
	authorization for a n	nurse 5 times a week.						
	An interview was c	onducted with Patient # 1's						
	sibling and full-time	e HHA on 9/25/18 at 1:50 PM.						
	The sibling reported	d the parent administered the						
	G-Tube feedings fo	r Patient #1 before he/she left						
		feeding schedule had been						
		rnoon when the parent came						
		edtime. The sibling reported						
		orking as a HHA it was not						
		e of practice to give the tube						
	feedings. He/she rep	ported they have not had a						
		s and have been told the						
		nurse for the feedings 5 days						
		reported she/he had been told						
	the PA visits for 5 t	imes a week had been denied.						
	An interview was c	onducted with the						
	administrator on 9/2	24/18 at 2:35 PM. The						
	administrator was a	sked if there was a complaint						
		ling the family's reported SN						
	needs 5 days a weel	k for G-Tube feedings while						
	the parent is at work	k. The administrator reported						
	the complaints had	not been reported or logged in						
		The administrator reported						
		made aware the family still						
	needed this service.	The administrator was made						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided. 3. The clinical record of Patient # 2 with a SOC date of 9/28/15 and a certification period of 7/14/18 to 9/11/18, with services to include HHA 8 hours a day 5 days a week for assistance with IADL's and ADL's was reviewed with the following findings: The HHA provided visits 6 days in week 4 of the certification period ranging from 3 to 11 hours a day for a weekly total of 46 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 4 days in week 5 of the certification period ranging from 8-9 hours a day for a weekly total of 33 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 4 days in week 7 of the certification period ranging from 7-8 hours a day for a weekly total of 31 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 6 days in week 8 of the certification period ranging for 7 hours daily for a weekly total of 42 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 3 days in week 9 of the certification period ranging from 4 to 11 hours for a weekly total of 22 hours. The HHA failed to perform the visits as ordered. An interview was conducted with the administrator on 9/26/18 at 2:45 PM regarding the failure to provide HHA visits 8 hours/ 5 days a week as ordered. The administrator reported, " All Event ID: 106K11 Facility ID: 013593 Page 52 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE I can say the changes and hours are an error ... It doesn't look like the aide reported changes in schedule." The administrator had no further documentation to be provided. 4. The clinical record of Patient # 4 with a SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed with the following findings: The SN failed to conduct a supervisory visit in the month of August 2018. This exceeded the Agency policy by 2 days. For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during week 5, 6, 7 and 2 visits during week 8. For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3. An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind." An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be Event ID: 106K11 Facility ID: 013593 Page 53 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COMP	e survey leted 2/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
G 0574	date of 6/19/16 wi days a week for 20 IADL's and ADL's following findings During the certific 8/17/16, the HHA during weeks 3 an week 6, and 4 hou During the certific 10/16/16, there we 1,2, 3, 4, 5, 6, we missing with the e 9/29/16, 9/30/16, 1 During the certific 12/14/16 the HHA during week 1, 18 during week 3 and visit on 12/6/18. T notes for the certific An interview was Administrator on 1 absence of HHA m orders to change th reported he/she was during that time po	eation period of 6/19/16 to failed to provide 2 hours of care d 4, 10 hours of care during rs of care during weeks 8 and 9. eation period of 8/18/16 to ere no HHA visit notes for weeks ek. Week 7, 8, and 9 all were exception of 2-hour notes on 10/3/16 and 10/13/16. eation period of 10/17/16 to a failed to provide 10 hours hours during week 2, 18 hours I with the exception of a 2-hour There were no further HHA				
Bldg. 00		ion, record review and ncy failed to accurately	G 0574	G 574 The Administrator or designee will immediately r all clinical records for accur	eview	11/30/201

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	· · · · · · · · · · · · · · · · · · ·	X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	157681	B. WING	<u>00</u>	10/02/2018
NAME OF	PROVIDER OR SUPPLIE	CR .		ADDRESS, CITY, STATE, ZIP COD	
AGING a	& DISABLED HOM	E HEALTH CARE LLC		CROSSPOINTE BLVD, NAPOLIS, IN 46256	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		of care to include the frequency		completed plan of care including	-
		sits to be conducted for 4 of 7		frequency and duration of service	
		5), the nutritional requirements		to be provided. If the POC is for	und
		#1, 3), all medications and		to be missing frequency or	
		7 (Patient # 1, 2, 3), and		duration the DON will call the P	
		for 1 of 7 (Patient # 1) in a		for a verbal order to update the	
	sample of 7 clinica	al records.		POC and the POC of care will b	e
				updated with a physician order	
	Findings Include:			and then sent to PCP to be	
				signed. The DON will do weekly	1
	· ·	"Plan of Care" was reviewed		audits to ensure the POC is	
		care services are furnished		updated, includes frequency,	
	-	ion and direction of the client's		duration of visits, nutritional	
		n of care is based on a		requirements, all medications,	
	-	sessment and information		treatments with measurable goa	
		ient/family and health team		and current and past findings up	ntil
	_	an will be consistently reviewed		100% compliance is met.	
		nt needs are met and will be		The DON or designee will educ	ate,
	-	ary, but at least every sixty (60)		administration/management all	
		of care shall be completed in		clinicians on policy:	
		Гуре, frequency, and duration of			
		k. Specific dietary or		Plan of Care	
	_	ments or restrictions. l.		Home Health Admission	
		ments, and procedures p.		Service Agreement	
	-	t. other appropriate items 9.			
		ification and recertification, a		To prevent this deficiency in the	
		of the client's current status and		future, the DON will monitor the	:
		provided are submitted with		services of all clients weekly	
		r review. The summary shall		through audits of services provi	
		limited to: changes in clients		and any trends will be addresse	;d
		osocial condition, client		weekly with the administrator.	
	-	ervices and outcome of care		The Administrator or designee	
		Professional staff shall		also do clinical records audits u	ntil
		physician to any changes that		100% compliance is met, then	
	suggest a need to a	alter the plan of care"		10% of clinical records thereafte	er
				quarterly to ensure deficiency	
		ord of patient # 1 with a SOC		does not reoccur.	
		of 7/18/16 was reviewed with			
	the following find	ings:			
				Education completed on	

TERS FO	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-03	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	È É	MULTIPLE CO BUILDING	DNSTRUCTION 00		ATE SURVEY MPLETED
		157681	В. У	WING		10)/02/2018
NAME OF	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP		
AGING 8	& DISABLED HOME	HEALTH CARE LLC			CROSSPOINTE BLVD IAPOLIS, IN 46256	3	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	ODDECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	SHOULD BE	COMPLET
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The POC for the ce	rtification period of 7/18/16 to			11/08/2018.		
	9/15/16, included of	rders for skilled nurse 5 times a					
	week and HHA serv	vices 6 times a week. The POC					
		duration for the SN (skilled					
	nurse) and failed to						
	Health Aide) time a provided.	nd duration and services to be					
		rtification period of 9/16/16 to					
		orders for SN 5 times a week					
		times a week. The POC failed					
	duration.	uration or HHA time and					
		rtification period of $11/15/16$ to					
		rders for SN 5 times a week and k. The POC failed to include					
		HHA time and duration.					
		rtification period of $1/14/17$ to					
		rders for SN 1 time a week and					
		k. The POC failed to include HHA time and duration.					
		rtification period of 3/15/17 to					
	· · · ·	rders for SN 1 time a week and					
		k. The POC failed to include					
	the SN duration or I	HHA time and duration. POC.					
		rtification period of 5/14/17 to					
		rders for SN 1 time a week and					
		for 5 days a week. The POC					
	failed to include du services.	ration of the SN and HHA					
		rtification period of 7/13/17 to					
		rders for SN 5 times a week and					
	-	The POC failed to include					
	duration for the SN	and HHA services.					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	A. B	IULTIPLE CO UILDING /ING	DNSTRUCTION 00	CON	te survey 1pleted 02/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC		10500 (ADDRESS, CITY, STATE, ZIP CC CROSSPOINTE BLVD, IAPOLIS, IN 46256	D	
(X4) ID PREFIX	SUMMARY	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO		(X5) COMPLETIO
TAG		DR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE
	11/9/17, included HHA 9 hours a da failed to include d services.	ertification period of 9/11/17 to orders for SN 5 times a week and y for 5 days a week. The POC uration for the SN and HHA ertification period of 11/10/17 to					
	1/8/18, included of HHA 9 hours a da	rders for SN 5 times a week and y for 5 days a week. The POC uration for the SN and HHA					
	3/9/18, included of HHA 9 hours a da	ertification period of 1/9/18 to rders for SN 5 times a week and y, 5 days a week. The POC uration for the SN and HHA					
	5/8/18, included of HHA 9 hours a da	ertification period of 3/10/18 to rders for SN 2 times a week and y, 5 days a week. The POC uration for the SN and HHA					
	7/7/18, included of HHA 9 hours a da	ertification period of 5/9/18 to orders for SN 2 times a week and y, 5 days a week. The POC uration for the SN and HHA					
	9/5/18, included of HHA 9 hours a da	ertification period of 7/8/18 to rders for SN 2 times a week and y, 5 days a week. The POC uration for the SN and HHA					
	11/4/18 included of HHA 9 hours a da	ertification period of 9/6/18 to orders for SN 2 times a week and y, 5 days a week. The POC uration for the SN and HHA					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	COMI	e survey pleted 2/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP CO CROSSPOINTE BLVD, IAPOLIS, IN 46256	D	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	nutritional supplet hours. During an i patient's family m he/she reported th G-Tube feeding: T AM, 240 ml bolus 9-10 PM daily dur home from work. accurate nutritiona The POC included Aquaphor Externa healing of skin) 1 hours, Mupirocin once a day. The or ointments would b Ciprofloxacin (and per feeding tube e omitted from the H on 6/21/18. A pain goal on the remain tolerable th goal was not speci- for an assessment	l orders for Two Cal HN (a ment) oral 240 ml bolus every 6 nterview conducted with the ember on 9/24/18 at 10:00 AM, e following was the accurate Ywo Cal HN 480 ml bolus at 6 or 7 at 4:00 PM and 480 ml bolus at ing the time the mother is at The POC failed to include the al requirements. I the following topical ointments: 1 (for protection and moisture apply to healed areas every 12 External (antibacterial) 2 % 1 ders failed to specify where the be applied. An order for ibiotic) HCL oral 500 mg 1 tab very 12 hours failed to be POC and had been discontinued				
	Administrator on 9 POC findings. The was no further door 3. The clincial rec	conducted with the 9/24/18 at 4:45 PM to review the e Administrator reported there cumentation to be provided. ord of Patient # 2 with a SOC as reviewed with the following				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM	e survey pleted 2/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500 (ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, APOLIS, IN 46256		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETIO
TAG	,	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
	The POC for the c 9/11/18 and 9/12/2 include HHA 8 ho The POC failed to visits. The POC for the c 9/11/18, included External (healing j apply to open area not any better call week continued on and failed to inclu for application. An interview was Administrator on 9 POC findings. The was no further doc	ertification period of 7/14/18 to 18 to 11/10/18, with services to urs a day 5 days was reviewed. include a duration for the HHA ertification period of 7/14/18 to the following order: "Silvadene protective ointment) 1 % 2 x day 2 times per day for a week if physician." The order for one in the POC for 9/12/18 to 11/10/18 de the specific area of the body conducted with the 9/26/18 at 4:30 PM regarding the e Administrator reported there cumentation to be provided				
	7/25/18 was review The POC for the c 9/22/18 included of nutritional require no concentrated sw interviewed on 9/2 had a 32 ounce da is a diabetic/renal An interview was regarding his med during a home the for the certificatio included orders fo Levothyroxine So Synthroid) Oral 17 Synthroid (thyroid	conducted with the patient ications on 9/26/18 at 9:48 AM rapy visit observation. The POC n period of 7/25/18 to 9/22/18 r the following medications: dium (thyroid pill also know as 75 mcg 1 tablet daily and				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE mornings daily. The patient reported the order was a duplicate. Nortriptyline (for diabetic neuropathy pain) HCL oral 10 mg 2 caps bedtime, the patient reported this medication had been discontinued 2 months ago. Insulin aspart (fast acting diabetic insulin) subcutaneous 100 units/ml 15-20 units daily before meals, using sliding scale (insulin amount depends on the patient's blood sugar). The order failed to include the specific sliding scale orders. An interview was conducted with the Administrator on 9/26/18 at 12:07 PM regarding the findings for Patient # 3. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this." A fax was obtained from the dialysis facility on 9/28/18 that included the following daily diet restrictions: Sodium 3 GM, Phosphorus 1200 mg and 1500 ml. The fax also included the following orders specific to the patients ESRD: Heparin Sodium 1,000 units/ml to arterial port 2,200 units and 2,300 units to venous port (of a central dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The POC failed to include the patient's special nutritional needs related ESRD (End Stage Renal Disease) and failed to include the patient's medication regimen for ESRD. 5. The clincial record of Patient # 4 with a SOC date of 3/13/18 was reviewed with the following findings: Event ID: 106K11 Facility ID: 013593 Page 60 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 10/02/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	i address, city, state, zip cod) CROSSPOINTE BLVD, NAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	 9/8/18 included ar days a week. The duration of the HF An interview was administrator on 1 administrator repord documentation to 6. The clinical rec date of 6/19/16 wa findings: The POC for the c 8/17/16, 8/18/16 to 12/14/16 included 5 days a week. Th duration of the HF An interview was Administrator on POC. The Admini working at the age The administrator 	conducted with the 0/1/18 at 4:30 PM and the rted there was no further be provided. ord of Patient # 5 with a SOC as reviewed with the following ertification periods of 6/19/16 to o 10/16/16 and 10/17/16 to an order for HHA 4 hours a day/ e POC failed to include the			
G 0602					
Bldg. 00	failed to ensure co nephrologist carin Dialysis) for 1 of (Patient # 3) in a s An agency policy	eview and interview, the agency mmunication occurred with the g for 1 ESRD (End State Renal l patient receiving hemodialysis ample of 7 clinical records. titled, "Coordination of Client iewed and stated: "All	G 0602	G 602 The Administrator or designee will immediately revi all clinical records for coordina of care with any patient receiv dialysis, wound care. If coordination of care has not b established the DON or RN ca manager will establish this coordination of care by calling	ation ring een ase

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLI A. BUILDINC B. WING	e construction G <u>00</u>	COM	e survey pleted 2/2018
	PROVIDER OR SUPPLIE		1050	EET ADDRESS, CITY, STATE, ZIP (00 CROSSPOINTE BLVD,		
AGING 8	& DISABLED HOMI	E HEALTH CARE LLC	INDI	IANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE
IAG	personnel furnishin liaison to assure the effectively and sup the Plan of Care. T care conferences, n care plans, and wr Purpose To ensu between members ensure appropriate to clients To more needs or changes i team to determin and /or future plan attending physicia of the client and id services provided. as necessary to est and coordinated ev disciplines involve the initial assessmet (Registered Nurse) findings of the initi Manager to ensure care orders. d. Clie caree. Need for community resour agencies and instit Care conferences w conference summa " An interview was 9/26/18 at 9:48 AM observation. The p venous dialysis car (collarbone) area f times weekly relat patient reported he	ng services shall maintain a at their efforts are coordinated oport the objective outlined in This may be done through formal maintaining complete, current itten and verbal interaction. re services are coordinated of the interdisciplinary team. To , quality care is being provided dify the plan to reflect the dentified by members of the ne the continuation of services s for care. To provide the n with an ongoing assessment lentify the client's response to 1. Care conferences will be held ablish interchange, reporting, valuation between all ed in the client's care 3. After ent, the admitting RN o or Therapist shall discuss the ial visit with the Clinical a. Clarification of the plan of ent's need for skilled nursing other services and/or referral to cesG. Coordination with other utions, if the need arises 6. will be determined on the care ary form or in the progress note		dialysis center or wou center and request we updates on patients ca The DON or designee administration/manage clinicians on policy: Coordination Services To prevent this deficient future, the DON will and clinical records weekly updates from these pri- present in the clinical present the DON will de provider for an update the RN case Manager update so the RN can POC if needed. The Administrator or of be responsible for act record audits until 100 compliance is met the clinical records will be quarterly for evidence compliance is met to e this deficiency will not Education completed 11/11/2018.	eekly are. e will educate ement, all n of Client ency in the udit these y to ensure roviders are record, if not call the e and notify of the update the designee will ive clinical 0% on 10 % of all e audited after 100% ensure that reoccur.	DAIE

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	CON	te survey Mpleted 02/2018
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500 (ADDRESS, CITY, STATE, ZIP CO CROSSPOINTE BLVD, IAPOLIS, IN 46256	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	care of 7/25/18 ar certification period orders for the follo "No added salt, reg The POC failed to related to the patie The administrator 12:07 AM and rep documentation the with the Hemodial The Administrator information regard medication, diet ar administrator repo medication finding do. There is no exo The agency was as and obtain the curr patient to include of medication. A fax facility] on 9/28/13 orders specific to to Sodium (to preven arterial port (red) 2 venous (blue) por treatment (3 times medication for ane push) every treatmen for anemia) 200 m The fax included a dietary restriction Phosphorus daily.	agency had coordinated care ysis facility or the Nephrologist. reported they did not have any ling the patients dialysis ad fluid restrictions. The rted in regards to the gs, "I have some education to				

106K11

Facility ID: 013593

If continuation sheet

sheet Page 63 of 206

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		157681	B. WI	ING		10/02/2018	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
		E HEALTH CARE LLC			CROSSPOINTE BLVD, IAPOLIS, IN 46256		
	1				I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		K5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DA	TE
60606							
Bldg. 00							
			G 0	606	N 606 The Administrator or	11/30	/2018
	Based on record re	eview and interview, the agency			designee will immediately revie	w	
	failed to ensure the	e clinical record included			all clinical records for supervisi		
	documentation of	coordination between the SN			of HHA's every 30 days for		
	(skilled nurse) and	the HHA (home health aide)			patients receiving non-skilled		
	regarding a change	e in the patient's skin condition			nursing services. If there are		
		om irritation to a stage 3			clinical records in which		
		1 of 4 patient's receiving home			supervision of HHA is not		
	*	es (Patient $\#2$) in a sample of 4.			completed every 30 days, the F	RN	
		- (case manager will be brought i		
	Findings Include:				immediately to be counseled of		
					supervisory regulations.		
	An agency policy	titled, "Coordination of Client			The Administrator or designee	will	
		ewed and stated: "All			educate	vv III	
		ng services shall maintain a			administration/management, al		
	-	at their efforts are coordinated			clinicians on policy:	'	
		port the objective outlined in			clinicians on policy.		
		This may be done through formal			Home Health aide		
		naintaining complete, current			Home Health aide		
		itten and verbal interaction.			supervision		
	care plans, and will	itten and verbar interaction.			To prevent this deficiency in the		
	An agency policy	titled, "Home Health Aide			future, the DON will monitor	-	
		reviewed and stated, " Agency			supervisory visits to ensure ski	llod	
	-	e Health Aide Services under			supervisory visits are conducte		
	-	upervision of a RN/ Therapist			every 30 days through weekly		
		e services are indicated and					
					audits. The Administrator or	_	
		visician 1. The Nursing			designee will be responsible fo		
	-	gnated RN/Therapist will give			active clinical record audits unt		
		for client care by way of the			100% compliance is met then 1	10	
	Care Plan.				% of all clinical records will be	<u> </u>	
					audited quarterly for evidence a	atter	
		for Patient # 2, with a start of			100% compliance is met to		
		5, with a diagnosis to include			ensure that this deficiency will	not	
	-	Functional limitations to			reoccur.		
		Bowel and Bladder					
		urance and Ambulation. The					
	plans of care for th	e certification periods of					

ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				0	MB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00				E SURVEY LETED
AND FLAN	OF CORRECTION	157681	B. WING		00	10/02/2018	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
		HEALTH CARE LLC			CROSSPOINTE BLVD, APOLIS, IN 46256		
					Γ		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLETIC
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG		DEFICIENCE		DATE
		5/14/18 to 7/13/18 and 7/14/18					
		orders for HHA (Home Health					
		aily for, 5 visits weekly. The					
	findings:	reviewed with the following					
	intunigs.						
		ated 3/29/18 stated, "Skin in					
	the crack of [pt's name] butt (buttocks) is slightly irritated.						
	A SN visit was con	ducted on 4/11/18 (13 days					
	later). The SN note stated, "Educated about						
	pressure relief due to impaired mobility voices an						
	understanding. Patient states that she has wound						
	center appointment on $4/19/18$ due to opened area						
	to crack of buttocks. Unable to assess wound due						
	to patient sitting in wheelchair and unable to						
	transfer via hoyer to assess wound because						
		t to be transferred back."					
		clinical record dated 4/12/18 at					
		d, "[hospital name] office visit,"					
	included a new diag	gnosis for Stage 3 pressure					
	ulcer of the buttock						
	The administrator v	vas interviewed on 9/26/18 at					
		nistrator reported there was no					
	documentation that the aide and nurse						
	communicated abor	it the patient's irritated area					
		stage 3 pressure ulcer in the					
		administrator was asked about					
	the process for the home health aide notes to be						
	reviewed by an RN. The administrator reported,						
	"The HHA visits are audited every 60 days by						
	[director of nursing						
0708							
Bldg. 00							
	1			0708	G 708 The Administrator	or	11/30/20

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 10/02/2018	COMPLETED	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500	TADDRESS, CITY, STATE, ZIP CO CROSSPOINTE BLVD, NAPOLIS, IN 46256	D		
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE PROPRIATE		
TAG	Based on observat interview, the RN accurately comple frequency and dur for 4 of 7 (Patients requirements for 2 medications and tr 2, 3) , and measura in a sample of 7 cl Findings Include: 1. A policy titled, and stated, "Home under the supervis physician. The pla comprehensive ass provided by the cl members The pla comprehensive ass provided by the cl members The pla days2. The plan full to include: c. T all visits/services . nutritional require: Medications, treatu Treatment goals1 At the time of cert written summary of the services being the plan of care fo include, but is not physical or psycho response to care/se and services 10. promptly alert the suggest a need to a 2. The clinical reco	R LSC IDENTIFYING INFORMATION ion, record review and (Registered Nurse) failed to te the plan of care to include the ation of visits to be conducted # 1, 2, 4, 5), the nutritional of 7 (Patient #1, 3), all eatments for 3 of 7 (Patient # 1, able goals for 1 of 7 (Patient # 1) inical records. "Plan of Care" was reviewed care services are furnished ion and direction of the client's n of care is based on a sessment and information ient/family and health team an will be consistently reviewed at needs are met and will be rry, but at least every sixty (60) of care shall be completed in fype, frequency, and duration of k. Specific dietary or ments or restrictions. 1. ments, and procedures p. other appropriate items 9. ification and recertification , a of the client's current status and provided are submitted with r review. The summary shall limited to: changes in clients social condition, client rryices and outcome of care Professional staff shall physician to any changes that liter the plan of care"	TAG	designee will immediate all clinical records for ac and complete plan of ca including frequency, and of visits, nutritional requirements,medication treatments with measura and current and past find clinical records found to POC that is not updated will call PCP for a verbal update the plan of care, physician order will be w reflecting the update and PCP for signature. The DON or designee w all clinicians on policy: Plan of Care polic Home Health Adm Service Agreement To prevent this deficience future, The DON will rev plan of care for accuracy sending to PCP for signa Administrator or designee responsible for active cli record audits until 100% compliance is met then clinical records will be an quarterly for evidence af compliance is met to ens this deficiency will not re Education completed on 11/08/2018.	ly review curate re, I duration hs, able goals, dings. Any have a , the DON order to then a rritten d sent to ill educate y hission cy in the iew every y before ature. The he will be nical 10 % of all udited ter 100% sure that occur.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		СОМРІ	(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
	1						
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
-	the following find						
	 9/15/16, included week and HHA see failed to include the nurse) and failed to Health Aide) time provided. The POC for the construction 11/14/16, included and HHA services 	ertification period of 7/18/16 to orders for skilled nurse 5 times a rvices 6 times a week. The POC ne duration for the SN (skilled to include the HHA (Home and duration and services to be ertification period of 9/16/16 to a orders for SN 5 times a week 6 times a week. The POC failed duration or HHA time and					
	1/13/17, included HHA 6 times a we the SN duration or	ertification period of 11/15/16 to orders for SN 5 times a week and eek. The POC failed to include HHA time and duration.					
	3/14/17, included HHA 6 times a we	ertification period of 1/14/17 to orders for SN 1 time a week and eek. The POC failed to include HHA time and duration.					
	5/13/17, included HHA 6 times a we	ertification period of 3/15/17 to orders for SN 1 time a week and eek. The POC failed to include HHA time and duration. POC.					
	7/12/17, included HHA 9 hours a da	ertification period of 5/14/17 to orders for SN 1 time a week and y for 5 days a week. The POC uration of the SN and HHA					
	9/101/7, included	ertification period of 7/13/17 to orders for SN 5 times a week and y. The POC failed to include					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE duration for the SN and HHA services. The POC for the certification period of 9/11/17 to 11/9/17, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 11/10/17 to 1/8/18, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 1/9/18 to 3/9/18, included orders for SN 5 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services The POC for the certification period of 3/10/18 to 5/8/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 5/9/18 to 7/7/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 7/8/18 to 9/5/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week and Event ID: 106K11 Facility ID: 013593 Page 68 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA () AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681 NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	(X3) DATE SURVEY COMPLETED 10/02/2018	
		STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256					
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREG (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETIO	
	failed to include d services. The POC included nutritional supplet hours. During an i patient's family m he/she reported th G-Tube feeding: T AM, 240 ml bolus 9-10 PM daily dur home from work. accurate nutritiona The POC included Aquaphor Externa healing of skin) 1 hours, Mupirocin once a day. The or ointments would b Ciprofloxacin (and per feeding tube e omitted from the F on 6/21/18. A pain goal on the remain tolerable th goal was not speci for an assessment not include measu	y, 5 days a week. The POC uration for the SN and HHA A orders for Two Cal HN (a nent) oral 240 ml bolus every 6 nterview conducted with the ember on 9/24/18 at 10:00 AM, e following was the accurate Two Cal HN 480 ml bolus at 6 or 7 at 4:00 PM and 480 ml bolus at ting the time the mother is at The POC failed to include the al requirements. A the following topical ointments: al (for protection and moisture apply to healed areas every 12 External (antibacterial) 2 % 1 reders failed to specify where the be applied. An order for cibiotic) HCL oral 500 mg 1 tab very 12 hours failed to be POC and had been discontinued e POC stated, "Patient's pain will rroughout care period." The fic to include the Wong scale of a nonverbal patient and did rable outcomes for tolerable					
	Administrator on 9 POC findings. The was no further doo	conducted with the 9/24/18 at 4:45 PM to review the e Administrator reported there cumentation to be provided. ord of Patient # 2 with a SOC					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681 NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	COMP	(X3) DATE SURVEY COMPLETED 10/02/2018	
		STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	findings:					
	9/11/18 and 9/12/2 include HHA 8 ho	ertification period of 7/14/18 to 8 to 11/10/18, with services to urs a day 5 days was reviewed. include a duration for the HHA				
	9/11/18, included External (healing j apply to open area not any better call week continued on	ertification period of $7/14/18$ to the following order: "Silvadene protective ointment) 1 % 2 x day 2 times per day for a week if physician." The order for one in the POC for $9/12/18$ to $11/10/18$ de the specific area of the body				
	Administrator on 9 POC findings. The	conducted with the 0/26/18 at 4:30 PM regarding the e Administrator reported there sumentation to be provided				
		ord of Patient #3 with a SOC of wed with the following findings:				
	9/22/18 included of nutritional require no concentrated sy interviewed on 9/2	ertification period of 7/25/18 to orders for the following ments: "No added salt, regular, veets" The patient was 26/18 9:48 AM and reported he ily fluid restriction and his diet diet.				
	regarding his med during a home the for the certificatio included orders fo Levothyroxine So	conducted with the patient ications on 9/26/18 at 9:48 AM rapy visit observation. The POC n period of 7/25/18 to 9/22/18 r the following medications: dium (thyroid pill also know as 75 mcg 1 tablet daily and				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Synthroid (thyroid pill also know as levothyroxine) Oral 75 mcg 1 tablet in the mornings daily. The patient reported the order was a duplicate. Nortriptyline (for diabetic neuropathy pain) HCL oral 10 mg 2 caps bedtime, the patient reported this medication had been discontinued 2 months ago. Insulin aspart (fast acting diabetic insulin) subcutaneous 100 units/ml 15-20 units daily before meals, using sliding scale (insulin amount depends on the patient's blood sugar). The order failed to include the specific sliding scale orders. An interview was conducted with the Administrator on 9/26/18 at 12:07 PM regarding the findings for Patient # 3. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this." A fax was obtained from the dialysis facility on 9/28/18 that included the following daily diet restrictions: Sodium 3 GM, Phosphorus 1200 mg and 1500 ml. The fax also included the following orders specific to the patients ESRD: Heparin Sodium 1,000 units/ml to arterial port 2,200 units and 2,300 units to venous port (of a central dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The POC failed to include the patient's special nutritional needs related ESRD (End Stage Renal Disease) and failed to include the patient's medication regimen for ESRD. 5. The clincial record of Patient # 4 with a SOC 106K11 Facility ID: 013593 Page 71 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

11/27/2018

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE	
IAG		s reviewed with the following				DAIL	
	9/8/18 included an	ertification period of 7/11/18 to order for HHA 3 hours day/ 4 POC failed to include the IA visits.					
	administrator on 1	conducted with the 0/1/18 at 4:30 PM and the rted there was no further be provided.					
		ord of Patient # 5 with a SOC s reviewed with the following					
	8/17/16, 8/18/16 to 12/14/16 included	ertification periods of 6/19/16 to 0 10/16/16 and 10/17/16 to an order for HHA 4 hours a day/ e POC failed to include the IA visits.					
	Administrator on 1 POC. The Admini working at the age The administrator	conducted with the 0/1/18 at 1:58 PM regarding the strator reported he/she was not ncy during that time period. reported there was no tion to be provided.					
G 0710							
Bldg. 00	(Skilled Nurse) fai on the POC (Plan	eview and interview, the SN led to provide services outlined Of Care) for 1 of 4 (Patient #1) of patients receiving SN le of 7.	G 0710	G 710 The Administra designee will immedia all clinical records with services are being pro there is evidence that not being followed the call the PCP for a ver	ately review h SN ovided. If the POC is e DON will	11/30/2018	

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULT A. BUILI B. WING	DING	STRUCTION	(X3) DATE COMPL 10/02/	ETED
NAME OF	PROVIDER OR SUPPLIE	R			DRESS, CITY, STATE, ZIP COD ROSSPOINTE BLVD,		
AGING	& DISABLED HOM	E HEALTH CARE LLC	I	NDIANA	POLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETI
TAG		PR LSC IDENTIFYING INFORMATION	1	TAG		-	DATE
	Findings Include:				update the plan of care and the		
	A policy titled "D	lan of Coroll was reviewed and			POC will be updated in the clin		
		lan of Care" was reviewed and			record and sent to the PCP for		
		e services are furnished under			signature. If failure to follow the	е	
	-	d direction of the client's			POC is due to a shortage on		
		n of care is based on a sessment and information			staffing the DON will call the	-	
	-			-	patient and offer to transfer the		
		ient/family and health team lan will be consistently reviewed			to an agency that can provide a services in the POC. If patient		
	-	and will be consistently reviewed and needs are met and will be					
		ary, but at least every sixty (60)			agrees to be transferred to ano		
		of care shall be completed in			agency the DON will facilitate a	1	
		Fype, frequency, and duration of			transfer to an agency of the patients choice and		
		k. Specific dietary or		-	documentation of conversation		
		ments or restrictions. l.					
	_	ments, and procedures p.			with patient will be recorded in	uie	
		9. At the time of certification		1	patients clinical record.		
		, a written summary of the		-	The Administrator or designee	will	
		tus and the services being			educate	vviii	
		itted with the plan of care for			administration/management, al	I	
	-	ary shall include but is not			clinicians on policy:		
		s in clients physical or		Ì	chine and on policy.		
		ition, client response to			Plan of Care		
		butcome of care and services					
		aff shall promptly alert the		-	To prevent this deficiency in the	e	
		hanges that suggest a need to			future, the DON will monitor the		
	alter the plan of ca				services of all clients weekly	-	
					through audits of services prov	ided	
	The clinical record	l of patient # 1 with a SOC (start			and any trends will be address		
		18/16 was reviewed with the			weekly with the administrator.		
	following findings				The Administrator or designee	will	
					be responsible for active clinica		
	The POC for the c	ertification period of 7/18/16 to			record audits until 100%		
		orders for skilled nurse 5 times a			compliance is met then 10 % o	fall	
	week for G-Tube	feedings while the mother is at			clinical records will be audited		
		ed to provide services until			quarterly for evidence after 100	0%	
	8/9/16 (21 days) a	-			compliance is met to ensure the		
					this deficiency will not reoccur.		
	An OASIS assess	nent conducted 9/13/16 stated:			-		
	"SN to administer	feedings on time daily 5 days a			Education completed on		

					NOTRIGTION		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		INSTRUCTION	· · ·	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157681		UILDING /ING	00		1PLETED 02/2018
		157081	Б. W				02/2018
NAME OF	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP	COD	
		HEALTH CARE LLC			CROSSPOINTE BLVD, APOLIS, IN 46256		
					74 OEIO, 114 40200		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETI
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		is working." The POC for the			11/08/2018.		
	-	of 9/16/16 to 11/14/16 included					
		es a week for G-Tube feedings					
		t work. The agency failed to $\frac{1}{27/16}$					
	11/5/16 and 11/8/16	0/27/16, 10/28/18, 11/1/16 to					
	11/3/10 and 11/8/10	0.011/10/10.					
	A communication r	ote dated 11/1/16 stated, "Due					
		ng difficulties with this patient,					
	-	assist family in finding a					
		other agency at this time family					
	-	fer. Currently [parent] is					
		on to feed daughter via G-Tube					
	until nursing staff a	vailable."					
	An OASIS assessm	ent conducted 11/11/16					
	reported the follow	ng: "SN to administer feedings					
		ys a week while [parent] is					
	-	C for the certification period of					
		included orders for SN 5 times					
		nducted a total of 4 of the 45					
		e POC for the certification					
	period and failed to	provide G-Tube feedings.					
	The POC for the ce	rtification period of 1/14/17 to					
		ders for SN 1 time a week for					
	-	ch visit. The SN conducted a					
		ne certification period and with					
	-	SN visit 2/8/17 no G-Tube					
	feedings were given	by the nurse.					
	The POC for the ce	rtification period of 7/13/17 to					
		ders for SN 5 times a week for					
		ne SN provided 1 visit during					
		of the certification period and					
		visits per week as ordered for					
	G-Tube feedings.						
	The POC for the ce	rtification period of 9/11/17 to					
		ders for SN 5 times a week for					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	COMI	e survey pleted 2/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500 (ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256		
(X4) ID PREFIX		/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO) BE	(X5) COMPLETIO
TAG		PR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	during weeks 1, 4, week 2 and 1 visit certification period G-Tube feedings a A SN note dated 9 request daily SN tr mother is at work. [parent]states at th able to cover the o not been a daily R The POC for the c 1/8/18 included or tube G-tube feedir change the SN free and week 9 of the provided 2 visits of during weeks 1 an	/11/17 stated, "continues to o cover G-Tube feedings while Will discuss with leadership. is time his/her family has been ther days of the week there has				
	The POC for the c 3/9/18 included or tube G-tube educa The SN provided v times during week The SN failed to p as ordered 5 times The POC for the c 5/8/18 included or G-Tube education SN provided 1 vis certification period feedings as ordere	nes weekly on weeks 1-6 and 8. ertification period of 1/9/18 to ders for SN 5 times a week for tion, monitoring and feedings. visits 1 time during week 1 and 2 as 2-9 of the certification period. rovide G-Tube feedings visits weekly on the POC. ertification period of 3/10/18 to ders for SN 2 times a week for , monitoring and feedings. The sit during week 9 of the d and failed to provide G-Tube d on the POC. ertification period of 5/9/18 to ders for SN 2 times a week for				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	· /	JILDING	NSTRUCTION <u>00</u>	CON	te survey Mpleted 02/2018
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COE CROSSPOINTE BLVD,)	
AGING 8	& DISABLED HOM	E HEALTH CARE LLC		INDIAN	APOLIS, IN 46256		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE	(X5) COMPLETIC
TAG		PR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		, monitoring and feedings. The					
	-	hospital from 5/17/18 to 6/1/18					
	-	acute care facility from 6/1/18 to					
		gnosis of 3rd-degree burns and					
	-	N provided 1 visit during week 1					
		period and failed to provide					
	G-Tube Feedings	as ordered on the POC.					
		conducted with the Parent of					
		4/18 at 10: 00 AM. The Parent					
	-	e worked 5-6 days a week. The					
	-	HHA for the agency, the					
		n not administer tube feedings					
		IA. Without a nurse to come to					
	-	parent had to change the					
	-	be feeding schedule. The parent					
	-	patient had been admitted on					
		ngs had been given in midday					
		gency. The parent reported the					
		t the agency around November					
		after the agency stopped					
	-	days a week. The parent					
	-	as told that the agency was					
		g a replacement nurse. The					
		/she had reported to the					
	-	d to the agency that he/she					
		ays a week, but the staffing					
		een addressed or resolved. The					
	· ·	nurse had told him/her that a					
		essary and another nurse told					
		caid had denied the prior					
	authorization for a	nurse 5 times a week.					
		conducted with Patient # 1's					
	sibling and full-tin	ne HHA on 9/25/18 at 1:50 PM.					
	The sibling report	ed the parent administered the					
	G-Tube feedings f	or Patient #1 before he/she left					
		e feeding schedule had been					
		ernoon when the parent came					
		bedtime. The sibling reported					

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 157681	ì í	ILDING	00	(X3) DATE COMPI 10/02	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION orking as a HHA it was not		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	feedings. He/she ra nurse for 2/1/2 yea agency would get a a week. The sibling the PA visits for 5 An interview was administrator on 9, administrator was investigation regar needs 5 days a wee the parent is at wo the complaint log, he/she had not bee needed this service aware of the misse the POC for SN an	e of practice to give the tube ported they have not had a rs and have been told the a nurse for the feedings 5 days greported she/he had been told times a week had been denied. conducted with the 24/18 at 2:35 PM. The asked if there was a complaint ding the family's reported SN k for G-Tube feedings while k. The administrator reported not been reported or logged in The administrator reported n made aware the family still . The administrator was made d visits and the failure to follow d HHA visits. The administrator no further documentation to be					
G 0724 Bldg. 00			G 0 ⁷	724	G 724 The Administrator or		11/30/2018
	(skilled nurse) fail- included documen HHA (home health patient's skin cond irritation to a stage patient's receiving (Patient #2) in a sa Findings Include: An agency policy to	view and interview, the SN ed to ensure the clinical record ation of coordination with the aide) regarding a change in the tion that progressed from 3 pressure ulcer for 1 of 4 home health aide services mple of 4.			designee will immediately re all clinical records for coordi of care between SN/HHA. Immediately all RN case managers will be required to conference with the HHA we for patients they case manage and document this coordinate care through a communication note in the clinical record. The DON or designee will end administration/management clinicians on policy:	nation eekly ge, tion of on ducate	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	PR MEDICARE & MEDIC ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATI COMF	MB NO. 0938-039 E SURVEY PLETED 2/2018
	PROVIDER OR SUPPLIE & DISABLED HOMI	E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, JAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
IAG	 personnel furnishin liaison to assure the effectively and sup the Plan of Care. T care conferences, n care plans, and write An agency policy is Supervision" was a shall provide Hom the direction and s when personal care ordered by the phy Supervisor or design the HHA direction Care Plan. The clinical record care date of 9/28/1 Cerebral Palsy and include Paralysis, J Incontinence, Endu plans of care for the 3/15/18 to 5/13/18 to 9/11/18 included Aide) for 8 hours of clinical record was findings: A HHA visit note the crack of [pt's n irritated. A SN visit was con later). The SN note pressure relief due understanding. Patt center appointmen to crack of buttock 	A loc Patient # 2, with a start of 5, with a diagnosis to include a for client care by way of the logwel and Bladder urance and Ambulation. The ne certification periods of , 5/14/18 to 7/13/18 and 7/14/18 dorders for HHA (Home Health dially for, 5 visits weekly. The services distributed of the following dated 3/29/18 stated, "Skin in ame] butt (buttocks) is slightly inducted on 4/11/18 (13 days e stated, "Educated about to avec and to avec and the services and to avec and the services and to avec and to avec and the following and to avec and the following and the following and to avec and the following and the following and to avec and the following and the following and the following to avec and the following the foll		Coordination of Clier Services Home Health Aide Supervision Care Planning/ Coor of Care Home health aides will be educated on: "What to Report to F Case Manager" Home Health Aide Documentation To prevent this deficiency future, the RN case manage be required to review all H documentation and perform weekly conference with HH all the patients they case r RN case manager will also the aide care plan with the assigned home health aide the home health aide prov services to the patient and the home health aide care with the home health aide every 60 days or when the change in the patients' cor the Administrator or design be responsible for active cor record audits until 100% compliance is met then 10 clinical records will be aud quarterly for evidence afte compliance is met to ensu this deficiency will not record	dination RN, in the gers will HA m HA's for manage. o review e prior to iding I review plan at least ere is a ndition. nee will dinical % of all ited r 100% re that	DATE

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

Event ID:

106K11 Facility ID: 013593

If continuation sheet Page 78 of 206

PRINTED: 11/27/2018 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	r í	JILDING	DNSTRUCTION 00	COMP	E SURVEY LETED 2/2018
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
G 0750	patient did not wan A document in the 11:00 AM and title included a new dia ulcer of the buttoc The administrator 2:45 PM. The adm documentation tha communicated abo that progressed to clinical record. Th the process for the reviewed by an RN	was interviewed on 9/26/18 at inistrator reported there was no t the aide and nurse but the patient's irritated area a stage 3 pressure ulcer in the e administrator was asked about home health aide notes to be V. The administrator reported, re audited every 60 days by					
Bldg. 00	failed to meet the 4 Home Health Aide failure to ensure the documentation the competency evalue contact (See tag G HHA (Home Heal change in the patie failure to ensure th provided all servic (See Tag G 800), f (SN) supervised th every 14 days (See The cumulative eff	eview and interviews the agency Conditions of Participation for e Services as evidenced by the e personnel files included home health aide competed a ation program before patient 766), failure to update the th Aide) care plan after a major ent's condition (See Tag G 798), the HHA (Home Health Aide) es outlined in the Plan Of Care ailure to ensure the Skilled Nurse the HHA (Home Health Aides) es Tag G 808).	G 0	750	G 750 The Administrator will immediately correct all deficiencies surrounding the Conditions of Participation thre education of staff on policies a procedures, focused audits of clinical records surrounding th deficiency sited, updating the of care with any changes in patient condition or failure to follow/update the plan of care continued oversite of all deficiencies through continued audits quarterly after 100% compliance is met in each deficient area sited. The Administrator will also become more involved with IA	and all le plan , and	11/30/2013

	T OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	<u>00</u>	COMPI	
		157681	B. WI	NG		10/02	/2018
	PROVIDER OR SUPPLIE	D.		STREET	ADDRESS, CITY, STATE, ZIP COD	-	
					CROSSPOINTE BLVD,		
AGING 8	& DISABLED HOME	E HEALTH CARE LLC		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· · ·	lth care in a safe environment			to stay abreast of all new		
		f Participation at 42 CFR 484.36,			regulations and available train	ing	
	Home Health Aide	Service			for administration and staff.		
G 0766							
Bldg. 00							
			G 0	766	G 766 The Administrator will		11/30/2018
		view and interview, the			immediately alert HR Director	not	
		d to ensure the personnel file			hire any new HHA's. The		
		ation that the home health aide			Administrator or designee will		
		tency evaluation program			seek a contract RN to perform	1	
	-	act for 1 of 1 home health aide			HHA skills check off and		
	records reviewed (Employee E)			competency. No new home		
	The line of the later				health aides will be hired until		
	Findings Include:				contract is in place. Any HHA		
	An agency policy t	itled, "Personnel Records" was			that were found not to have sl check offs present in employe		
		d, "Personnel files will be			will be checked off by the con		
		intained for all personnel			RN on skills.	liuot	
		s: 1. Personnel Record-the			The Administrator or designed	e will	
	· ·	el record will include, but not be			educate		
		ployment information:			administration/management, I	HR	
	Competency testin	g for home health aides and			Director on policy:		
	specific competence	eies per job title signed job			Personnel Records		
	description"						
					To prevent this deficiency in the	ne	
	-	ersonnel file of Employee E with			future, the Administrator or		
		13/16 and first patient contact of			designee will be responsible f		
		wed on 10/1/18 at 4:00 PM. The			active employee record audits		
		iled to include evidence of a			100% compliance is met then		
		est competency and a skills			% of all employee records will		
	competency upon l	nre.			audited quarterly for evidence	atter	
	The administrator	was interviewed on 10/1/18 at			100% compliance is met to	not	
		ted he/she would search for the			ensure that this deficiency wil	not	
	_	n. The administrator was			reoccur.		
	-	2/18 at 10:30 AM and reported					
		to locate the missing					
	income was unable	to rocate the missing					

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Event ID:

PRINTED: 11/27/2018 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

106K11 Facility ID: 013593

If continuation sheet Page 80 of 206

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION C	x3) date survey completed 10/02/2018
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, NAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION e personnel file of Employee E.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0798					
Bldg. 00	(Registered Nurse plan contained acc oral intake and fai was updated after condition for 1 of services (Patient # Findings Include: An agency policy /Update of Compr reviewed and state Assessment will b as the client's cond decline or improve Reassessment mus forty-eight (48) ho hospital admission hours for any rease Purposemodif change that may a Nurse is responsib Home Health Aide will identify the pi the client and care aide will follow th new services or dis contacting the sup	eview and interview the RN) failed to ensure the aide care urate information in regards to led to ensure the aide care plan a major change in the patient's 4 patients receiving HHA 1) in a sample of 4 titled, "Client Reassessment ehensive Assessment" was d, "The Comprehensive e updated and revised as often lition warrants due to major ement in health status t be done at least2. Within urs of client return home from a of more than twenty-four (24) on other than diagnostic testing by the plan of care and document ffect care6. The Registered le for reassessing the need for e services8. The assessment oblems, needs, and strengths of the family can provide The e care plan and will not initiate scontinue services without ervising Nurse/Therapist"	G 0798	G 798 The Administrator or designee will immediately revier all clinical record home health a care plans for accurate and upor information. Any home health a care plans that are found in rev containing inaccurate information will be updated after the DON of the PCP to receive a verbal ord to update the HHA care plan, and order will be written and then set to PCP for signature. The Administrator or designee we educate all clinicians on policy: Coordination of Client Services Home Health Aide Supervision To prevent this deficiency in the future, the RN case managers we review the patients care plan wit the assigned home health aide prior to the home health aide providing services to the patient and review the home health aide providing services to the patient and review the home health aide providing services to the patient and review the home health aide providing services to the patient and review the home health aide providing services to the patient and review the home health aide providing services to the patient and review the home health aide providing services to the patient and review the home health aide aide at least every 60 days or when there is a change in the patients' condition. The DON wi audit weekly HHA care plans at	aide date ide iew on salls der n ent will will t t le
	or therapist assess	ewed and stated, "2. The nurse es the need for personal care les the services in the		re-cert for accurate and updated information and with any chang condition with patient. The	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE physician plan of care (orders). A specific care Administrator or designee will be plan is developed documenting the aide services responsible for active clinical to be provided" record audits until 100% compliance is met then 10 % of all The POC for Patient #1 with a start of care date of clinical records will be audited 7/18/16 and a certification period of 5/9/18 to guarterly for evidence after 100% 7/7/18 was reviewed with the following findings: compliance is met to ensure that this deficiency will not reoccur. A Transfer OASIS dated 5/17/18 was reviewed and stated, "Patient hospitalized at this time due to reports of burns" An acute rehab hospital facility transfer report dated 6/13/18 was reviewed and reported the following altered skin conditions related to burns and skin grafting "Burns: Left forearm, bilateral buttocks, left lateral thigh, entire lower leg, and foot, Surgery: Left thigh, right thigh, left back. Trauma : right posterior knee and Left posterior knee" In addition the follow was stated under special treatments and procedures / Skin Care-"Use skin protection to high risk areas-support edematous areas and areas with decreased circulation-maintain a clean dry environment -evaluate for signs and symptoms of impaired wound healing/infections-relieve pressure on bony prominence's-use preventive skin care devices-observe for unusual/unexplained bruising-minimize exposure to sunlight" A Resumption of Care OASIS dated 6/13/18 was reviewed and the nurse documented, "Patient suffered from burns during bathing and required skin graft surgery x 2." The following sites were listed as 3rd Degree Burns: "left lower leg, left foot, buttock, abdominal wall, left thigh, left forearm." Pt had a new medication for pain Fentanyl (a small patch applied to the skin to allow the medication to absorb slowly). Event ID: 106K11 Facility ID: 013593 Page 82 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	· · ·	JLTIPLE CO ILDING	ONSTRUCTION 00	. ,	TE SURVEY IPLETED
AND FLAN	OF CORRECTION	157681	B. WI		00		02/2018
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD,		
AGING 8	DISABLED HOMI	E HEALTH CARE LLC		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE)PRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		n dated 5/9/18 was reviewed.					
		nments stated, "notify agency					
		ntake, N/V/D (nausea, vomiting,					
		n 24 hours, No BM (bowel					
		ys, fever, cough, congestion,					
	· ·	wn, any other concerns					
	immediately upon	noting. Keep head elevated					
	-	nuch as possible to prevent					
		on." The Aide Care Plan had					
	not been updated a	fter the patient's burns, skin					
	grafts and hospital	ization to include any special					
	precautions regard	ing positioning care of skin and					
	dressing sites and	specific signs to report to the					
	nurse. In addition,	the patient did not take oral					
	food, water or med	ls by mouth. He/she had a					
	gastric feeding tub	e and received hydration,					
		quid feedings in the gastric					
		direction regarding the pain					
	patch.						
		conducted with the					
		Director of Nursing service on					
		I regarding the failure of the SN					
	*	plan of care after a serious					
		ent's conditions. They had no					
	further documenta	tion to be provided.					
G 0800							
Bldg. 00							
-			G 08	800	G 800 The Administrator o	r	11/30/201
	Based on record re	eview and interviews, the HHA			designee will immediately	-	11,50,201
		e) failed to provide all services			all clinical records for provi		
		C (Plan Of Care) for 4 of 4			services according to the F		
		IHA services (Patients # 1, 2, 4			there is evidence that the I		
	and 5) in a sample				not being followed the DOI		
					call the PCP for a verbal o		
	Findings Include:				update the plan of care an		
	1. A policy titled	"Plan of Care" was reviewed			POC will be updated in the record and sent to the PCF		
	1 r poncy uneu,	i mil ul cale was leviewed	1		T ICCOLU ALLU SELLE LU LILE PUL	101	1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	r í	JILDING	ONSTRUCTION 00	COM	te survey ipleted 0 2/2018
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP CO CROSSPOINTE BLVD, IAPOLIS, IN 46256	DD	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETIC DATE
	and stated, "Home under the supervisi physician. The pla comprehensive ass provided by the cli members 10. Pre alert the physician need to alter the pl 2. The clinical reco (start of care) date the following findi The POC for the ca 9/15/16, included of a week. The HHA during week 1- 2 a	care services are furnished ion and direction of the client's n of care is based on a essment and information ent/family and health team of care is based on a ent/family and health team of essional staff shall promptly to any changes that suggest a an of care"			signature. If failure to f POC is due to a shortag staffing the DON will ca patient and offer to tran to an agency that can p services in the POC. If agrees to be transferred agency the DON will fa transfer to an agency o patients choice and documentation of conver- with patient will be reco patients clinical record. The DON or designee v administration/manager clinicians on policy: Plan of Ca	follow the ge on all the asfer them provide all patient d to another cilitate a f the ersation orded in the will educate ment, all	
	11/14/16, included times a week for as ADL's. The HHA s during week 5 of th to be conducted as The POC for the cc 5/13/17, included of for assistance. The evidence documen during weeks 4-9 of The POC for the cc 7/12/17 included of 5 days a week. The evidence documen weeks 1 and 2. The	ertification period of 3/15/17 to orders for HHA 6 times a week clinical record failed to tation of any HHA visits of the certification period. ertification period of 5/14/17 to rders for HHA 9 hours a day for e clinical record failed to tation of HHA visits during e HHA conducted 6 visits und 4 visits during week 9 of the			future, the DON or desi do weekly audits on HH schedules to ensure tha patients are receive the that are ordered in the Administrator or design responsible for active c record audits until 100% compliance is met then clinical records will be a quarterly for evidence a compliance is met to er this deficiency will not r Education completed o 11/08/2018.	ignee will IA at all e services POC. The eee will be linical % 10 % of all audited after 100% nsure that reoccur.	

NAME OF PROVIDER OR SUPPLIERAGING & DISABLED HOME HEALTH CARE LLC(X4) IDSUMMARY STATEMENT OF DEFICIENCIEPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLTAGREGULATORY OR LSC IDENTIFYING INFORMATION59/10/17 included orders for HHA 9 hours a day for5days a week. The HHA conducted 3 visitsduring week 1 and 6 visits during weeks 2-9 of thecertification period and failed to provide visits 5times weekly as ordered.The POC for the certification period of 9/11/17 to11/9/17 included orders for HHA 9 hours a day for5 days a week. The HHA provided 6 visits duringweeks 1-6, 2 visits during week 7, 4 visits duringweeks 8 and 9 of the certification period of 11/10/17 to1/8/18, included orders for HHA 9 hours a day for5 days a week. The HHA provided 6 visits duringweeks 8 and 9 of the certification period. TheHHA failed to provide visits as ordered.The POC for the certification period of 11/10/17 to1/8/18, included orders for HHA 9 hours a day for5 days a week. The HHA provided visits 6 timesduring weeks 5-9 during the certification period.The HHA failed to provide visits as ordered.The POC for the certification period of 1/9/18 to3/9/18 included orders HHA 9 hours a day, 5 daysa week. The HHA provided visits 4 times a week1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and1/11/18. The HHA provided visits 5 times a week1/15/18 to 1/19/18 with 14-hour visits on 1/16/18	r o r	D500 CROSSP DIANAPOLIS, FIX		RECTION IOULD BE	(X5) COMPLETIC DATE
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIONThe POC for the certification period of 7/13/17 to 9/10/17 included orders for HHA 9 hours a day for 5 days a week. The HHA conducted 3 visits during week 1 and 6 visits during weeks 2-9 of the certification period and failed to provide visits 5 times weekly as ordered.The POC for the certification period of 9/11/17 to 11/9/17 included orders for HHA 9 hours a day for 5 days a week. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during weeks 8 and 9 of the certification period. The HHA failed to provide visits as ordered.The POC for the certification period of 11/10/17 to 11/8/18, included orders for HHA 9 hours a day for 5 days a week. The HHA provided visits 6 times during weeks 5-9 during the certification period. The HHA failed to provide visits as ordered.The POC for the certification period of 11/10/17 to 1/8/18, included orders for HHA 9 hours a day for 5 days a week. The HHA provided visits 6 times during weeks 5-9 during the certification period. The HHA failed to provide visits as ordered.The POC for the certification period of 1/9/18 to 3/9/18 included orders HHA 9 hours a day, 5 days 	, PREI N TA	FIX (EACH CROSS-R	CORRECTIVE ACTION SH REFERENCED TO THE A	IOULD BE	COMPLETIO
 9/10/17 included orders for HHA 9 hours a day for 5 days a week. The HHA conducted 3 visits during week 1 and 6 visits during weeks 2-9 of the certification period and failed to provide visits 5 times weekly as ordered. The POC for the certification period of 9/11/17 to 11/9/17 included orders for HHA 9 hours a day for 5 days a week. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during weeks 8 and 9 of the certification period. The HHA failed to provided visits as ordered. The POC for the certification period of 11/10/17 to 11/8/18, included orders for HHA 9 hours a day for 5 days a week. The HHA provided visits a ordered. The POC for the certification period of 11/10/17 to 1/8/18, included orders for HHA 9 hours a day for 5 days a week. The HHA provided visits 6 times during weeks 5-9 during the certification period. The HHA failed to provide visits as ordered. The POC for the certification period of 11/9/18 to 3/9/18 included orders HHA 9 hours a day, 5 days a week. The HHA provided visits 4 times a week 1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and 1/11/18. The HHA provided visits 5 times a week 					
 and 1/18/18. The HHA provided visits 6 times a week from 1/21/18 to 3/9/18. The HHA failed to provide visits as ordered. The HHA failed to provide visits as ordered. The POC for the certification period of 3/10/18 to 5/8/18 included orders for HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The HHA provided 6 visits during week 1, 2, 3, 4, 6, 8, and 3 visits week 9. The HHA failed t provide visits as ordered. The POC for the certification period of 5/9/18 to 1000 million for the function of the function					

	R MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA			ISTRUCTION	(Y2) D	OMB NO. 0938-03
	NT OF DEFICIENCIES	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>			ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			COMPLETED		
		157681	B. WI	NG		10	/02/2018
NAME OF	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP O	COD	
					ROSSPOINTE BLVD,		
AGING 8	& DISABLED HOME	HEALTH CARE LLC		INDIANA	POLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COP	RRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETI
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	7/7/18 included ord	ers for HHA 9 hours a day, 5					
	days a week for ass	istance with IADL's and					
	ADL's. The patient	was in the hospital from					
	5/17/18 to 6/1/18. T	The HHA conducted a 14-hour					
	visit on 5/9/18 and	a 10-hour visit 5/12/18. The					
	HHA provided 4 vi	sits a week from 5/13/18 to					
	-	weekly from 5/17/18 to 7/7/18.					
	The HHA failed to	provide visits as ordered.					
	The POC for the ce	rtification period of 7/8/18 to					
		ers for HHA 9 hours a day, 5					
		HA provided 6 visits during					
	-	ts during week 9 of the					
		The HHA provided 14-hour					
	-	0/18, 7/12/18. The HHA failed					
	to provide visits as						
	The POC for the ce	rtification period of 9/6/18 to					
	11/4/18 included or	ders for HHA 9 hours a day, 5					
	days a week. The H	HA provided 3 visits during					
	week 1, and 6 visits	during week 2 and 3 of the					
	certification period.	The HHA provided 14-hour					
	visits on 9/6/18, 9/1	1/8.9/13/18, 9/18/18, and					
	9/20/18 and 16-hou	r visits on 9/9/18 and 9/16/18.					
	The HHA failed to	provide services as ordered.					
	3. The clinical reco	ord of Patient # 2 with a SOC					
	date of 9/28/15 and	a certification period of 7/14/18					
		vices to include HHA 8 hours a					
		or assistance with IADL's and					
		ed with the following findings:					
	The HHA provided	visits 6 days in week 4 of the					
	<u>^</u>	ranging from 3 to 11 hours a					
	-	tal of 46 hours. The HHA failed					
	to perform the visit						
	The HHA provided	visits 4 days in week 5 of the					
	-	ranging from 8-9 hours a day					
	-	f 33 hours. The HHA failed to					
		1 55 Hours. The THTA failed W					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681			(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018			
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256					
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APF	ULD BE COMPLETIO			
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION as ordered.	TAG	DEFICIENCY)	DATE			
	certification period for a weekly total perform the visits The HHA provide certification period weekly total of 42 perform the visits The HHA provide certification period	d visits 6 days in week 8 of the d ranging for 7 hours daily for a hours. The HHA failed to as ordered. d visits 3 days in week 9 of the d ranging from 4 to 11 hours for						
	 perform the visits 4. The clinical recordate of 3/13/18 and to 9/8/18 and 9/9/1 include HHA 3 ho 	ord of Patient # 4 with a SOC d certification period of 7/11/18 8 to 11/7/18, with services to urs a day for 4 days a week was						
	For the certification the HHA failed to evidenced by the f during week 1, 1 v	following findings: n period of 7/11/18 to 9/18/18, conduct visits as ordered as following missed visits: 3 visits isit during week 2, 1 visit during ring week 5, 6, 7 and 2 visits						
	the HHA failed to	n period of 9/9/18 to 11/17/18, conduct visits as ordered as ollowing missed visits: 3 visits and 3.						
	9/25/18 at 3:45 PM been 2-3 weeks sin than 1 day a week.	conducted with Patient # 4 on I. The patient reported it had nee he/she had a HHA more The patient reported, "It's been get any answers out of the office						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE ... I've told them and doesn't do any good ... I'm out of sight and out of mind." An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided. 5. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week was reviewed with the following findings: During the certification period of 6/19/16 to 8/17/16, the HHA failed to provide 2 hours of care during weeks 3 and 4, 10 hours of care during week 6, and 4 hours of care during weeks 8 and 9. During the certification period of 8/18/16 to 10/16/16, there were no HHA visit notes in the clinical record for weeks 1, 2, 3, 4, 5, 6. During weeks 7, 8, and 9 there were no HHA visit notes in the clinical record, except four (4), 2-hour HHA visits notes for services on (9/29/16, 9/30/16, 10/3/16 and 10/13/16) During the certification period of 10/17/16 to 12/14/16 the HHA failed to provide 10 hours during week 1, 18 hours during week 2, 18 hours during week 3 and with the exception of a 2-hour visit on 12/6/18, there were no further HHA notes for the certification period. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes and if there were any orders to change the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be Event ID: 106K11 Facility ID: 013593 Page 88 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

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ENTERS FOI	R MEDICARE & MEDI						
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157681	B. WI	NG		10/02/2018	
ł				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	NAME OF PROVIDER OR SUPPLIER				CROSSPOINTE BLVD,		
AGING 8	& DISABLED HOMI	E HEALTH CARE LLC		INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	provided.						
G 0808							
Bldg. 00			G 0	000	G 808 The Administrator or	11/30/20	
	Based on record re	eview and interview the agency	0.0	000	designee will immediately revie		
		killed Nurse (SN) supervision to			all clinical records for supervisi		
	-	Iealth Aides) every 14 days for 2			of HHA's every 14 days for	511	
		ving skilled nursing services			patients receiving skilled nursir	n	
	-	in a sample of 4 records.			services. If there are clinical	9	
	(Futfolie # Futfolie 2)	in a sample of Treeoras.			records in which supervision of	,	
	Findings Include:				HHA is not completed every 14		
	i manigo merade.				days, the RN case manager wi		
	1 An agency polic	y titled, "Home Health Aide			be brought in immediately to be		
		reviewed and stated, "Agency			counseled on supervisory	,	
	-	services under the direction			regulations.		
	~	a Registered Professional			The Administrator or designee	will	
	_	hen personal care services are			educate		
		red by the physician. The			administration/management, al		
		vision will be in response to			clinicians on policy:		
		ons, agency policy and other					
		uirements3. Supervisory			Home Health aide		
		l be according to the following			supervision		
		n skilled services are being					
		t, a Registered Nurse/Therapist			To prevent this deficiency in the	e.	
	-	visory visit to the client's			future, the DON will monitor	-	
		every two (2) weeks"			supervisory visits to ensure ski	led	
		/			supervisory visits are conducte		
	2. The skilled clini	cal record of Patient # 1 with a			every 14 days through weekly		
) date of 7/18/16 was reviewed			audits. The Administrator or		
	with the following				designee will be responsible fo	r	
		-			active clinical record audits unt		
	The POC for the c	ertification period of 7/18/16 to			100% compliance is met then 1		
		orders for skilled nurse 5 times a			% of all clinical records will be		
	week HHA service	es 6 times a week. HHA services			audited quarterly for evidence a	after	
		the record contained a RN			100% compliance is met to		
		ote on 8/16/16 which exceeded			ensure that this deficiency will	not	
		by 14 days. The next			reoccur.		
		vas 9/13/16 which exceeded the					
	1		1		1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018			
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256					
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH) CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETIO		
TAG	agency policy by	DR LSC IDENTIFYING INFORMATION 14 days.	TAG			DATE		
	11/14/16 included and HHA services visit had been con supervisory visit v agency policy by 2 The POC for the c 1/13/17 included of	ertification period of 11/15/16 to orders for SN 5 times a week and re were no documented						
	3/14/17 included of HHA 6 times a we was 10/29/16 and 2/14/17, which ex- days. The next sup	ertification period of 1/14/17 to orders for SN 1 time a week and eek. The prior supervisory visit the next supervisory visit was ceeded the agency policy by 77 pervisory visit was 3/14/17, and agency policy by 14 days.						
	5/13/17 included of 6 times a week. Th 3/14/17 and the ne which exceeded th The next supervise	ertification period of 3/15/17 to orders for SN 1 time a week HHA ne prior supervisory visit was ext supervisory visit was 4/10/17 ne agency policy by 13 days. ory visit was 5/9/17 which cy policy by 15 days.						
	7/12/17 included of	ertification period of 5/14/17 to orders for SN 1 time a week and y for 5 days a week. There were pervisory visits.						
	9/101/7 included of HHA 9 hours a da supervisory visits	ertification period of 7/13/17 to orders for SN 5 times a week and y for 5 days a week. The prior was 5/9/17 and the next vas 8/8/17 which exceeded the						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681			(X2) MULTIPLE CC A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/02/2018				
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETIC			
	agency policy by 7	74 days. The next supervisory hich exceeded the agency policy						
	11/9/17 included of HHA 9 hours a day supervisory visit w agency policy by 8 visits were 10/6/17 exceeded the agen The POC for the c 1/8/18 included or HHA 9 hours a day supervisory visit w	ertification period of 9/11/17 to orders for SN 5 times a week and y for 5 days a week. The prior vas 9/6/17 and the next vas 9/29/17, which exceeded the 8 days. The next supervisory 7 and then 11/8/17 which cy policy by 17 days. ertification period of 11/10/17 to ders for SN 5 times a week and y for 5 days a week. The prior vas 11/8/17 and the next vas 12/8/17, which exceeded the						
	agency policy by 1	15 days. The next supervisory hich exceeded the agency policy						
	3/9/18 included or HHA 9 hours a day supervisory visit w supervisory visit w agency policy by 2	ertification period of 1/9/18 to ders for SN 5 times a week and y, 5 days a week. The prior vas 1/5/18 and the next vas 2/9/18, which exceeded the 20 days. The next supervisory which exceeded the agency						
	5/8/18 included or and HHA 9 hours supervisory visit w supervisory visit w agency policy by 6	ertification period of 3/10/18 to ders for SN 2 times a week for a day, 5 days a week. The prior vas 3/5/18 and the next vas 3/26/18, which exceeded the 6 days. The next supervisory which exceeded the agency						

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500	I ADDRESS, CITY, STATE, ZIP COD O CROSSPOINTE BLVD, NAPOLIS, IN 46256	-	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	 7/7/18 included or and HHA 9 hours patient was hospita The next supervise 7/7/18, which excess The POC for the c 9/5/18 included or HHA 9 hours a day supervisory visit was supervisory visit was agency policy by 5 visits were 8/6/18, exceeded the agen The clincial recordate of 9/28/15 was findings: During the period nursing services was 9 weeks and HHA a day 5 days a wee supervisory visit days a wee 	ertification period of 5/9/18 to ders for SN 2 times a week for a day, 5 days a week. The ilized from 5/17/18 to 6/13/18. rry visits were 6/20/18 and then eed the agency policy by 2 days. ertification period of 7/8/18 to ders for SN 2 times a week and γ , 5 days a week. The prior ras 7/7/18 and the next ras 7/27/18 which exceeded the days. The next supervisory and then 8/31/18 which cy policy by 10 days. ord of Patient # 2 with a SOC is reviewed with the following of 7/14/18 to 8/8/18, skilled ere ordered 3 times a week for services were ordered 8 hours k. The nurse failed to conduct a ue every 14 days. A ras due by 7/30/18 for a skilled				
G 0814						
Bldg. 00	failed to provide S the HHA (Home H of 2 patient receiv	view and interview the agency killed Nurse (SN) supervision to tealth Aides) every 60 days for 1 ing non-skilled nursing services ample of 2 non-skilled clinical	G 0814	G 814 The Administrator or designee will immediately rev all clinical records for supervi of HHA's every 60 days for patients receiving non-skilled nursing services. If there are clinical records in which supervision of HHA is not completed every 60 days, the	sion	

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA				
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
AND I LAIN	or connection	157681	B. WING	00	10/02/2018	
			STREE	T ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE			0 CROSSPOINTE BLVD,		
AGING &	DISABLED HOMI	E HEALTH CARE LLC	INDIA	ANAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				case manager will be brought		
		titled, "Home Health Aide		immediately to be counseled	on	
	-	reviewed and stated, "Agency		supervisory regulations.		
	shall provide HHA	services under the direction		The Administrator or designee	e will	
	and supervision of	a Registered Professional		educate		
	Nurse/Therapist w	hen personal care services are		administration/management, a	all	
		red by the physician. The		clinicians on policy:		
		vision will be in response to				
	Medicare regulation	ons, agency policy and other		Home Health aide		
	state or federal req	uirementsc. Home Health		supervision		
	Aide services only	: When HHA services are				
	being furnished to	a client, who does not require		To prevent this deficiency in t	he	
	the skilled services	s of a nurse or therapist, a RN or		future, the DON will monitor		
	qualified therapist	must make a supervisory visit		supervisory visits to ensure sl	killed	
	to the cline's reside	ence at least once every sixty		supervisory visits are conduct	ed	
	(60) days"			every 60 days through weekl	у	
				audits. The Administrator or	-	
	The non-skilled cl	inical record of Patient # 4 with a		designee will be responsible f	or	
	SOC date of 3/13/	18 was reviewed. The POC for		active clinical record audits ur	ntil	
	the certification pe	eriod of 7/11/18 to 9/8/18		100% compliance is met then	10	
	included orders for	r SN monthly for aide		% of all clinical records will be	e	
	supervisory visit a	nd HHA 3 hours a day for 4		audited quarterly for evidence	after	
	days a week.	·		100% compliance is met to		
	The clinical record	l evidenced a supervisory visit		ensure that this deficiency wil reoccur.	Inot	
		xt supervisory visit was on				
		visory visit exceeded the				
	agency policy by 3	-				
	An interview was	conducted with the				
		0/1/18 at 4:30 PM regarding late				
		isory visits. The administrator				
	_	no further documentation to be				
	provided.	no receiver accomponation to be				
0940						
3ldg. 00						
Diag. 00			G 0940	G 940 The Administrator has	11/12/201	
	Based on record re	eview and interview the		ensured public information		

DEPARTMENT OF HEALTH AND HUM

ENTERS FOR STATEMEN	COFHEALTH AND HU R MEDICARE & MEDIC TOF DEFICIENCIES OF CORRECTION		A. BL	(2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			APPROVED MB NO. 0938-039 E SURVEY LETED 2/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, JAPOLIS, IN 46256		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	LD BE COMPLET	
	parent location die	ed to ensure the home health l not relocate without ior approval of CMS for 1 of 1			regarding address of parent agency is correct by:		
agency (See Tag G 940) and the clinical manager failed to ensure the HHA (Home Health Aide) documentation notes were completed and entered into the clinical record (See G Tag 958).					CMS 855 filed on 9/24/ Parent location address given to the answering servic 9/21/18	S	
	The cumulative ef	fect of these systemic problems			Letter sent to ISDH on 7/19/2018		

Correction letter sent to

The agency has not received a

confirmation letter for approval of

deficiency is corrected and will not

submitted and the agency will not

move locations until approval letter

reoccur. Any future change in

ISDH on 9/24/2018

change of location.

The Administrator will be responsible for these corrective

actions to ensure that this

location a CMS 855 will be

has been received.

resulted in the home health agency's inability to provide quality health care in a safe environment for the Condition of Participation at 42 CFR 484.36, Organization and Administrative Service. In relationship to G 940 findings Include: The State Operations Manual Chapter 2, section 2185 was reviewed and indicated, "HHA Change of Address: It is inherent in the provider certification process that a provider notifies CMS (Center for Medicare and Medicaid Service) of its intent to change the location or site from which it provides services. Absent such notification, CMS has no way of carrying out its statutorily mandated obligation of determining whether the provider is complying with applicable participation requirements at the new site or location. It is longstanding CMS policy that there is no basis for a provider to bill Medicare for services provided from a site or location that has not been determined to meet applicable requirements of participation ... When an existing HHA (Home Health Agency) intends to move from its surveyed and certified location to a new site or location that is within the current approved geographic area, it notifies its MAC (Centers for Medicare and Medicaid) within 90 days of the move, and submits all required documentation including an amended Form CMS -855 A. The RHHI (Regional Home Health Intermediary)

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

Event ID:

Page 94 of 206

106K11

Facility ID: 013593

If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018		
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		10500	STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
	the RO (Regional final decision to an The provider notifi through the SA1 approval notice, the information, toget documentation froe relevant information its decision" A letter from the an 7/19/18 addressed of health was revise Disabled Home He (17-013593-1) wo mailing and addree Crosspoint Blvd, I Tillotson Avenue, corporate mailing Indianapolis, IN. V send us a license r corporate mailing this address chang Blvd building was not allow us to app which is required to letter was signed to The letter did not is relocation. On 9/20/18 at 10:0 called to validate to The answering ser have moved, but I On 9/21/18 at 9:00 called and followin employees, it beca	and makes a recommendation to Office). The RO then makes the pprove the change of location. The CMS either directly or Upon receipt of the MAC's the RO will carefully evaluate the her with any supporting on the provider and any other on known to the RO in making agency corporate office dated to the Indiana State Department ewed and indicated, "Aging & ealth Care License # uld like to make a corporate ss change from 10500 indianapolis, IN 46256 to 625 S Muncie, IN 47304 The address will be PO Box 17460, We would also like for you to enewal form to the PO Box address please. The reason for e is that our 10500 Crosspoint sold and the new owner would ply signage to the building, by state regulations" The by the agency administrator. indicate an effective of the 00 PM, the agency number was the agency's current location. vice indicated, "I know they don't know the new address." 6 AM, the agency number was ng speaking with 3 different ume known the agency had lianapolis to Muncie, IN.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, JAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIATI DEFICIENCY)	E	(X5) COMPLETION DATE
G 0958	interviewed and in	0 AM the administrator was dicated no CMS-855 had been cal intermediary for the					
Bldg. 00	Director of Nursin HHA (Home Heal were completed ar record for 2 of 4 p (Patient's #1 and 5 records. Findings Include: 1. An agency poli Documentation" w "Agency will docu the client. This dou by the direct careg skilled professiona clients' care. Purpo accurate record of response and ongo document conform modifications to th involvement 2. completed for each dated by the appro and length of the c each note 5. Doo on the plan of care services are render	eview and interviews, the (DON) g Services failed to ensure the th Aide) documentation notes d entered into the clinical atient's receiving HHA services) in a sample of 7 clinical cy titled, "Clinical as reviewed and stated, ment each direct contact with cumentation will be completed iver and monitored by the d responsible for managing the ose: To ensure that there is an the services provided, client ing need for care. To hance with the Plan of Care, the plan and interdisciplinary a separate note shall be n visit/shift and signed and priate professional. Actual time lient visit will be included in cumentation of services ordered will be completed the day ed and incorporated into the hin seven (7) days after the care	G 0	958	G 958 The Administrator will immediately review with the DC job description, responsibilities, expectations of job performance The Administrator or designee reducate administration/management on policy: Clinical Documentation Director of Nursing To prevent this deficiency in the future, the Administrator or designee will have written documentation of orientation of DON, outlining job description, responsibilities, and expectation job performance.	, e. will e the job	11/30/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 2. A job description titled, " Director of Nursing" was reviewed and stated, " ... Position Summary: Responsible for the overall supervision and direction of healthcare services ... shares responsibilities with the Administrator for the agency's overall compliance with State and Federal guidelines and standard of nursing practice. Duties and Responsibilities: Supervise and direct all clinical services. Promote, review and evaluate the quality and appropriateness of patient care practices ... Participate in assigning personnel to patients based on patient need and physician's plan of care ... Coordinate and ensure that the patient is well serviced through the assignment of skilled services and personal caregivers" 3. The clinical record for Patient # 1 with a start of care date of 7/18/16 failed to evidence any HHA documentation notes from 4/2/17 to 5/21/17 in the clinical record. 4. The clinical record for Patient # 5 with a start of care date of 6/19/16 to 12/14/16 failed to evidence any HHA documentation notes from 8/10/16 to 9/29/16 in the clinical record. 5. An interview was conducted with the DON on 9/21/18 at 1:06 PM. The DON reported, "I'm in charts all day long." The DON reported having assessed quality of care, performed "pop- up" visits with nursing staff, looked at clinical notes, and did Quality audits of 10 % of clinical records quarterly. 6. The administrator was interviewed on 9/26/18 at 2:45 PM about the missed HHA visit documentation for Patient # 1 and 5. The administrator reported the aides' visits notes had Event ID: 106K11 Facility ID: 013593 Page 97 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP CO CROSSPOINTE BLVD, IAPOLIS, IN 46256	D	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
G 1012 Bldg. 00	scheduler. The sch assigned visits and for the aide to hav administrator repo- uploaded the visits would not have ha to the computer pr reported the proce nursing services to computer to ensur- schedule for HHA the HHA notes ever reported the HHA ¹ the visits had not be the audits failed to missing the HHA ¹ Based on record re- failed to accurately include the frequer made for 4 of 7 (P nutritional require all medications an 1, 2, 3), measurabli- failed to ensure the documentation not into the clinical re- HHA services (Pat ensure written not included in the clinical cline clinical re-	by the computer schedule by the eduler should have put the the times into the computer e documented their visit. The rted if the scheduler had not to the computer the HHA d a way to document their visit ogram. The administrator ss was for the director of check the assignments in the e the POC matched the visits and was to have audited ery 60 days. The administrator S had not informed the agency een uploaded in computer and discover the records were documentation.	G 10	012	G 1012 The Administrate designee will immediate all clinical records for ac complete plan of care to the frequency and durate visits, the nutritional requ all medications and treatments, measurable of completed HHA docume notes are in the clinical in and written notice of the rights are in the clinical in Any clinical record found have current updated inti in the clinical record, the call the PCP for a verbai update the plan of care, physician order will be w	ly review ccurately include ion of uirements, goals, entation record, patient's record. d not to formation e DON will l order to a written	11/30/2018

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018	
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E (X5) COMPLET DATE	
	 An agency poli Documentation" w "Agency will docu the client. This do by the direct careg skilled professional clients's care. Purp accurate record of response and ongo document conform modifications to th involvement 2. a completed for each dated by the approp and length of the c each note 5. Do on the plan of car services is rendere clinical record wit A policy titled, and stated, "Home under the superviss physician. The pla comprehensive ass provided by the cli members The pla to ensure that clier updated as necessa days2. The plan full to include: c. 7 all visits/services nutritional require: Medications, treatu Treatment goals1 	cy titled, "Clinical vas reviewed and stated, iment each direct contact with cumentation will be completed iver and monitored by the al responsible for managing the iose: To ensure that there is an the services provided, client ing need for care. To hance with the Plan of Care, he plan and interdisciplinary a separate note shall be in visit/shift and signed and priate professional. Actual time lient visit will be included in cumentation of services ordered will be completed the day d and incorporated into the hin seven "Plan of Care" was reviewed care services are furnished ion and direction of the client's in of care is based on a sessment and information ient/family and health team lan will be consistently reviewed at needs are met and will be try, but at least every sixty (60) of care shall be completed in Type, frequency, and duration of k. Specific dietary or ments or restrictions. 1. ments, and procedures p. t. other appropriate items 9. ification and recertification , a		and then sent to PCP for signature. Any HHA documentation not up to data clinical record will be obtained from HHA. Any clinical record found not to have written documentation of patients rig a new Home Health Admissis Service Agreement will be obtained from the Patient or Representative and placed in clinical record. The Administrator or designed educate administration/management, clinicians, HHA's on policy: Clinical Documentation Plan of Care To prevent this deficiency in future, the DON will monitor clinical record is correct, upd as needed and with any char patients condition, that documentation is completed timely manner according to agency policy and will review documentation was obtained during the initial comprehense	the all gh the lated nge in in a v all litting	
	written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include, but is not limited to: changes in clients			assessment, the Administrat designee will be responsible active clinical record audits u 100% compliance is met the	or or for intil	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE physical or psychosocial condition, client % of all clinical records will be response to care/services and outcome of care audited quarterly for evidence after and services ... 10. Professional staff shall 100% compliance is met to promptly alert the physician to any changes that ensure that this deficiency will not suggest a need to alter the plan of care" reoccur. 3. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16, included orders for skilled nurse 5 times a week and HHA services 6 times a week. The POC failed to include the duration for the SN (skilled nurse) and failed to include the HHA (Home Health Aide) time and duration and services to be provided. The clinical record failed to include a case conference/ 60 day summary. The POC for the certification period of 9/16/16 to 11/14/16, included orders for SN 5 times a week and HHA services 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 11/15/16 to 1/13/17, included orders for SN 5 times a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 1/14/17 to 3/14/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The notes dated 2/16/17 and 3/9/17 failed to include skilled nurse services 1 time a week, and the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided Event ID: 106K11 Facility ID: 013593 Page 100 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/27/2018

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	COMI	(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	STREET A 10500 (INDIAN	D			
(X4) ID PREFIX		7 STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION	TAG CROSS-REFERENCED TO THE APPROPRI		PROPRIATE	ATE DATE	
	 5/13/17, included HHA 6 times a we the SN duration or The POC for the c 7/12/17, included HHA 9 hours a da failed to include d services. The POC for the c 9/10/17, included HHA 9 hours a da 	ertification period of 3/15/17 to orders for SN 1 time a week and eek. The POC failed to include THHA time and duration. ertification period of 5/14/17 to orders for SN 1 time a week and y for 5 days a week. The POC uration of the SN and HHA ertification period of 7/13/17 to orders for SN 5 times a week and y. The POC failed to include					
	The POC for the c 11/9/17, included HHA 9 hours a da failed to include d services. The note skilled nursing ser services were daily week. The note da reported skilled nu provided 5 days a 1-2 times a week) "no change." The patient's current pl condition and pati- of care/services pr The POC for the c	ertification period of 11/10/17 to					
	1/8/18, included o HHA 9 hours a da failed to include d services. The note stated, "continue p acute changes note	rders for SN 5 times a week and y for 5 days a week. The POC uration for the SN and HHA s dated 12/4/17 and 1/4/18 both blan of care as developed" . No ed at this time. The notes failed ent's current physical or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			CON	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	-	STREET 10500 INDIAI				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO T	N SHOULD BE	(X5) COMPLETIO	
TAG	psychosocial cond	R LSC IDENTIFYING INFORMATION ition and patient's response to re/services provided.		TAG	DEFICIENCY		DATE	
	3/9/18, included of HHA 9 hours a day failed to include d services. The clini nurse note dated 2 mother, patient fel were dated 2/55/18 "Continue plan of noted. No acute ch mention of the fall the patient's currer condition and patie of care/services pr The POC for the c 5/8/18, included of HHA 9 hours a day	ertification period of 1/9/18 to rders for SN 5 times a week and y, 5 days a week. The POC aration for the SN and HHA cal record evidenced a skilled /19/18 that reported, "per 1 off bed yesterday." The notes 8 and 3/5/18 and both stated, care as developed. No distress anges noted." There was no and the notes failed to include at physical or psychosocial ent's response to and outcome ovided. ertification period of 3/10/18 to rders for SN 2 times a week and y, 5 days a week. The POC aration for the SN and HHA						
	7/7/18, included of HHA 9 hours a day	ertification period of 5/9/18 to rders for SN 2 times a week and y, 5 days a week. The POC uration for the SN and HHA						
	9/5/18, included of HHA 9 hours a day	ertification period of 7/8/18 to rders for SN 2 times a week and y, 5 days a week. The POC uration for the SN and HHA						
	11/4/18 included of HHA 9 hours a day	ertification period of 9/6/18 to rders for SN 2 times a week and y, 5 days a week. The POC uration for the SN and HHA						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			COM	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRC DEFICIENCY)) BE	(X5) COMPLETIC DATE	
	services.							
	nutritional suppler hours. During an i patient's mother or reported the follow feeding: Two Cal 240 ml bolus at 4: PM daily during th from work. The PC nutritional require							
	Aquaphor Externa healing of skin) 1 hours, Mupirocin once a day. The or ointments would b Ciprofloxacin (ant per feeding tube ex	the following topical ointments: l (for protection and moisture apply to healed areas every 12 External (antibacterial) 2 % 1 ders failed to specify where the e applied. An order for ibiotic) HCL oral 500 mg 1 tab very 12 hours failed to be POC and had been discontinued						
	remain tolerable the goal was not speci- for an assessment	POC stated, "Patient's pain will proughout care period." The fic to include the Wong scale of a nonverbal patient and did rable outcomes for tolerable						
		I failed to evidence any HHA tes from 4/2/17 to 5/21/17 in the						
	Administrator on 9 POC findings. The	conducted with the D/24/18 at 4:45 PM to review the Administrator reported there cumentation to be provided						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	СОМ	(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP C CROSSPOINTE BLVD, NAPOLIS, IN 46256	OD	_	
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TAG	,	OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE	
	4. The clincial rec	ord of Patient # 2 with a SOC as reviewed with the following					
	9/11/18 and 9/12/2 include HHA 8 hc	ertification period of 7/14/18 to 18 to 11/10/18, with services to ours a day 5 days was reviewed. include a duration for the HHA					
	9/11/18, included External (healing apply to open area not any better call week continued or	ertification period of $7/14/18$ to the following order: "Silvadene protective ointment) 1 % 2 x day 2 times per day for a week if physician." The order for one n the POC for $9/12/18$ to $11/10/18$ de the specific area of the body					
		ord of Patient # 2 with a SOC as reviewed with the following					
	9/11/18 and 9/12/2 include HHA 8 hc	ertification period of 7/14/18 to 18 to 11/10/18, with services to ours a day 5 days was reviewed. include a duration for the HHA					
	9/11/18, included External (healing apply to open area not any better call week continued on	ertification period of 7/14/18 to the following order: "Silvadene protective ointment) 1 % 2 x day 2 times per day for a week if physician." The order for one n the POC for 9/12/18 to 11/10/18 de the specific area of the body					
		conducted with the 9/26/18 at 4:30 PM regarding the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	STREET 10500 INDIA	COD	_		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	RRECTION HOULD BE	(X5) COMPLETIO	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG CROSS-REFERENCED TO THE APPROPRIA		APPROPRIATE	DATE	
	-	Administrator reported there sumentation to be provided					
		ord of Patient #3 with a SOC of wed with the following findings:					
	9/22/18 included of nutritional require no concentrated sw interviewed on 9/2 had a 32 ounce da is a diabetic/renal [the dialysis facilit following daily dio Phosphorus 1200 a to include the patie	ertification period of 7/25/18 to orders for the following ments: "No added salt, regular, veets" The patient was 6/18 9:48 AM and reported he ly fluid restriction and his diet diet. A fax was obtained from y] on 9/28/18 and included the et restrictions: Sodium 3 GM, ng and 1500 ml. The POC failed ents special nutritional needs d Stage Renal Disease).					
	regarding his med during a home the for the certification included orders fo Levothyroxine Son Synthroid) Oral 17 Synthroid (thyroid levothyroxine) Ora mornings daily. Th was a duplicate. N neuropathy pain) I the patient reporte discontinued 2 mo acting diabetic ins 15-20 units daily t (insulin amount data)	al 75 mcg 1 tablet in the ne patient reported the order ortriptyline (for diabetic HCL oral 10 mg 2 caps bedtime, d this medication had been nths ago. Insulin aspart (fast ulin) subcutaneous 100 units/ml perfore meals, using sliding scale epends on the patient's blood cailed to include the specific					
	An interview was	conducted with the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Administrator on 9/26/18 at 12:07 PM regarding the findings for Patient # 3. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this." No further documentation to be provided. A fax was obtained from [the dialysis facility] on 9/28/18 and included the following orders specific to the patients ESRD: Heparin Sodium 1,000 units/ml to arterial port 2,200 units and 2,300 units to venous port (of a central dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The POC failed to include the patient's medication regimen for ESRD. 7. The clincial record of Patient #4 with a SOC date of 3/13/18 was reviewed with the following findings: The POC for the certification period of 7/11/18 to 9/8/18 included an order for HHA 3 hours day/ 4 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided. 8. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification periods of 6/19/16 to 106K11 Facility ID: 013593 Page 106 of 206 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

11/27/2018

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE 8/17/16, 8/18/16 to 10/16/16 and 10/17/16 to 12/14/16 included an order for HHA 4 hours a day/ 5 days a week. The POC failed to include the duration of the HHA visits. The clinical failed to evidence any HHA documentation notes from 8/10/16 to 9/29/16 in the clincial record The clinical record failed to evidence a contain a copy of the patient's rights. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be provided. N 0000 Bldg. 00 N 0000 This visit was a State re-licensure survey with investigation of 2 complaints Dates of survey: 9/21/18, 9/24/18 - 9/28/18, 10/1/18-10/2/18 Facility # 013593 Medicaid #: 201284430 Complaints # IN 00243261: Substantiated with findings IN 00220561: Substantiated with findings 12 Month Unduplicated Census: 257 Home visits with record review: 3 Records reviewed without home visit : 4 Event ID: Facility ID: 013593 Page 107 of 206 106K11 If continuation sheet State Form

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	1	E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	-	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
N 0447 Bldg. 00	410 IAC 17-12-1 Home health age administration/m Rule 12 Sec. 1(c may also be the registered nurse shall do the follow (4) Ensure the a materials and ac Based on record re failed to provided regarding the relow location for 1 of 1 Findings Include: A letter from the a 7/19/18 addressed of health was revio Disabled Home Hi (17-013593-1) wo mailing and addre Crosspoint Blvd, I Tillotson Avenue, corporate mailing Indianapolis, IN. V send us a license r corporate mailing this address chang Blvd building was not allow us to app which is required b	(c)(4) ency anagement c)(4) The administrator, who supervising physician or required by subsection (d), wing: ccuracy of public information tivities. eview and interview, the agency appropriate public information cation address of the parent	N 0	447	N 447 The Administrator has immediately corrected public information regarding address parent agency is correct by: CMS 855 filed on 9/24/1 Parent location address given to the answering service 9/21/18 Letter sent to ISDH on 7/19/2018 Correction letter sent to ISDH on 9/24/2018 The agency has not received confirmation approval letter or change of location. The Administrator will be responsible for these correctiv actions to ensure that this deficiency is corrected and wil reoccur and will file a CMS 85 and wait for approval letter be moving location of corporate of in the future.	8 e on n ve II not 55 fore	11/12/201

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/02/2018
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	1050	T ADDRESS, CITY, STATE, ZIP COD 0 CROSSPOINTE BLVD, ANAPOLIS, IN 46256	•
(X4) ID PREFIX TAG	(EACH DEFICIE	7 STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
N 0449 Bldg. 00	 called to validate to The answering series have moved, but I On 9/21/18 at 9:06 called and following employees it because relocated from Indian On 9/21/18 at 11:32 interviewed and reass answering service been made aware of since they had not agency's new addrease accurately report to phone inquiry. 410 IAC 17-12-1 Home health age administration/m Rule 12 Sec. 1(c may also be the registered nurse shall do the follow (6) Ensure that the meets all rules and Based on record reassure the agency licensure for 1 of 2 Findings include: The administrator Health Aide) documents and the follow of the administrator for the administrator and the follow of the follow of the follow of the administrator for the adm	failed to ensure the accuracy of	N 0449	N 449 The Administrator will immediately correct all deficiencies through educati staff on policies and procedu focused audits of all clinical records surrounding the defi sited, updating the plan of c with any changes in patient condition or failure to follow plan of care, and continued oversite of all deficiencies th continued audits quarterly a 100% compliance is met.	on of ures, ciency are the rough

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00		PLETED	
		157681	B. WING	<u></u>	_	10/02/2018	
		_	STREE	T ADDRESS, CITY, STATE, ZIP	COD		
	PROVIDER OR SUPPLIE			0 CROSSPOINTE BLVD,			
AGING a	& DISABLED HOM	E HEALTH CARE LLC	INDIA	ANAPOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	Tag N 453).			The Administrator will			
	T 1 1	C 1 1 / J		become more involve			
		failed to ensure the agency		to stay abreast of all r			
	employment polic	y was followed (See Tag N 458).		regulations and availa	-		
	The administrator	failed to ensure personnel files		for administration and	i stan.		
		iders contained either a valid					
	· · ·	TST (tuberculosis skin test)					
		lid negative TST within the					
	-	r a valid two-step TST upon					
	hire (See Tag 464)						
	The administrator	failed to ensure the clinical					
	record included do	ocumentation of coordination					
	between the SN (s	killed nurse) and the HHA					
	(home health aide)) regarding a change in the					
	patient's skin cond	ition that progressed from					
	irritation to a stage	e 3 pressure ulcer (See Tag N					
	484/ N545).						
		failed to ensure communication					
		nephrologist caring for 1 ESRD					
	(End State Renal I	Dialysis) (See Tag N 486/ N546)					
	The administrator	failed to ensure the clinical					
		ocumentation that the patient					
		nily had received written notice					
	of patient's rights ((See Tag N 494).					
		failed to ensure the patient was					
		g of the disciplines and the					
	frequency of the se N 504).	ervices to be provided (See Tag					
		6.1.1.4					
		failed to ensure complaints were stigated, and resolved (See Tag					
	N 514).						
		failed to ensure the patient's					
	needs were met (S	ee Tag N 520).					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The administrator failed to ensure the plan of care was followed (See Tag N 522/ N537). The administrator failed to ensure the plan of care included the frequency and duration of visits to be made, the nutritional requirements, all medications and treatments and measurable goals (See Tag N 524/ N542). The administrator failed to ensure a written summary for each patient is completed and sent to the physician every 2 months (See Tag N 529). The administrator failed to ensure the clinical record included documentation of coordination with the HHA (Home Health Aide) regarding a change in the patient's skin condition that progressed from irritation to a stage 3 pressure ulcer and the HHA failed to provide all services outlined in the POC (Plan Of Care) (See Tag N 533). The administrator failed to ensure personnel files included documentation the Home Health Aide completed a competency evaluation program (See Tag N 596). The administrator failed to ensure supervision to the HHA (Home Health Aides) every 30 days for HHA only services (See Tag N 606). The administrator and failed to ensure the clinical record contained pertinent past and current findings for every patient (See Tag N 608). N 0453 410 IAC 17-12-1(d) Home health agency Bldg. 00 administration/management Rule 12 Sec. 1(d) A physician or a 106K11 Facility ID: 013593 Page 111 of 206 Event ID: State Form If continuation sheet

11/27/2018

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	A.	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018		
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC				ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256	ROSSPOINTE BLVD,		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TON D BE OPRIATE	(X5) COMPLETION DATE	
	nursing experien of supervisory or shall supervise a therapeutic servic Based on record re Director of Nursin HHA (Home Heal were completed ar record for 2 of 4 p (Patient's #1 and 5 records. Findings Include: 1. An agency poli Documentation" w "Agency will docu the client. This do by the direct careg skilled professiona clients' care. Purpo accurate record of response and ongo document conform modifications to th involvement 2. 3 completed for each dated by the appro and length of the c each note 5. Do on the plan of care services are render clinical record witt has been provided 2. A job descriptio	eview and interviews, the (DON) ag services failed to ensure the th Aide) documentation notes and entered into the clinical atient's receiving HHA services (i) in a sample of 7 clinical action of 7 clinical action of 7 clinical action of 8 completed avas reviewed and stated, ament each direct contact with cumentation will be completed giver and monitored by the al responsible for managing the ose: To ensure that there is an the services provided, client ong need for care. To nance with the Plan of Care, ne plan and interdisciplinary a separate note shall be h visit/shift and signed and opriate professional. Actual time client visit will be included in cumentation of services ordered e will be completed the day red and incorporated into the hin seven (7) days after the care	N	0453	N 453 The Administrator v immediately review The D description, job expectation job performance with the I The Administrator or designed educate the administration/management on policy: Clinical Documentate DON job description To prevent this deficiency future, the DON will be rest to ensure clinical document in clinical records is comp according to agency policy through weekly audits of documentation. The Admin or designee will be respont active clinical record audite 100% compliance is met tt % of all clinical records with audited quarterly for evided 100% compliance is met tt ensure that this deficiency reoccur.	ON job ons, and DON. gnee will ent staff ion in the sponsible ntation leted y nistrator nsible for s until hen 10 II be ence after o	11/30/201	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE direction of healthcare services ... shares responsibilities with the Administrator for the agency's overall compliance with State and Federal guidelines and standard of nursing practice. Duties and Responsibilities: Supervise and direct all clinical services. Promote, review and evaluate the quality and appropriateness of patient care practices ... Participate in assigning personnel to patients based on patient need and physician's plan of care ... Coordinate and ensure that the patient is well serviced through the assignment of skilled services and personal caregivers" 3. The clinical record for Patient # 1 with a start of care date of 7/18/16 failed to evidence any HHA documentation notes from 4/2/17 to 5/21/17 in the clinical record. 4. The clinical record for Patient # 5 with a start of care date of 6/19/16 to 12/14/16 failed to evidence any HHA documentation notes from 8/10/16 to 9/29/16 in the clinical record. 5. An interview was conducted with the DON on 9/21/18 at 1:06 PM. The DON reported, "I'm in charts all day long." The DON reported having assessed quality of care, performed "pop- up" visits with nursing staff, looked at clinical notes, and did Quality audits of 10 % of clinical records quarterly. 6. The administrator was interviewed on 9/26/18at 2:45 PM about the missed HHA visit documentation for Patient # 1 and 5. The administrator reported the aides' visits notes had to be uploaded into the computer schedule by the scheduler. The scheduler should have put the assigned visits and the times into the computer for the aide to have documented their visit. The 106K11 Facility ID: 013593 Page 113 of 206 Event ID: State Form If continuation sheet

11/27/2018

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018			
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500	STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE			
1 0458 Bldg. 00	administrator repo uploaded the visits would not have ha to the computer pr reported the proces nursing services to computer to ensure schedule for HHA the HHA notes ever reported the HHA' the visits had not b the audits failed to missing the HHA of 410 IAC 17-12-10 Home health age administration/ma Rule 12 Sec. 1(f) employees shall policies. All emp Indiana shall be s certification, or re perform the respon records of emplo health services s shall include doc the job, including (1) Receipt of jo (2) Qualification (3) A copy of lin	rted if the scheduler had not to the computer the HHA d a way to document their visit ogram. The administrator ss was for the director of check the assignments in the the POC matched the visits and was to have audited ery 60 days. The administrator S had not informed the agency een uploaded in computer and discover the records were locumentation. f) ncy anagement Personnel practices for be supported by written loyees caring for patients in subject to Indiana licensure, gistration required to ective service. Personnel yees who deliver home hall be kept current and umentation of orientation to the following: b description. s. bited criminal history						
	or registration.	rrent license, certification,	N 0458	N 458 The Administrator or	11/30/201			
	administrator faile employment policy annual evaluation	view and interview, the d to ensure the agency was followed to include an for 1 of 5 employees (Employee check and signed job		designee immediately had HR Director audit all employee files regulatory items. Audit was completed on 11/2/2018. Any missing regulatory items will be	s for			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/02/2018
	PROVIDER OR SUPPLIE & DISABLED HOM	R E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
	-	f 5 employees (Employee D) reviewed in a sample of 5.		obtained by the HR Director a placed in the personnel file of employee.	
	 An agency poli was reviewed and hire individuals will of character and su goals of the Agence are to be consisten other such acts and employment relatii carefully select qui written application reference checks. A thoroughly evaluar applicant a job witt clear criminal histor Criminal backgrout background check candidate who rece An agency poli was reviewed and established and ma Purpose: The purp the content of pers maintaining accurra information. Speciar Record-the employ include, but not be informationCrim checks as required information:Con health aides and sp title signed job of Employment Pe Medical History/H 	cy titled, "Employment Policy" stated, "The agency seeks to no meet the highest standards abscribe to the purpose and by. All employment practices t with applicable laws and d regulations that control the onship. Guideline: Supervisors alified employees through a personal interview and After all available information is ted, a supervisor may offer the h the agency contingent upon a ory check Procedures: and Check-A criminal must be done for any eived a job offer." cy titled, "Personnel Records" stated, "Personnel files will be aintained for all personnel ose of this policy is to identify onnel files and a system for tte, complete and current al Instructions: 1. Personnel yee personnel record will limited to : a. Pre-employment ninal history and background by law B. Employment mpetency testing form home pecific competencies per job description C. Ongoing rformance appraisals D. ealth Status- Maintained Pre-Employment physical, if		The Administrator or designed educate administrative/management staff/HR Director on policy: Employment policy Personnel Records por To prevent this deficiency in t future, the employment proces and documents used for employment process were redesigned for use in the hirir process. HR Director is responsible for all new hire employee files to ensure all personnel records are comple before employee has first cor with patient, a check off shee be utilized as evidence and maintained in employee file, t Administrator or designee will responsible for active employ record audits until 100% compliance is met then 10 % employee records will be aud quarterly for evidence after 10 compliance is met to ensure t this deficiency will not reoccu	olicy he ss ng eted htact t will he be ee of all ited 00% hat

	CORRECTION	IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 10/02/2018	
	OVIDER OR SUPPLIE	R E HEALTH CARE LLC	-	10500 0	ADDRESS, CITY, STATE, ZIP (CROSSPOINTE BLVD, APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
N 0464 Bldg. 00	3. The confidential with a date of hire contact of 1/5/17, y PM. The employed annual evaluation. 4. The confidential with a date of hire contact of 9/7/17, y PM. The employed evidence of a crim description to his/f 5. The administrat at 4:30 PM and rep the missing inform 6. The administrat at 10:30 AM and r locate the missing files of Employees 410 IAC 17-12-14 Home health age administration/ma Rule 12 Sec. 1(i) shall ensure that members, persor he agency, and patient contact an and documentation (1) Any person v uberculosis or a nave a baseline f using the Mantou	l personnel file of Employee D of 9/7/17 and first patient was reviewed on 10/1/18 at 3:15 e record failed to include hinal check, a or a signed job her role of registered nurse. tor was interviewed on 10/1/18 ported he/she would search for hation. tor was interviewed on 10/2/18 eported he/she was unable to information for the personnel a A and D. (i) ency anagement The home health agency all employees, staff hs providing care on behalf of contractors having direct re evaluated for tuberculosis on as follows: with a negative history of negative test result must two-step tuberculin skin test					

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 10/02/2018	
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, NAPOLIS, IN 46256			
(X4) ID PREFIX		/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF	LD BE	(X5) COMPLETIC	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	OFRIATE	DATE	
	 was negative. (2) The second is skin test using the administered one the first tuberculi administered. (3) Any person with the first tuberculi administered. (3) Any person with a documentation of tuberculosis; or (iii) previously positive skin test; must have one (10) newly positive skin test; must have one (11) exclude a diagnor (4) After baseline screening must: (A) be complete (B) include, at a test using the Marguantiferon-TB are was subject to set (5) Any person here tuberculosis eval (A) work in the here (B) provide direct unless approved (6) The home here documentation or showing that any (A) working for the shad a negative state of the state of the shad a negative state of the sta	with: ed: erculosis; sitive test result for treatment for tuberculosis; we results to the tuberculin 1) chest rediograph to osis of tuberculosis. e testing, tuberculosis d annually; and minimum, a tuberculin skin antoux method or a ssay unless the individual ubdivision (3). naving a positive finding on a uation may not: nome health agency; or et patient contact; by a physician to work. ealth agency must maintain f tuberculosis evaluations or person: he home health agency; or	N 0464	N 464 The Administrator		11/30/20	
	Based on record re	eview and interview, the agency	11 0404	immediately called for an	audit of	11/30/20	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157681	A. BUILDING B. WING	00	COMPLETED 10/02/2018
NAMEOE	PROVIDER OR SUPPLIE	P	STREE	T ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIE	ĸ		0 CROSSPOINTE BLVD,	
AGING a	& DISABLED HOMI	E HEALTH CARE LLC	INDIA	ANAPOLIS, IN 46256	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTI	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE OPRIATE COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	failed to ensure per	rsonnel files of direct care		all active employee files ar	nd this
	providers containe	d either a valid negative		was completed on 11/12/2	018.
	one-step TST (tube	erculosis skin test) upon hire		Any employee found durin	g audit
	and a valid negativ	e TST within the prior 12		that were missing a negati	ve TB
	months; or a valid	two-step TST upon hire for 3 of		upon hire and a valid nega	ative TB
	5 employees whos	e personnel files were reviewed		within the prior 12 months	
	(Employees A, D,	and E) in a sample of 5.		given a TB test to meet thi	
				requirement on 11/19/2018	8 and
	Findings Include:			placed in the employee file	e.
				Mandatory TB testing will I	be
	1. An agency poli	cy titled, "Employment Policy"		completed on 11/19/18 on	all
	was reviewed and	stated, "The agency seeks to		employees and in May the	n yearly
	hire individuals wh	no meet the highest standards		thereafter. If personnel file	
	of character and su	bscribe to the purpose and		evidence of 2-step TB, a s	econd
	goals of the Agenc	y. All employment practices		clinic will be held on 11/26	/18 for
	are to be consisten	t with applicable laws and		the 2nd step TB.	
	other such acts and	l regulations that control the			
	employment relation	onship. Guideline: Supervisors		The Administrator or desig	nee will
	carefully select qua	alified employees through		educate	
	written application	, personal interview and		administrative/managemer	nt/HR
	reference checks.	After all available information is		Director on policy:	
	thoroughly evaluat	ted, a supervisor may offer the		Employment policy	
	applicant a job wit	h the agency contingent upon a		Personnel Records po	licy
	clear criminal histo	bry check Procedures:			
	Criminal backgrou	nd Check-A criminal		To prevent this deficiency	in the
	-	must be done for any		future, the employment pro	ocess
	candidate who reco	eived a job offer."		and documents used for	
				employment process were	•
		cy titled, "Personnel Records"		redesigned for use in the h	niring
		stated, "Personnel files will be		process. HR Director is	
		intained for all personnel		responsible for all new hire	
		ose of this policy is to identify		employee files to ensure a	
	-	onnel files and a system for		personnel records are com	
		ate, complete and current		before employee has first of	
		al Instructions: 1. Personnel		with patient. The Administr	
		vee personnel record will		designee will be responsib	
		limited to : a. Pre-employment		active employee record au	
		ninal history and background		100% compliance is met th	
		by law B. Employment		% of all employee records	
	information: Co	mpetency testing form home		audited quarterly for evide	nce after

IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	A. BU	ILDING	DNSTRUCTION 00	COMF	e survey pleted 2/2018
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(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU	ILD BE	(X5) COMPLETION DATE
health aides and sp title signed job c Employment Pe Medical History/H Confidentially: I required TB scre 3. The confidential with a date of hire contact of 1/5/17, v PM. The employee	ecific competencies per job lescription C. Ongoing rformance appraisals D. ealth Status- Maintained Pre-Employment physical, if pening (2-step Mantoux)" personnel file of Employee A of 1/5/17 and first patient was reviewed on 10/1/18 at 2:00 precord failed to include					
 4. The confidential with a date of hire contact of 9/7/17, v PM. The employee evidence of a 2nd 5. The confidential 	of 9/7/17 and first patient was reviewed on 10/1/18 at 3:15 record failed to include step Mantoux skin test on hire. personnel file of Employee E					
contact of 7/13/16, PM. The employee	was reviewed on 10/1/18 at 4:00 record failed to include					
at 4:30 PM and rep	orted he/she would search for					
at 10:30 AM and relocate the missing	eported he/she was unable to information for the personnel					
Q A and performation	ance improvement					
	TOF DEFICIENCIES OF CORRECTION ROVIDER OR SUPPLIE DISABLED HOME SUMMARY (EACH DEFICIEN REGULATORY O health aides and sp title signed job d Employment Per Medical History/H Confidentially: I required TB scree 3. The confidential with a date of hire contact of 1/5/17, w PM. The employee evidence of a 1st o upon hire. 4. The confidential with a date of hire contact of 9/7/17, w PM. The employee evidence of a 2nd 5. The confidential with a date of hire contact of 7/13/16, PM. The employee evidence of a 1st o upon hire. 6. The administrat at 4:30 PM and rep the missing inform 7. The administrat at 10:30 AM and rep	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DOF CORRECTION IDENTIFICATION NUMBER 157681 ROVIDER OR SUPPLIER DISABLED HOME HEALTH CARE LLC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION health aides and specific competencies per job title signed job description C. Ongoing Employment Performance appraisals D. Medical History/Health Status- Maintained Confidentially Pre-Employment physical, if required TB screening (2-step Mantoux)" 3. The confidential personnel file of Employee A with a date of hire of 1/5/17 and first patient contact of 1/5/17, was reviewed on 10/1/18 at 2:00 PM. The employee record failed to include evidence of a 1st or 2nd step Mantoux skin test upon hire. 4. The confidential personnel file of Employee D with a date of hire of 7/13/16 and first patient contact of 7/13/16, was reviewed on 10/1/18 at 3:15 PM. The employee record failed to include evidence of a 1st or 2nd step Mantoux skin test upon hire.	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MI DF CORRECTION IDENTIFICATION NUMBER A. BU IS7681 B. WI ROVIDER OR SUPPLIER EDISABLED HOME HEALTH CARE LLC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION health aides and specific competencies per job title signed job description C. Ongoing Employment Performance appraisals D. Medical History/Health Status- Maintained Confidential personnel file of Employee A with a date of hire of 1/5/17 and first patient contact of 1/5/17, was reviewed on 10/1/18 at 2:00 PM. The employee record failed to include evidence of a 1st or 2nd step Mantoux skin test upon hire. 4. The confidential personnel file of Employee D with a date of hire of 9/7/17 and first patient contact of 9/7/17, was reviewed on 10/1/18 at 3:15 PM. The employee record failed to include evidence of a 2nd step Mantoux skin test on hire. 5. The confidential personnel file of Employee E with a date of hire of 7/13/16 and first patient contact of 7/13/16, was reviewed on 10/1/18 at 4:00 PM. The employee record failed to include evidence of a 1st or 2nd step Mantoux skin test upon hire. 6. The administrator was interviewed on 10/1/1	TOF DEFICIENCIES X1) PROVIDER/SUPPLER/CLIA X2) MULTIPLE CA DENTIFICATION NUMBER A BUILDING B.WING	TO DEFICIENCIES N1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION DECORRECTION IDSTITUCATION NUMBER A. BUILDING QO	OPF CORRECTION IDENTIFICATION NUMBER 137681 A BUILDING QQ COMI 10/02 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256 International Content of the Content of

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	ì í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	appropriately corr support the object The means of co shall be document minutes of case of Based on record re- failed to ensure the documentation of of (skilled nurse) and regarding a change that progressed fro- pressure ulcer for health aide service Findings Include: An agency policy of Services'' was revi- personnel furnishin liaison to assure the effectively and sup- the Plan of Care. To care conferences, in care plans, and wri- An agency policy of Supervision'' was of shall provide Hom- the direction and s- when personal care ordered by the phy- Supervisor or design the HHA direction Care Plan. The clinical record	to assure that their efforts inplement one another and stives of the patient's care. immunication and the results inted in the clinical record or conferences. eview and interview, the agency e clinical record included coordination between the SN the HHA (home health aide) e in the patient's skin condition in irritation to a stage 3 1 of 4 patient's receiving home s (Patient #2) in a sample of 4. titled, "Coordination of Client ewed and stated: "All ing services shall maintain a at their efforts are coordinated oport the objective outlined in this may be done through formal maintaining complete, current itten and verbal interaction. titled, "Home Health Aide reviewed and stated, " Agency e Health Aide Services under upervision of a RN/ Therapist e services are indicated and trician 1. The Nursing gnated RN/Therapist will give for client care by way of the	NO	484	N 484 The Administrator or designed immediately review all clinical records for coordination of car between SN/HHA. Immediatel RN case managers will be required to conference with the HHA weekly for patients they of manage, and document this coordination of care through a communication note in the clin record. The DON or designee will edu administration/management, a clinicians on policy: Coordination of Client Services Home Health Aide Supervision Care Planning/ Coordinat of Care Home health aides will be educated on: "What to Report to RN, Case Manager" Home Health Aide Documentation To prevent this deficiency in the future, the RN case managers be required to review all HHA documentation and perform	re y all e case nical ncate all ation	11/30/201

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		, ,	E SURVEY PLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157681	A. BUILDING B. WING	00		/02/2018	
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GING 8	& DISABLED HOM	E HEALTH CARE LLC		NAPOLIS, IN 46256			
X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	DN DE	(X5)	
REFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	COMPLETION DATE	
-		Bowel and Bladder		all the patients they case m	anage.		
		urance and Ambulation. The		RN case manager will also	review		
	-	ne certification periods of		the aide care plan with the			
		, 5/14/18 to 7/13/18 and 7/14/18		assigned home health aide	prior to		
		d orders for HHA (Home Health		the home health aide provi	-		
	· · · · · · · · · · · · · · · · · · ·	daily for, 5 visits weekly. The		services to the patient and			
	clinical record was findings:	s reviewed with the following		the home health aide care with the home health aide a	at least		
	A HHA visit note	dated 3/29/18 stated, "Skin in		every 60 days or when the change in the patients' con			
		ame] butt (buttocks) is slightly		the Administrator or design			
	irritated.	uniej out (outtoeks) is slightly		be responsible for active cl			
	A CNI - i i i t	$\frac{1}{10000000000000000000000000000000000$		record audits until 100%	0/ - 5 - 11		
		nducted on 4/11/18 (13 days		compliance is met then 10			
		e stated, "Educated about to impaired mobility voices an		clinical records will be audi			
	-	tient states that she has wound		quarterly for evidence after			
	-	t on $4/19/18$ due to opened area		compliance is met to ensur this deficiency will not reoc			
	~ ~	s. Unable to assess wound due			cui.		
		wheelchair and unable to					
		to assess wound because					
	-	nt to be transferred back."					
		clinical record dated 4/12/18 at					
		ed, "[hospital name] office visit,"					
	included a new dia ulcer of the buttoc	ngnosis for Stage 3 pressure k.					
		was interviewed on 9/26/18 at					
		inistrator reported there was no					
		t the aide and nurse					
		but the patient's irritated area					
		a stage 3 pressure ulcer in the e administrator was asked about					
		home health aide notes to be					
	·	N. The administrator reported,					
		re audited every 60 days by					
	[director of nursin					1	

Facility ID: 013593

If continuation sheet

Page 121 of 206

		157681 R	D. WIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 10/02/2018	
AGING & (X4) ID PREFIX TAG	DISABLED HOME	R				10/02/	/2018	
(X4) ID PREFIX TAG					ADDRESS, CITY, STATE, ZIP COD			
PREFIX TAG	SUMMARY	E HEALTH CARE LLC			CROSSPOINTE BLVD, NAPOLIS, IN 46256			
TAG		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
0486	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
0.00	410 IAC 17-12-2([h)						
	Q A and performa	ance improvement						
ldg. 00	Rule 12 Sec. 2(h)) The home health agency						
	shall coordinate it	ts services with other health						
	or social service	providers serving the patient.						
			N 04	-86	N 486 The Administrator or		11/30/2018	
	Based on record re	view and interview, the agency			designee will immediately revi	ew		
	failed to ensure con	mmunication occurred with the			all clinical records for coordina	ation		
	nephrologist caring	g for 1 ESRD (End State Renal			of care with any patient receiv	ing		
	Dialysis) for 1 of 1	patient receiving hemodialysis			dialysis, wound care. If	U		
		ample of 7 clinical records.			coordination of care has not b	een		
					established the DON or RN ca			
	An agency policy t	itled, "Coordination of Client			manager will establish this			
		ewed and stated: "All			coordination of care by calling	the		
		ng services shall maintain a			dialysis center or wound care			
		at their efforts are coordinated			center and request weekly			
		port the objective outlined in			updates on patients care.			
		This may be done through formal			The DON or designee will edu	cate		
		naintaining complete, current			administration/management, a			
		tten and verbal interaction.			clinicians on policy:	•••		
	-	re services are coordinated						
	-	of the interdisciplinary team. To			Coordination of Clie	nt		
		, quality care is being provided			Services			
		dify the plan to reflect the						
		dentified by members of the			To prevent this deficiency in the			
	U	the continuation of services			future, the DON will audit thes			
		s for care. To provide the			clinical records weekly to ensu			
	-	n with an ongoing assessment			updates from these providers			
		entify the client's response to			present in the clinical record, i			
		1. Care conferences will be held			present the DON will call the	mot		
	-	ablish interchange, reporting,			provider for an update and not	hifv		
	-	valuation between all			the RN case Manager of the	liny		
		d in the client's care 3. After			update so the RN can update	the		
	-	ent, the admitting RN			POC if needed.	uic		
		or Therapist shall discuss the			The Administrator or designee	will		
		ial visit with the Clinical			be responsible for active clinic			
	-	a. Clarification of the plan of			record audits until 100%			
		ent's need for skilled nursing			compliance is met then 10 % of	of all		
		other services and/or referral to			clinical records will be audited			
		cesG. Coordination with other			quarterly for evidence after 10			

Event ID: 106K11

Facility ID: 013593

If continuation sheet

Page 122 of 206

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE agencies and institutions, if the need arises ... 6. compliance is met to ensure that Care conferences will be determined on the care this deficiency will not reoccur. conference summary form or in the progress note ... " Education completed on 11/11/2018. An interview was conducted with the patient on 9/26/18 at 9:48 AM during a home visit observation. The patient reported he had a central venous dialysis catheter in his right subclavian (collarbone) area for hemodialysis treatments 3 times weekly related to his ESRD. In addition, the patient reported he was getting medication for anemia, fluid restriction and dietary restrictions related to his ESRD. The clinical record of Patient #3 with a Start of care of 7/25/18 and a POC (Plan of Care) for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets." The POC failed to include any medication orders related to the patient's dialysis 3 times weekly The administrator was interviewed on 9/26/18 at 12:07 AM and reported there was no documentation the agency had coordinated care with the Hemodialysis facility or the Nephrologist. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this." The agency was asked to call the dialysis facility and obtain the current treatment orders for the patient to include diet, fluid restriction, and medication. A fax was obtained from [the dialysis facility] on 9/28/18 and included the following orders specific to the patient's ESRD: Heparin 106K11 Facility ID: 013593 Page 123 of 206 Event ID: State Form If continuation sheet

11/27/2018

PRINTED:

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500	T ADDRESS, CITY, STATE, ZIP COE O CROSSPOINTE BLVD, NAPOLIS, IN 46256)	
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O Sodium (to preven arterial port (red) 2	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION t blood clots) 1,000 units/ml to ,200 units and 2,300 units to (of the dialysis catheter) every	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	medication for ane push) every treatm for anemia) 200 m The fax included a dietary restriction Phosphorus daily.	weekly), Venofer (iron mia) 100 mg IVP (intravenous ent x 5 and Micera (medication cg IVP every 2 week x 365 days. 1500 ml fluid restriction and o 3 gm sodium, and 1200 mg The POC failed to include the n regimen for ESRD, diet and				
N 0494 Bldg. 00	legal representat informed of the p effective means of health agency me exercise of these following: (1) Provide the of the patient's rig (A) in advance of patient; or (B) during the ini- the initiation of the (2) Maintain door	The patient or the patient's ve has the right to be atient's rights through of communication. The home ust protect and promote the rights and shall do the patient with a written notice ght: f furnishing care to the tial evaluation visit before				
failed to provide document the patient's family had rec	view and interview, the agency ocumentation that the patient or had received written notice of for 1 of 1 patient's (Patient' # 5 clinical records reviewed.	N 0494	N 494 The Administrator designee will immediated all active patient records evidence that the patient legal representative rece notice of their rights in a and manner the individua understands during the in evaluation, and if not obt	y review for and or ived language al nitial	11/30/2018	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING <u>00</u>	COM	PLETED
		157681	B. WING		10/02/2018	
	PROVIDER OR SUPPLIE	P	S	TREET ADDRESS, CITY, STATE, ZIF	P COD	
				0500 CROSSPOINTE BLVD),	
AGING 8	& DISABLED HOMI	E HEALTH CARE LLC	II	IDIANAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	П	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRE	FIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE IE APPROPRIATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	T	AG DEFICIENCY)		DATE
		titled, "Home Care Bill of		during this initial eva	luation, will	
	Rights" was review	ved and stated, "Clients will be		correct the deficiency	y by obtaining	
	informed of their r	ights as a consumers of home		evidence that the de	ficiency has	
	care services. This	include the right to voice		been corrected by ot	otaining a new	
	grievances and req	uest changes without		Home Health Admiss	sion Service	
	discrimination, rep	risal or unreasonable		Agreement signed by	y patient and	
	interruption of service	vices1. A designated		or legal representativ		
	Registered Nurse/	Therapist shall provide the		The Administrator or		
	-	en notice of the Home Care Bill		educate	5	
	of Rights in advan	ce of furnishing care to the		administration/mana	gement/all	
		e initial evaluation visit before		clinicians on policy:	90	
	-	ed. In the event that the client is		Home Care Bi	ll of Rights	
		cision, the Home Care Bill of		Agency Servic	-	
		en to the client's legal guardian		Agency Cervic	e Agreement	
		egiver shall be advised orally		To prevent this defici	iency in the	
		neir right to voice grievances		future, the DON will i	-	
	-	the receipt of the Home Care				
		be maintained in the clinical		documentation with to ensure all docume	-	
	record"	be maintained in the chinear				
				correct and present a		
	The aligitations and	of Patient # 5 with a start of		comprehensive asse		
				Administrator or desi	-	
		6 and a discharge date of		responsible for active		
		ical record failed to evidence a		record audits until 10		
	contain a copy of t	he patient's rights.		compliance is met th		
				clinical records will b		
		was interviewed on 10/1/18 at		quarterly for evidenc		
		the failure of the agency to		compliance is met to		
		the patient's rights in the		this deficiency will no	ot reoccur.	
		e administrator was unable to				
		er documentation of the		Education completed	d on	
	patient's rights in t	he clinical records.		11/08/2018.		
l 0504	410 IAC 17-12-3	′b)(2)(D)(i)				
	Patient Rights	~/~//~///				
Bldg. 00		patient has the right to				
g. 00		er rights as a patient of the				
	home health age					
	-	has the right to the				
	following:					
	l ionowing.					

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

-

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	A. BUIL B. WINC	DING	00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLII & DISABLED HOM	ER E HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / TAG DEFICIENCY)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	furnished, and or be furnished as f (i) The home he patient in advance (AA) disciplines (BB) frequency furnished. Based on record re failed to inform the disciplines and the provided for 2 of 7 (Patient # 2 and 5) Findings Include: 1. An agency pole Rights" was revier informed of their care services. This grievances and read discrimination, rep interruption of ser Registered Nurse/ client with a writte of Rights in advar client or during the treatment is initiat unable to make de Rights shall be giv 2. The client/car and in writing or to Documentation of Bill of Rights will record" 2. The clinical reco care date of 9/28/7 7/14/18 to 9/11/18	ealth agency shall advise the ce of the: that will furnish care; and of visits proposed to be eview and interview, the agency the patient in writing the e frequency of the services to be 7 clincial record reviewed	N 050	14	N 504 The Administrator or designee will immediately review all active patient records for evidence that the patient and or legal representative received notice of their rights in a langua and manner the individual understands which includes discipline, frequency, duration a the extent of payment from federally funded programs durin the initial evaluation, and if not obtained during this initial evaluation, will correct the deficiency by obtaining evidence that the deficiency has been corrected by obtaining a new Home Health Admission Service Agreement signed by patient ar or legal representative. The DON or designee will educa administration/management/all clinicians on policy: Home Health Admission Service Agreement Home Care Bill of Rights To prevent this deficiency in the future, the DON will review all documentation with Admitting R to ensure all documentation is	ge ind ig e id ate	11/30/201

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
AND FLAN	OF CORRECTION	157681	B. WING	00	10/02/2018
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIE	R		CROSSPOINTE BLVD,	
AGING 8	& DISABLED HOM	E HEALTH CARE LLC	INDIAN	APOLIS, IN 46256	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLET
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Admission Service	e Agreement" dated 3/14/18.		correct and present after the ir	nitial
	The section of the	form to indicate services,		comprehensive assessment, the	he
	frequency, and du	ation was blank and not		Administrator or designee will	be
	completed.			responsible for active clinical	
				record audits until 100%	
	3. The clinical rec	ord of Patient # 5 with a start of		compliance is met then 10 % of	of all
	care date of 6/19/1	6 and a discharge date of		clinical records will be audited	
	12/14/16. The clin	ical record failed to evidence a		quarterly for evidence after 10	0%
	contain a copy of	he patient's rights.		compliance is met to ensure th	
				this deficiency will not reoccur.	
	4. The administra	tor was interviewed on 9/26/18		, ,	
	at 4:00 PM regard	ing the incomplete service		Education completed on	
		s in the clinical record of		11/08/2018.	
	-	administrator stated, "I see			
		lled at them about this."			
	5. The administra	tor was interviewed on 10/1/18			
	at 1:58 PM regard	ing the failure of the agency to			
		the patient's rights in the			
	clinical record for	Patient # 5. The administrator			
	was unable to proc	luce any further documentation			
	of the patient's rig	nts in the clinical records.			
N 0514	410 IAC 17-12-3	(c)			
	Patient Rights				
Bldg. 00	Rule 12 Sec. 3(c)			
		ealth agency shall do the			
	following:				
	(1) Investigate	complaints made by a			
		ient's family or legal			
		garding either of the			
	following:				
	(A) Treatment c	r care that is (or fails to be)			
	furnished.				
	(B) The lack of	respect for the patient's			
	property by anyo	ne furnishing services on			
	behalf of the hon	ne health agency.			
		both the existence of the			
	complaint and th	e resolution of the complaint.			
			N 0514	N 514 The phone message	11/30/2
			I	1	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	ILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE & DISABLED HOMI	R E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	FION LD BE COPRIATE	(X5) COMPLETIC DATE
	Based on record r failed to document complaints for 3 o (Patients # 1, 4 and Findings Include: 1. An agency poli Complaint /Grieva stated, " Definition complaint is define dissatisfaction by a services that can b complaint by staff grievance is any for expression of dissa that is expressed b solved at that time complaint that fits require a written re complaints will be complaints will be complaint form an an administrative f above include trea documented on the receiving the comp forwarded as soon director for inve Grievance will be director or his/her the complainant w responsible person calendar days with All persons with a notice of the invess are considered com response has been client/complainant	eview and interview, the agency s, investigate and resolve f 7 patients record reviews. 1 5) in a sample of 7. cy titled, "Client/Family nce Policy" was reviewed and as: Client Complaint: A ed as "any expression of a client/family regarding care or e addressed at the time of present" Grievance: A ormal or informal written atisfaction with care or services y the client/family that is not by staff present Any the grievance definition will esponse to the person ecial Instructions 2. Client documented on a client d filed with the complaint log in file. 3. The grievance as defined tment, services will be e grievance form by the person olain/grievances e and as possible to the appropriate estigation action and trending. 4. addressed by the department designee and response made to ithin 7 calendar days and the will report back within 30 a resolution of the grievances appleted when an approved		system will be updated immediately to include the Administrators number in event that a patient or fan member wishes to file a c or grievance and all comp /grievances will be forwar the Administrator or desig will be documented, inves with resolution and logged complaint log book, comp grievances will be proces according to agency polic The Administrator will rev Client/Family complaint/g policy. The Administrator designee will educate administration/manageme clinicians on policy: Client/Family complaint/grievance polic To prevent this deficiency future, all complaints/griev will be reviewed with the c committee and Governing quarterly for trending of ca / grievances. Any trends investigated and QAPI co will address any trends id	the nily omplaint olaints ded to nee and stigated, d in the laints / sed y. iew the rievance or ent, all y r in the vances QAPI g Body omplaints will be mmittee	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE & DISABLED HOM	E HEALTH CARE LLC	STREE 1050 INDIA			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
mo		for tabulation and trending of				
		ord of patient # 1 with a SOC of 7/18/16 was reviewed with ings:				
	9/15/16 included of week for G-Tube (liquid nutrition is p parent was at work week. The SN fail 8/9/16 (21 days) a services 5 times a	ertification period of 7/18/16 to orders for skilled nurse 5 times a (a tube in the stomach where provided) feedings while the a and HHA services 6 times a ed to provide services until fter the SOC. The HHA provided week 1- 2 and 3 times week 6 of period and failed to conduct visits				
	11/14/16 included G-Tube feedings w HHA services 6 tin IADL's and ADL's times during week during week 8, and	ertification period of 9/16/16 to orders for SN 5 times a week for while the parent was at work and mes a week for assistance with s. SN services were provided 4 6, 3 times during week 7, 0 times d 2 times during week 9 of the d and failed to be provided as				
	to nursing schedul we have offered to nursing care via ar has declined this o coming home at no until nursing staff were provided 3 ti	note dated 11/1/16 stated, "Due ing difficulties with this patient, assist the family in finding a nother agency at this time family ffer. Currently, mother is boon to feed daughter via G-Tube available." The HHA services mes during week 5 of the d and failed to be conducted as				
	The POC for the c	ertification period of 11/15/16 to				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	COM	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	1050	T ADDRESS, CITY, STATE, ZIP 0 CROSSPOINTE BLVD, ANAPOLIS, IN 46256			
	T					(115)	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	G-Tube feedings a assistance with IA conducted a total of the POC for the co provide visits as of The POC for the co 3/14/17 included of G-tube feedings ea week for assistance SN conducted a to period and failed to There were no ord A SN note 3/14/17 (caregiver) of SN intervention, but th not necessary whe	ertification period of 1/14/17 to orders for SN 1 time a week for ach visit and HHA 6 times a the with IADL's and ADL's. The otal of 5 visits in the certification to provide visit as ordered. Hers to change the POC. 7 stated, "Informed the cg visits weekly for skilled that daily is not achievable and en available CG competent in feedings. Encourage to call					
	5/13/17 included of assessment and in: HHA 6 times a we and ADL's. The S for the weeks 1-3 clinical record fail any HHA visits fo period. The POC for the of 7/12/17 included of assessment and HI week for assistance POC failed to incl HHA services. Th evidence documer	ertification period of 3/15/17 to orders for SN 1 time a week for struction to caregivers and eek for assistance with IADL'S N failed to provide 1 visit weekly of the certification period. The led to evidence documentation of or weeks 4-9 of the certification ertification period of 5/14/17 to orders for SN 1 time a week for HA 9 hours a day for 5 days a we with IADL's and ADL's. The ude the duration of the SN and e clinical record failed to ntation of HHA visits for week 1 conducted 6 visits week 4-8 and					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	È Í	UILDING	00	CON	te survey Mpleted 02/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC		10500 0	ADDRESS, CITY, STATE, ZIP C CROSSPOINTE BLVD, APOLIS, IN 46256	OD	
	1						
(X4) ID		Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	COMPLETIC DATE
TAU		ek 9 of the certification period.		TAG			DATE
	The POC for the c 9/101/7 included of G-tube feedings ar days a week for as ADL's. The SN pr and 5-9 of the cert provide 5 visits pe conducted 3 visits during week 2-9 o failed to provide v The POC for the c 11/9/17 included of tube G-tube feedin days a week for as ADL's. The SN pr and 4-8, 0 visits du week 9 of the certi provide as ordered during weeks 1-6, during week 8 and The HHA failed to A SN note dated 9 request daily SN to mother is at work. Parent states at thi able to cover the o not been a daily R	ertification period of 7/13/17 to orders for SN 5 times a week for ad HHA 9 hours a day for 5 sistance with IADL's and ovided 1 visit during weeks 2-3 ification period and failed to r week as ordered. The HHA during week 1 and 6 visits f the certification period and isits 5 times weekly as ordered. ertification period of 9/11/17 to orders for SN 5 times a week for ags and HHA 9 hours a day for 5 sistance with IADL's and ovided 2 visits during weeks 1 aring week 2 and 1 visit during fication period. The SN failed to 1. The HHA provided 6 visits 2 visits during week 7, 4 visits 19 of the certification period. provided visits as ordered. //11/17 stated, "continues to b cover G-Tube feedings while Will discuss with leadership. s time his/her family has been ther days of the week there has					
	1/8/18 included or tube G-tube feedin days a week for as ADL's. There wen SN frequency to 1 certification period	ders for SN 5 times a week for ags and HHA 9 hours a day for 5 sistance with IADL's and re orders present to change the visit during week 7 and 9 of the d. The SN failed to follow the l visits 2 times during weeks 2-6.					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	, í	ULTIPLE CON JILDING ING	STRUCTION 00	COM	te survey Mpleted 02/2018
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		STREET AL 10500 CH INDIANA			
(X4) ID PREFIX	SUMMARY	Ý STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO
TAG	No SN visits were The HHA provide certification period weekly from 12/3/ provide visits as o The POC for the c 3/9/18 included or tube G-tube educa and HHA 9 hours assistance with IA provided visits 1 t during week 2-9 o failed to provide v provided visits 4 t 1/12/18 with 14-ha The HHA provide 1/15/18 to 1/19/18 and 1/18/18. The I week from 1/21/18 provide visits as o The POC for the c	ertification period of 1/9/18 to ders for SN 5 times a week for tion, monitoring and feedings a day, 5 days a week for DL's and ADL's. The SN ime during week 1 and 2 times f the certification period. The SN isits as ordered. The HHA times a week from 1/9/18 to pur visits on 1/9/18 and 1/11/18. d visits 5 times a week from with 14-hour visits on 1/16/18 HAA provided visits 6 times a 8 to 3/9/18. The HHA failed to		TAG	DEFICIENCY)		DATE
	G-Tube education HHA 9 hours a da with IADL's and A during week 9 of t to provide visits as visits during week during week 9. Th as ordered. The POC for the c 7/7/18 included or G-Tube education HHA 9 hours a da with IADL's and A and a 10-hour visi	a, monitoring and feedings and y, 5 days a week for assistance ADL's. The SN provided 1 visit he certification period and failed s ordered. The HHA provided 6 s 1, 2, 3, 4, 6, 8, and 3 visits e HHA failed to provide visits ertification period of 5/9/18 to ders for SN 2 times a week for , monitoring and feedings and y, 5 days a week for assistance ADL's. A 14-hour visit on 5/9/18 t 5/12/18. The HHA provided 4 5/13/18 to 5/16/18 and 6 visits					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	. ,	UILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	•	10500 C	DDRESS, CITY, STATE, ZIP CROSSPOINTE BLVD, APOLIS, IN 46256		
				<u> </u>			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	/18 to 7/7/18, when the clinical that the patient was in the 1/18 to 6/1/18.					
	9/5/18 included or	ertification period of 7/8/18 to ders for SN 2 times a week for dressing changes and HHA 9					
	IADL's and ADL's week 9 of the cert	s a week for assistance with s. The SN provided 1 visit during ification period and failed to rdered. The HHA provided 6					
	visits during week of the verification	s 1-8 and 3 visits during week 9 period. The HHA provided 7/8/18, 7/10/18, 7/12/18. The					
	HHA failed to provide visits as ordered.	vide visits as ordered.					
	11/4/18 included of	ertification period of 9/6/18 to orders for SN 2 times a week for lressing changes and HHA 9					
	hours a day, 5 day IADL's and ADL'	s a week for assistance with s. The SN provided 1 visit during ification period and failed to					
	provide visits as o visits during week	rdered. The HHA provided 3 1 and 6 visits during weeks 2 ication period. The HHA					
	9/18/18, and 9/20/	visits on 9/6/18, 9/11/8.9/13/18, 18 and 16-hour visits on 9/9/18 HHA failed to provide services					
	as ordered.						
	patient # 1. The ac the period of 8/8/1	rization) was requested for Iministrator provided a PA for 8 to 2/6/19. The administrator					
	record #1. The cu	sent any other PAs for clinical rent PA established the SN uested for 2 times weekly and					
	An interview was	conducted with the Parent of 4/18 at 10: 00 AM. The Parent					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE & DISABLED HOMI	R E HEALTH CARE LLC		10500 C	DDRESS, CITY, STATE, ZIP CO ROSSPOINTE BLVD, APOLIS, IN 46256	E BLVD,	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETIC
TAG	reported that he/sh patient's full-time patient's sibling ca in the role of a HH the home daily the patient bolus G-tul reported when the (7/18/16) the feedii by a nurse of the a full-time nurse left of 2016 and soon a sending a nurse 5 of reported he/she wa working on getting parent reported he/she wa working on getting parent reported he/she wa needed a nurse 5 d concern had not be parent reported a m nurse was not need him/her that Media authorization for a An interview was sibling and full-tim The sibling reported G-Tube feedings f for work. The tube changed to late aft home and then at b since he/she was w within his/her scop feedings. He/she ra nurse for 2/1/2 yea agency would get a	R LSC IDENTIFYING INFORMATION e worked 5-6 days a week. The HHA for the agency, the n not administer tube feedings A. Without a nurse to come to parent had to change the be feeding schedule. The parent patient had been admitted on ngs had been given in mid day gency. The parent reported the the agency around November offer the agency stopped days a week. The parent is told that the agency was g a replacement nurse. The she had reported to the d to the agency that he/she ays a week, but the staffing een addressed or resolved. The urse had told him/her that a essary and another nurse told eaid had denied the prior nurse 5 times a week. conducted with Patient # 1's he HHA on 9/25/18 at 1:50 PM. ed the parent administered the or Patient #1 before he/she left feeding schedule had been ernoon when the parent came bedtime. The sibling reported vorking as a HHA it was not be of practice to give the tube eported they have not had a rs and have been told the a nurse for the feedings 5 days g reported she/he had been told times a week had been denied.		TAG	DEFICIENCY		DATE
	administrator on 9	/24/18 at 2:35 PM. The					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided. 3. The clinical record of Patient # 4 with an original SOC of 7/29/16, a recent readmission SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed with the following findings: The SN failed to conduct a supervisory visit in the month of August, 2018. This exceeded the Agency policy by 2 days. For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during weeks 5, 6, 7 and 2 visits during week 8. For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3. An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had 106K11 Facility ID: 013593 Page 135 of 206 Event ID: State Form If continuation sheet

11/27/2018

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIP A. BUILDIN B. WING		STRUCTION 00	C	DATE SURVEY DMPLETED D/02/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10	reet ad 500 CF DIANA)	•	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREF	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	ILD BE	(X5) COMPLETIC
	than 1 day a week hit or miss I can't f I've told them at out of sight and ou An interview was administrator on 1 missed visits for P failed to include at services for Patien reported he/she wa visits or the compl Patient # 4. The ac no further docume 4. The clinical rec date of 6/19/16 wi days a week for 20 IADL's and ADL's following findings A SN note for a H was reviewed and night time coverag knew about client patient highly satis (complained of) pu The agency compl 10/1/18 and failed of a complaint froi regarding missed of	conducted with the 0/1/18 at 4:30 PM regarding the atient #4. The complaint log ny complaints regarding missed t # 4. The administrator as not made aware of the missed aints expressed to the staff by liministrator reported there was ntation to be provided. ord of Patient # 5 with a SOC th services to include HHA 5 0 hours week for assistance with as was reviewed with the					
	Administrator on absence of HHA n of care, patient rig	conducted with the 10/1/18 at 1:58 PM regarding the otes, orders to change the plan hts and admission agreement. reported he/she could not					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS. IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE locate the missing documents. In addition the Administrator was asked about the failure of the agency to document the complaint from the family of Patient # 5. The Administrator reported he/she was not working at the agency during 2016 and did not know why the complaint was not documented or investigated. N 0520 410 IAC 17-13-1(a) Patient Care Bldg. 00 Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. N 520 The Administrator or N 0520 11/30/2018 Based on record review and interviews, the designee will immediately review agency failed to meet the needs for 1 out of 4 all clinical records with SN/ HHA (Patient #1) record reviewed of patients receiving services are being provided. If SN (Skilled Nurse) and 4 of 4 patient's (Patients # there is evidence that the POC is 1, 2, 4 and 5) records reviewed receiving HHA not being followed the DON will (Home Health Aide) in a sample of 7 patients. call the PCP for a verbal order to update the plan of care and the Findings Include: POC will be updated in the clinical record and sent to the PCP for 1. A policy titled, "Plan of Care" was reviewed signature. If failure to follow the and stated, "Home care services are furnished POC is due to a shortage on under the supervision and direction of the client's staffing the DON will call the physician. The plan of care is based on a patient and offer to transfer them comprehensive assessment and information to an agency that can provide all provided by the client/family and health team services in the POC. If patient members ... The plan will be consistently reviewed agrees to be transferred to another to ensure that client needs are met and will be agency the DON will facilitate a updated as necessary, but at least every sixty (60) transfer to an agency of the days ... The plan of care shall be completed in full patients choice and to include: c. Type, frequency, and duration of all documentation of conversation visits/services ... k. Specific dietary or nutritional with patient will be recorded in the requirements or restrictions. Medications, patients clinical record. treatments, and procedures ... p. Treatment goals ... At the time of certification and recertification, a The Administrator or designee will 106K11 Page 137 of 206 Event ID: Facility ID: 013593 State Form If continuation sheet

11/27/2018

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE written summary of the client's current status and educate the services being provided are submitted with administration/management, all the plan of care for review. The summary shall clinicians/home health aides on include but is not limited to: changes in clients policy: physical or psychosocial condition, client response to care/services and outcome of care Plan of Care and services ... Professional staff shall promptly alert the physician to any changes that suggest a To prevent this deficiency in the need to alter the plan of care" future, the DON will monitor the services of all clients weekly 2. The clinical record of patient # 1 with a SOC through audits of services provided (start of care) date of 7/18/16 was reviewed. The and any trends will be addressed agency failed to meet the patient's needs as weekly with the administrator. evidenced by the following findings: The Administrator or designee will also do clinical records audits until The POC for the certification period of 7/18/16 to 100% compliance is met, then 9/15/16 included orders for skilled nurse 5 times a 10% of clinical records thereafter week for G-Tube (a tube in the stomach where quarterly to ensure deficiency liquid nutrition is provided) feedings while the does not reoccur. parent was at work and HHA services 6 times a week. The SN failed to provide services until Education completed on 8/9/16 (21 days) after the SOC. The HHA provided 11/08/2018. services 5 times a week 1-2 and 3 times week 6 of the certification period and failed to conduct visits as ordered. The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while the parent was at work and HHA services 6 times a week for assistance with IADL's and ADL's. SN services were provided 4 times during week 6, 3 times during week 7, 0 times during week 8, and 2 times during week 9 of the certification period and failed to be provided as ordered. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist the family in finding a nursing care via another agency at this time family Event ID: 106K11 Facility ID: 013593 Page 138 of 206 State Form If continuation sheet

11/27/2018

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	SHOULD BE	(X5) COMPLETIC	
	coming home at n until nursing staff were provided 3 ti certification period ordered. The POC for the c 1/13/17 included of G-Tube feedings a assistance with IA conducted a total of the POC for the c provide visits as of The POC for the c 3/14/17 included of G-tube feedings ex week for assistance SN conducted a total of the feedings ex week for assistance SN conducted a total period and failed to There were no ord A SN note 3/14/17 (caregiver) of SN intervention, but tf not necessary whe administration of agency office prm The POC for the c 5/13/17 included of assessment and in HIHA 6 times a wo and ADL's. The S for the weeks 1-3 clinical record fail	ertification period of 1/14/17 to orders for SN 1 time a week for ach visit and HHA 6 times a the with IADL's and ADL's. The otal of 5 visits in the certification to provide visit as ordered. Hers to change the POC. 7 stated, "Informed the cg visits weekly for skilled that daily is not achievable and en available CG competent in feedings. Encourage to call					

NTERS FO	R MEDICARE & MEDIC	AID SERVICES					OMB NO. 0938-03
	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIEI ND PLAN OF CORRECTION IDENTIFICATION NUMB 157681		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		CO	(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF	AME OF PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZI		
		HEALTH CARE LLC			ROSSPOINTE BLVE POLIS, IN 46256),	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		0000000000	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO	N SHOULD BE	COMPLETI
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO T DEFICIENCY		DATE
		rtification period of 5/14/17 to					
		ders for SN 1 time a week for					
		A 9 hours a day for 5 days a					
		with IADL's and ADL's. The					
		de the duration of the SN and					
		clinical record failed to					
	evidence document						
	and 2. The HHA co						
	4 visits during week						
	The POC for the ce						
	9/101/7 included or						
	G-tube feedings and						
	days a week for ass						
	ADL's. The SN pro						
	and 5-9 of the certif	fication period and failed to					
	provide 5 visits per	week as ordered. The HHA					
	conducted 3 visits d	luring week 1 and 6 visits					
	during week 2-9 of	the certification period and					
	failed to provide vis	sits 5 times weekly as ordered.					
		rtification period of 9/11/17 to					
		ders for SN 5 times a week for					
		s and HHA 9 hours a day for 5					
	days a week for ass	istance with IADL's and					
	^	vided 2 visits during weeks 1					
		ring week 2 and 1 visit during					
		ication period. The SN failed to					
	^	The HHA provided 6 visits					
		2 visits during week 7, 4 visits					
		9 of the certification period.					
	The HHA failed to	provided visits as ordered.					
		11/17 stated, "continues to					
		cover G-Tube feedings while					
		Will discuss with leadership.					
		time his/her family has been					
		her days of the week there has					
	not been a daily RN	l."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		STREET 10500 INDIAN	COD				
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE /	HOULD BE	(X5) COMPLETIC	
TAG	The POC for the c 1/8/18 included or tube G-tube feedin days a week for as ADL's. There wen SN frequency to 1 certification period POC and provided No SN visits were The HHA provide certification period weekly from 12/3/ provide visits as o The POC for the c 3/9/18 included or tube G-tube educa and HHA 9 hours assistance with IA provided visits 1 t during week 2-9 o failed to provide v provided visits 4 t 1/12/18 with 14-h The HHA provide 1/15/18 to 1/19/18 and 1/18/18. The I week from 1/21/13 provide visits as o The POC for the c 5/8/18 included or G-Tube education HHA 9 hours a da with IADL's and A during week 9 of t to provide visits as	ertification period of 1/9/18 to ders for SN 5 times a week for tion, monitoring and feedings a day, 5 days a week for DL's and ADL's. The SN ime during week 1 and 2 times f the certification period. The SN risits as ordered. The HHA imes a week from 1/9/18 to our visits on 1/9/18 and 1/11/18. d visits 5 times a week from 8 with 14-hour visits on 1/16/18 HHA provided visits 6 times a 8 to 3/9/18. The HHA failed to	TAG			DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. A 14-hour visit on 5/9/18 and a 10-hour visit 5/12/18. The HHA provided 4 visits a week from 5/13/18 to 5/16/18 and 6 visits weekly from 5/17/18 to 7/7/18, when the clinical record evidenced that the patient was in the hospital from 5/17/18 to 6/1/18. The POC for the certification period of 7/8/18 to 9/5/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1-8 and 3 visits during week 9 of the verification period. The HHA provided 14-hour visits on 7/8/18, 7/10/18, 7/12/18. The HHA failed to provide visits as ordered. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 1 of the certification period and failed to provide visits as ordered. The HHA provided 3 visits during week 1 and 6 visits during weeks 2 and 3 of the certification period. The HHA provided 14-hour visits on 9/6/18, 9/11/8.9/13/18, 9/18/18, and 9/20/18 and 16-hour visits on 9/9/18 and 9/16/18. The HHA failed to provide services as ordered. A PA (prior authorization) was requested for patient # 1. The administrator provided a PA for 106K11 Facility ID: 013593 Page 142 of 206 Event ID: State Form If continuation sheet

11/27/2018

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 157681	(X2) MULTIPLE CC A. BUILDING B. WING	COM	(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET 2 10500 (INDIAN	COD		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	was unable to pres record #1. The cur	8 to 2/6/19. The administrator ent any other PAs for clinical rent PA established the SN ested for 2 times weekly and 7.				
	Patient # 1 on 9/24 reported that he/sh patient's full-time patient's sibling ca in the role of a HH the home daily the patient bolus G-tul reported when the (7/18/16) the feedi by a nurse of the a full-time nurse left of 2016 and soon a sending a nurse 5 of reported he/she wa working on getting parent reported he, patient's nurses an needed a nurse 5 d concern had not be parent reported a r nurse was not nece him/her that Media	conducted with the Parent of /18 at 10: 00 AM. The Parent e worked 5-6 days a week. The HHA for the agency, the n not administer tube feedings A. Without a nurse to come to parent had to change the be feeding schedule. The parent patient had been admitted on ngs had been given in mid day gency. The parent reported the the agency around November offer the agency stopped days a week. The parent is told that the agency was g a replacement nurse. The she had reported to the d to the agency that he/she ays a week, but the staffing teen addressed or resolved. The urse had told him/her that a tessary and another nurse told caid had denied the prior nurse 5 times a week.				
	sibling and full-tim The sibling report G-Tube feedings f for work. The tube changed to late aff home and then at b since he/she was w	conducted with Patient # 1's ne HHA on 9/25/18 at 1:50 PM. ed the parent administered the or Patient #1 before he/she left feeding schedule had been ernoon when the parent came bedtime. The sibling reported vorking as a HHA it was not be of practice to give the tube				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(x2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			COM	(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256					
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL	ECTION OULD BE	(X5) COMPLETIO	
TAG		OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE AI DEFICIENCY)	PPROPRIATE	DATE	
n a tt A a a a in n tt tt tt tt tt tt tt tt tt tt tt tt	urse for 2/1/2 yea gency would get week. The siblin he PA visits for 5 an interview was dministrator on 9 dministrator was hvestigation regared eds 5 days a we he parent is at wo he complaints had he complaint log. e/she had not bee eeded this service ware of the misse he POC for SN an	eported they have not had a ars and have been told the a nurse for the feedings 5 days g reported she/he had been told times a week had been denied. conducted with the /24/18 at 2:35 PM. The asked if there was a complaint rding the family's reported SN ek for G-Tube feedings while rk. The administrator reported d not been reported or logged in The administrator reported en made aware the family still e. The administrator was made ed visits and the failure to follow and HHA visits. The administrator e no further documentation to be						
d to d f t f f f t t c t t t f f f f f f f f	ate of 9/28/15 an o 9/11/18, with se ay 5 days a week DL's was review he patient's needs ndings: the HHA provide ertification period ay for a weekly to perform the visits	d visits 4 days in week 5 of the d ranging from 8-9 hours a day of 33 hours. The HHA failed to as ordered.						
c fe p	ertification peor or a weekly to erform the vis	erio otal sits		eriod ranging from 8-9 hours a day otal of 33 hours. The HHA failed to	eriod ranging from 8-9 hours a day otal of 33 hours. The HHA failed to sits as ordered.	eriod ranging from 8-9 hours a day otal of 33 hours. The HHA failed to sits as ordered.	eriod ranging from 8-9 hours a day otal of 33 hours. The HHA failed to sits as ordered.	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	СОМ	'E SURVEY PLETED 2/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	STREET A 10500 INDIAN	DD	•	
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	DULD BE	(X5) COMPLETIC
TAG	certification period for a weekly total perform the visits The HHA provide certification period weekly total of 42 perform the visits The HHA provide certification period a weekly total of 2 perform the visits An interview was administrator on 9 failure to provide 1 week as ordered. T I can say the chang doesn't look like th schedule." The ad documentation to 4. The clinical rece date of 3/13/18 an to 9/8/18 and 9/9/1 include SN month HHA 3 hours a da and ADL's was re- meet the patient's 1 following findings The SN failed to c	d visits 6 days in week 8 of the d ranging for 7 hours daily for a hours. The HHA failed to as ordered. d visits 3 days in week 9 of the d ranging from 4 to 11 hours for 2 hours. The HHA failed to as ordered. conducted with the /26/18 at 2:45 PM regarding the HHA visits 8 hours/ 5 days a The administrator reported, " All ges and hours are an error It he aide reported changes in ministrator had no further be provided. ord of Patient # 4 with a SOC d certification period of 7/11/18 18 to 11/7/18, with services to ly for aide supervisory visit and y for 4 days a week for IADL's viewed. The agency failed to needs as evidenced by the	TAG			DATE
	the HHA failed to evidenced by the f	n period of 7/11/18 to 9/18/18, conduct visits as ordered as ollowing missed visits: 3 visits risit during week 2, 1 visit during				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MUL A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE & DISABLED HOM	E HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, Z 10500 CROSSPOINTE BLV INDIANAPOLIS, IN 46256)	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF	JLD BE	(X5) COMPLETIC
TAG		OR LSC IDENTIFYING INFORMATION tring week 5, 6, 7 and 2 visits		ΓAG	DEFICIENCY)		DATE
	the HHA failed to	on period of 9/9/18 to 11/17/18, conduct visits as ordered as following missed visits: 3 visits and 3.					
	9/25/18 at 3:45 PM been 2-3 weeks si than 1 day a week hit or miss I can't	conducted with Patient # 4 on A. The patient reported it had nce he/she had a HHA more . The patient reported, "It's been get any answers out of the office nd doesn't do any good I'm at of mind."					
	administrator on 1	conducted with the 0/1/18 at 4:30 PM and he/she s no further documentation to be					
	date of 6/19/16 wi days a week for 20 IADL's and ADL's	ord of Patient # 5 with a SOC th services to include HHA 5) hours week for assistance with s was reviewed. The agency patient's needs as evidenced by ings:					
	8/17/16, the HHA during weeks 3 an	ation period of 6/19/16 to failed to provide 2 hours of care d 4, 10 hours of care during rs of care during weeks 8 and 9.					
	10/16/16, there we 1,2, 3, 4, 5, 6, we missing with the e	eation period of 8/18/16 to ere no HHA visit notes for weeks ek. Week 7, 8, and 9 all were exception of 2-hour notes on 10/3/16 and 10/13/16.					
	During the certific	eation period of 10/17/16 to					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	r í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
N 0522 Bldg. 00	during week 1, 18 during week 3 and visit on 12/6/18. T notes for the certif An interview was Administrator on 1 absence of HHA n orders to change th reported he/she was during that time pe no additional infor 410 IAC 17-13-10 Patient Care Rule 13 Sec. 1(a written medical p periodically revie dentist, chiroprace podiatrist, as follo Based on record re failed to ensure all (Plan Of Care) wa #1) record review (Skilled Nurse) an 4 and 5) record rev HHA (Home Heal patients. Findings Include: 1. A policy titled, and stated, "Home under the supervis physician. The pla comprehensive ass provided by the cli	 conducted with the 10/1/18 at 1:58 PM regarding the otes and if there were any ne POC. The Administrator as not working at the agency eriod. He/she reported there was mation to be provided. (a)) Medical care shall follow a lan of care established and wed by the physician, etor, optometrist or 	N 0	522	N 522 The Administrator or designee will immediately rev all clinical records with SN/ H services are being provided. there is evidence that the PO not being followed the DON v call the PCP for a verbal orde update the plan of care and the POC will be updated in the cl record and sent to the PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON will call the patient and offer to transfer the to an agency that can provide services in the POC. If patient agrees to be transferred to an agency the DON will facilitated transfer to an agency of the	HA If C is vill er to he inical or the all nt nother	11/30/201

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COMP	E SURVEY LETED 2/2018
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C to ensure that clier updated as necessa days The plan o to include: c. Type visits/services k requirements or re treatments, and pro At the time of cert written summary C the services being the plan of care foo include but is not l physical or psycho response to care/se and services Pro alert the physician need to alter the pl 2. The clinical recc (start of care) date the following find The POC for the c 9/15/16 included c week for G-Tube (liquid nutrition is j parent was at work week. The SN fail 8/9/16 (21 days) a services 5 times a the certification pe as ordered. The POC for the c 11/14/16 included G-Tube feedings v	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION At needs are met and will be ary, but at least every sixty (60) f care shall be completed in full e, frequency, and duration of all . Specific dietary or nutritional strictions. Medications, becedures p. Treatment goals ification and recertification, a of the client's current status and provided are submitted with r review. The summary shall imited to: changes in clients social condition, client ervices and outcome of care of essional staff shall promptly to any changes that suggest a an of care" ord of patient # 1 with a SOC of 7/18/16 was reviewed with	INDIAI ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY) patients choice and documentation of convers with patient will be recorded patients clinical record. The Administrator or designed educate administration/manageme clinicians/home health aid policy: Plan of Care To prevent this deficiency future, the DON will monit services of all clients weel through audits of services and any trends will be add weekly with the administra The Administrator or designed also do clinical records au 100% compliance is met, 10% of clinical records the quarterly to ensure deficien does not reoccur. Education completed on 11/08/2018.	in the or the kly provided dator. gnee will dates on	(X5) COMPLETIO DATE
	IADL's and ADL's times during week	a. SN services were provided 4b. 3 times during week 7, 0 timesc. 3 times during week 9 of the				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULT A. BUILE B. WING		NSTRUCTION 00	_ C	DATE SURVEY OMPLETED 0/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	1	freet ai 0500 C NDIANA	D			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION and failed to be provided as	T	AG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE	
	to nursing schedul we have offered to nursing care via ar has declined this of coming home at ne until nursing staff were provided 3 ti certification period ordered. The POC for the c 1/13/17 included c G-Tube feedings a assistance with IA conducted a total of	note dated 11/1/16 stated, "Due ing difficulties with this patient, assist the family in finding a nother agency at this time family ffer. Currently, mother is bon to feed daughter via G-Tube available." The HHA services mes during week 5 of the 1 and failed to be conducted as ertification period of 11/15/16 to orders for SN 5 times a week for nd HHA 6 times a week for DL's and ADL's. The SN of 4 of the 45 visits ordered on rtification period and failed to ordered.						
	3/14/17 included of G-tube feedings ea week for assistanc SN conducted a to period and failed t There were no ord A SN note 3/14/17 (caregiver) of SN 4 intervention, but th not necessary whe administration of f agency office proc	ertification period of 1/14/17 to rders for SN 1 time a week for ich visit and HHA 6 times a e with IADL's and ADL's. The tal of 5 visits in the certification o provide visit as ordered. ers to change the POC. ' stated, "Informed the cg visits weekly for skilled nat daily is not achievable and n available CG competent in 'eedings. Encourage to call (as needed)."						
	5/13/17 included of	rders for SN 1 time a week for struction to caregivers and						

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 157681	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLII	E HEALTH CARE LLC	1050	ET ADDRESS, CITY, STATE, ZI 10 CROSSPOINTE BLVE ANAPOLIS, IN 46256		D		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE		
	and ADL's. The S for the weeks 1-3 clinical record fail any HHA visits for period. The POC for the of 7/12/17 included of assessment and H week for assistance POC failed to incl HHA services. Th evidence document and 2. The HHA of 4 visits during we The POC for the of 9/101/7 included of G-tube feedings a days a week for as ADL's. The SN pr and 5-9 of the cert provide 5 visits per conducted 3 visits during week 2-9 of failed to provide v The POC for the of 11/9/17 included of tube G-tube feeding as week for as ADL's. The SN pr and 4-8, 0 visits d week 9 of the cert provide as orderece during weeks 1-6, during week 8 and	week for assistance with IADL'S N failed to provide 1 visit weekly of the certification period. The led to evidence documentation of or weeks 4-9 of the certification ertification period of 5/14/17 to orders for SN 1 time a week for HA 9 hours a day for 5 days a we with IADL's and ADL's. The ude the duration of the SN and e clinical record failed to ntation of HHA visits for week 1 conducted 6 visits week 4-8 and ek 9 of the certification period. ertification period of 7/13/17 to orders for SN 5 times a week for nd HHA 9 hours a day for 5 ssistance with IADL's and rovided 1 visit during weeks 2-3 tification period and failed to er week as ordered. The HHA during week 1 and 6 visits of the certification period and risits 5 times weekly as ordered. ertification period of 9/11/17 to orders for SN 5 times a week for ng HHA 9 hours a day for 5 ssistance with IADL's and rovided 1 visit during weeks 2-3 tification period of 9/11/17 to orders for SN 5 times a week for ngs and HHA 9 hours a day for 5 ssistance with IADL's and rovided 2 visits during weeks 1 uring week 2 and 1 visit during ification period. The SN failed to 1. The HHA provided 6 visits 2 visits during week 7, 4 visits 4 9 of the certification period. by provided visits as ordered.						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MUI A. BUII B. WIN	LDING	nstruction 00	CC	ate survey ompleted 0/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC		STREET AI 10500 C INDIANA	COD			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		(X5) COMPLETIO	
TAG		PR LSC IDENTIFYING INFORMATION //1/17 stated, "continues to		TAG	DEFICIENCY)		DATE	
	mother is at work. Parent states at thi	o cover G-Tube feedings while Will discuss with leadership. s time his/her family has been ther days of the week there has N."						
	1/8/18 included or tube G-tube feedin days a week for as	ertification period of 11/10/17 to ders for SN 5 times a week for ogs and HHA 9 hours a day for 5 sistance with IADL's and re orders present to change the						
	certification period POC and provided No SN visits were	visit during week 7 and 9 of the d. The SN failed to follow the l visits 2 times during weeks 2-6. conducted during week 1 and 8.						
	certification period	d 1 visit week 1 of the d on 11/10/17, 6 visits during (17 to 1/6/18. The HHA failed to rdered.						
	3/9/18 included or tube G-tube educa and HHA 9 hours assistance with IA provided visits 1 ti	ertification period of 1/9/18 to ders for SN 5 times a week for tion, monitoring and feedings a day, 5 days a week for DL's and ADL's. The SN ime during week 1 and 2 times f the certification period. The SN						
	failed to provide v provided visits 4 ti 1/12/18 with 14-ha The HHA provide 1/15/18 to 1/19/18 and 1/18/18. The H	isits as ordered. The HHA imes a week from 1/9/18 to our visits on 1/9/18 and 1/11/18. d visits 5 times a week from with 14-hour visits on 1/16/18 HHA provided visits 6 times a 8 to 3/9/18. The HHA failed to						
	5/8/18 included or	ertification period of 3/10/18 to ders for SN 2 times a week for , monitoring and feedings and						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	ì í	ULTIPLE CON JILDING ING	struction 00	CON	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		STREET AD 10500 CF INDIANA	D			
	T			<u> </u>	1 0210, 111 40200			
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETIC	
TAG	HHA 9 hours a da with IADL's and A during week 9 of t to provide visits as visits during week during week 9. Th as ordered. The POC for the c 7/7/18 included or G-Tube education HHA 9 hours a da with IADL's and A and a 10-hour visi visits a week from weekly from 5/17/ record evidenced t hospital from 5/17 The POC for the c 9/5/18 included or G-Tube care and c hours a day, 5 day IADL's and ADL'S week 9 of the certi provide visits as o visits during week of the verification 14-hour visits on 7 HHA failed to pro The POC for the c	y, 5 days a week for assistance ADL's. The SN provided 1 visit he certification period and failed s ordered. The HHA provided 6 s 1, 2, 3, 4, 6, 8, and 3 visits e HHA failed to provide visits ertification period of 5/9/18 to ders for SN 2 times a week for , monitoring and feedings and y, 5 days a week for assistance ADL's. A 14-hour visit on 5/9/18 t 5/12/18. The HHA provided 4 5/13/18 to 5/16/18 and 6 visits '18 to 7/7/18, when the clinical hat the patient was in the		TAG	DEFICIENC 11		DATE	
	G-Tube care and c hours a day, 5 day IADL's and ADL's week 1 of the certi provide visits as o visits during week	Iressing changes and HHA 9 s a week for assistance with s. The SN provided 1 visit during fication period and failed to rdered. The HHA provided 3 1 and 6 visits during weeks 2 cation period. The HHA						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	CON	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE & DISABLED HOM	R E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP (CROSSPOINTE BLVD, NAPOLIS, IN 46256	COD	•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	provided 14-hour 9/18/18, and 9/20/ and 9/16/18. The H as ordered. A PA (prior author patient # 1. The add the period of 8/8/1 was unable to press record #1. The cur services were requined to press record #1. The cur services were requined to 5 times weekly An interview was Patient # 1 on 9/24 reported that he/sh patient's full-time patient's full-time patient's sibling cal in the role of a HH the home daily the patient bolus G-tul reported when the (7/18/16) the feedid by a nurse of the a full-time nurse left of 2016 and soon a sending a nurse 5 of reported he/she was working on getting parent reported he patient's nurses an needed a nurse 5 dd concern had not be parent reported a r nurse was not need him/her that Medid authorization for a An interview was	visits on 9/6/18, 9/11/8.9/13/18, 18 and 16-hour visits on 9/9/18 HA failed to provide services rization) was requested for ministrator provided a PA for 8 to 2/6/19. The administrator ent any other PAs for clinical rent PA established the SN ested for 2 times weekly and 7. conducted with the Parent of 1/18 at 10: 00 AM. The Parent e worked 5-6 days a week. The HHA for the agency, the n not administer tube feedings A. Without a nurse to come to parent had to change the be feeding schedule. The parent patient had been admitted on ngs had been given in mid day gency. The parent reported the the agency stopped days a week. The parent is told that the agency was g a replacement nurse. The she had reported to the d to the agency that he/she ays a week, but the staffing teen addressed or resolved. The turse had told him/her that a tessary and another nurse told caid had denied the prior nurse 5 times a week.					
	sibling and full-tin	ne HHA on 9/25/18 at 1:50 PM.					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE & DISABLED HOM	E HEALTH CARE LLC	10500 (ADDRESS, CITY, STATE, ZIP CROSSPOINTE BLVD, IAPOLIS, IN 46256		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE COL	(X5) MPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
	1	ed the parent administered the				
		or Patient #1 before he/she left				
	-	e feeding schedule had been				
		ernoon when the parent came				
		bedtime. The sibling reported				
		vorking as a HHA it was not				
		be of practice to give the tube				
	feedings. He/she r	eported they have not had a				
	nurse for 2/1/2 year	ars and have been told the				
	agency would get	a nurse for the feedings 5 days				
	a week. The siblin	g reported she/he had been told				
	the PA visits for 5	times a week had been denied.				
		conducted with the				
		/24/18 at 2:35 PM. The				
		asked if there was a complaint				
		rding the family's reported SN				
	-	ek for G-Tube feedings while				
	-	rk. The administrator reported				
	-	l not been reported or logged in The administrator reported				
		en made aware the family still				
		e. The administrator was made				
		ed visits and the failure to follow				
		nd HHA visits. The administrator				
		no further documentation to be				
	provided.					
	3. The clinical rec	ord of Patient # 2 with a SOC				
	date of 9/28/15 an	d a certification period of 7/14/18				
		ervices to include HHA 8 hours a				
		for assistance with IADL's and				
	ADL's was review	ved with the following findings:				
	The HHA provided visits 6 days in week 4 of the					
	_	d ranging from 3 to 11 hours a				
	day for a weekly to to perform the visi	otal of 46 hours. The HHA failed its as ordered.				
	The HHA provide	d visits 4 days in week 5 of the				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COI 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256			(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC						
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	(X5) COMPLETIO	
TAG	certification perio	DR LSC IDENTIFYING INFORMATION d ranging from 8-9 hours a day of 33 hours. The HHA failed to as ordered		TAG	DEFICIENCY)		DATE	
	The HHA provide certification perio	d visits 4 days in week 7 of the d ranging from 7-8 hours a day of 31 hours. The HHA failed to						
	certification perio	d visits 6 days in week 8 of the d ranging for 7 hours daily for a hours. The HHA failed to as ordered.						
	certification perio	d visits 3 days in week 9 of the d ranging from 4 to 11 hours for 22 hours. The HHA failed to as ordered.						
	administrator on 9 failure to provide week as ordered. I can say the chan doesn't look like th	conducted with the /26/18 at 2:45 PM regarding the HHA visits 8 hours/ 5 days a The administrator reported, " All ges and hours are an error It he aide reported changes in liministrator had no further be provided.						
	date of 3/13/18 an to 9/8/18 and 9/9/ include SN month HHA 3 hours a da	ord of Patient # 4 with a SOC d certification period of 7/11/18 18 to 11/7/18, with services to ly for aide supervisory visit and y for 4 days a week for IADL's viewed with the following						
		onduct a supervisory visit in the 2018. This exceeded the Agency						

AND PLAN (OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING STREET ADDRESS_CITY_STATE_ZIP.C		(X3) DATE SURVEY COMPLETED 10/02/2018		
	ROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500 C	DDRESS, CITY, STATE, ZIP (ROSSPOINTE BLVD, APOLIS, IN 46256		
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO
	the HHA failed to evidenced by the f during week 1, 1 v week 4, 3 visits du during week 8. For the certification the HHA failed to evidenced by the f during weeks 1, 2 An interview was 4 9/25/18 at 3:45 PM been 2-3 weeks sin than 1 day a week. hit or miss I can't g I've told them an out of sight and out An interview was 4 administrator on 1 reported there was provided. 5. The clinical reco date of 6/19/16 wir days a week for 20 IADL's and ADL's following findings During the certific 8/17/16, the HHA during weeks 3 an- week 6, and 4 hour During the certific 10/16/16, there we	conducted with Patient # 4 on A. The patient reported it had nee he/she had a HHA more The patient reported, "It's been get any answers out of the office nd doesn't do any good I'm it of mind." conducted with the 0/1/18 at 4:30 PM and he/she no further documentation to be ord of Patient # 5 with a SOC th services to include HHA 5 0 hours week for assistance with 5 was reviewed with the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 9/29/16, 9/30/16, 10/3/16 and 10/13/16. During the certification period of 10/17/16 to 12/14/16 the HHA failed to provide 10 hours during week 1, 18 hours during week 2, 18 hours during week 3 and with the exception of a 2-hour visit on 12/6/18. There were no further HHA notes for the certification period. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes and if there were any orders to change the POC. The Administrator reported he/she was not working at the agency during that time period. He/she reported there was no additional information to be provided. N 0524 410 IAC 17-13-1(a)(1) Patient Care Bldg. 00 Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: Mental status. (i) Types of services and equipment (ii) required. Frequency and duration of visits. (iii) (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. Any safety measures to protect (X) against injury. Instructions for timely discharge or (xi) 106K11 Facility ID: 013593 Page 157 of 206 Event ID: If continuation sheet State Form

11/27/2018

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPL A. BUILDING B. WING	e construction G <u>00</u>	COM	e survey pleted 2/2018
NAME OF	PROVIDER OR SUPPLIE	R	STRE 105			
AGING	& DISABLED HOM	E HEALTH CARE LLC	IND	ANAPOLIS, IN 46256		
X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	treatment. (xiii) Any other a Based on observation interview, the ager complete the pland and duration of vis (Patients # 1, 2, 4, for 2 of 7 (Patient treatments for 3 of measurable goals of sample of 7 clinical Findings Include: 1. A policy titled, and stated, "Home under the supervise physician. The plan comprehensive ass provided by the cline members The plan full to include: c. The all visits/services nutritional requireen Medications, treath Treatment goalst At the time of care for include, but is not physical or psycho- response to care/se	ion, record review and ney failed to accurately of care to include the frequency tits to be conducted for 4 of 7 5), the nutritional requirements #1, 3) , all medications and 7 (Patient # 1, 2, 3) , and for 1 of 7 (Patient # 1) in a	N 0524	N 524 The Administrator designee will immediately all clinical records for acc and complete plan of card including frequency, and of visits, nutritional requirements,medications treatments with measural and current and past find clinical records found to f POC that is not updated, will call PCP for a verbal update the plan of care, t physician order will be wr reflecting the update and PCP for signature. The DON or designee wil all clinicians on policy: Plan of Care policy Home Health Admi Service Agreement To prevent this deficiency future, the DON will revie plan of care for accuracy sending to PCP for signa Administrator or designee responsible for active clin record audits until 100% compliance is met then 1 clinical records will be au quarterly for evidence afte compliance is met to ensu-	v review urate e, duration s, ole goals, ings. Any have a the DON order to hen a itten sent to I educate ssion v in the w every before ture. The e will be ical 0 % of all dited er 100% ure that	11/30/2018

Event ID: 106K11

Facility ID: 013593

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If continuation sheet

Page 158 of 206

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	COMI	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	TADDRESS, CITY, STATE, ZIP C CROSSPOINTE BLVD, NAPOLIS, IN 46256	OD		
(X4) ID PREFIX		/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE	IOULD BE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		DATE	
		physician to any changes that alter the plan of care"		Education completed of 11/08/2018.	חכ		
		ord of patient # 1 with a SOC of 7/18/16 was reviewed with ings:					
	9/15/16, included week and HHA se failed to include th nurse) and failed	ertification period of 7/18/16 to orders for skilled nurse 5 times a rvices 6 times a week. The POC ne duration for the SN (skilled to include the HHA (Home and duration and services to be					
	11/14/16, included and HHA services	ertification period of 9/16/16 to l orders for SN 5 times a week 6 times a week. The POC failed duration or HHA time and					
	1/13/17, included HHA 6 times a we	ertification period of 11/15/16 to orders for SN 5 times a week and eek. The POC failed to include HHA time and duration.					
	3/14/17, included HHA 6 times a we	ertification period of 1/14/17 to orders for SN 1 time a week and eek. The POC failed to include HHA time and duration.					
	5/13/17, included HHA 6 times a we	ertification period of 3/15/17 to orders for SN 1 time a week and eek. The POC failed to include HHA time and duration. POC.					
	7/12/17, included HHA 9 hours a da	ertification period of 5/14/17 to orders for SN 1 time a week and y for 5 days a week. The POC uration of the SN and HHA					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE services. The POC for the certification period of 7/13/17 to 9/101/7, included orders for SN 5 times a week and HHA 9 hours a day. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/11/17 to 11/9/17, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services The POC for the certification period of 11/10/17 to 1/8/18, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 1/9/18 to 3/9/18, included orders for SN 5 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 3/10/18 to 5/8/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 5/9/18 to 7/7/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 7/8/18 to 9/5/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC Page 160 of 206 Event ID: 106K11 Facility ID: 013593 State Form If continuation sheet

11/27/2018

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MUL A. BUIL B. WING	DING	NSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE & DISABLED HOM	E HEALTH CARE LLC		STREET AI 10500 C INDIANA	COD			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	PI	ID REFIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETIO	
TAG		OR LSC IDENTIFYING INFORMATION uration for the SN and HHA		TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE	
	11/4/18 included of HHA 9 hours a da	ertification period of 9/6/18 to orders for SN 2 times a week and y, 5 days a week. The POC uration for the SN and HHA						
	nutritional suppler hours. During an i patient's family me he/she reported the G-Tube feeding: T AM, 240 ml bolus 9-10 PM daily dur	d orders for Two Cal HN (a ment) oral 240 ml bolus every 6 nterview conducted with the ember on 9/24/18 at 10:00 AM, e following was the accurate Two Cal HN 480 ml bolus at 6 or 7 at 4:00 PM and 480 ml bolus at ting the time the mother is at The POC failed to include the al requirements.						
	Aquaphor Externa healing of skin) 1 hours, Mupirocin once a day. The or ointments would b Ciprofloxacin (and per feeding tube e	I the following topical ointments: I (for protection and moisture apply to healed areas every 12 External (antibacterial) 2 % 1 rders failed to specify where the be applied. An order for fibiotic) HCL oral 500 mg 1 tab very 12 hours failed to be POC and had been discontinued						
	remain tolerable the goal was not specified for an assessment	POC stated, "Patient's pain will proughout care period." The fic to include the Wong scale of a nonverbal patient and did rable outcomes for tolerable						
		conducted with the 9/24/18 at 4:45 PM to review the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE POC findings. The Administrator reported there was no further documentation to be provided. 3. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings: The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits The POC for the certification period of 7/14/18 to 9/11/18, included the following order: "Silvadene External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18and failed to include the specific area of the body for application. An interview was conducted with the Administrator on 9/26/18 at 4:30 PM regarding the POC findings. The Administrator reported there was no further documentation to be provided 4. The clinical record of Patient #3 with a SOC of 7/25/18 was reviewed with the following findings: The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets" The patient was interviewed on 9/26/18 9:48 AM and reported he had a 32 ounce daily fluid restriction and his diet is a diabetic/renal diet. An interview was conducted with the patient regarding his medications on 9/26/18 at 9:48 AM Event ID: 106K11 Facility ID: 013593 Page 162 of 206 State Form If continuation sheet

11/27/2018

	R MEDICARE & MEDI				(X2) MULTIPLE CONSTRUCTION				
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	È É				ATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING	00		OMPLETED		
		157681	В.	WING		10)/02/2018		
NAME OF	PROVIDER OR SUPPLIE	D		STREET A	ADDRESS, CITY, STATE, ZIP	COD			
NAME OF I					CROSSPOINTE BLVD,				
AGING &	& DISABLED HOMI	E HEALTH CARE LLC		INDIAN	APOLIS, IN 46256				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	during a home the	rapy visit observation. The POC							
	for the certification	n period of 7/25/18 to 9/22/18							
	included orders for	the following medications:							
	Levothyroxine Soc	dium (thyroid pill also know as							
	Synthroid) Oral 17	75 mcg 1 tablet daily and							
	Synthroid (thyroid	e ;							
		al 75 mcg 1 tablet in the							
		ne patient reported the order							
	was a duplicate. N	ortriptyline (for diabetic							
	-	HCL oral 10 mg 2 caps bedtime,							
	the patient reported	d this medication had been							
	· ·	nths ago. Insulin aspart (fast							
		ulin) subcutaneous 100 units/ml							
	-	before meals, using sliding scale							
		pends on the patient's blood							
		failed to include the specific							
	sliding scale order								
		conducted with the							
	Administrator on 9	0/26/18 at 12:07 PM regarding							
	-	tient # 3. The Administrator							
	reported they did r	not have any information							
	regarding the patie	ents dialysis medication, diet							
	and fluid restrictio	ns. The administrator reported							
	in regards to the m	edication findings, "I have							
	some education to	do. There is no excuse for							
	this."								
	A. C	1 Come de la distancia Constitución							
		d from the dialysis facility on							
		led the following daily diet							
		m 3 GM, Phosphorus 1200 mg							
		fax also included the following							
	-	he patients ESRD: Heparin							
		s/ml to arterial port 2,200 units							
		venous port (of a central							
		every treatment (3 times weekly),							
		ication for anemia) 100 mg IVP							
	· • •	every treatment x 5 and Micera							
		emia) 200 mcg IVP every 2 week							
		OC failed to include the patient's							

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE special nutritional needs related ESRD (End Stage Renal Disease) and failed to include the patient's medication regimen for ESRD. 5. The clincial record of Patient # 4 with a SOC date of 3/13/18 was reviewed with the following findings: The POC for the certification period of 7/11/18 to 9/8/18 included an order for HHA 3 hours day/ 4 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the administrator on 10/1/18 at 4:30 PM and the administrator reported there was no further documentation to be provided. 6. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification periods of 6/19/16 to 8/17/16, 8/18/16 to 10/16/16 and 10/17/16 to 12/14/16 included an order for HHA 4 hours a day/ 5 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be provided. N 0529 410 IAC 17-13-1(a)(2) Patient Care Bldg. 00 Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; State Form Event ID: 106K11 Facility ID: 013593 Page 164 of 206 If continuation sheet

11/27/2018

	IT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 157681	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION O	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	STREET 10500 INDIA			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
	failed to send a wr every 60 days for records reviewed i services provided Findings Include: A policy titled, "P. stated, "Home care the supervision an physician. The pla comprehensive ass provided by the cl members The pl to ensure that clier updated as necessa days At the tim recertification , a v current status and submitted with the summary shall inc changes in clients condition, client re outcome of care an The clinical record of care) date of 7/1 following findings The clinical record conference/ 60 day	or o (2) months. eview and interview, the agency ritten summary for each patient 1 of 7 (Patient #1) clincial in a sample of patients 5 with for more than 60 days. lan of Care" was reviewed and e services are furnished under d direction of the client's m of care is based on a sessment and information ient/family and health team lan will be consistently reviewed at needs are met and will be ary, but at least every sixty (60) we of certification and written summary of the client's the services being provided are e plan of care for review. The lude, but is not limited to: physical or psychosocial esponse to care/services and nd services" d of patient # 1 with a SOC (start 18/16 was reviewed with the s: d failed to include a case y summary for the certification to 9/15/16, 9/16/16 to 11/14/16,	N 0529	N 529 The Administrator or designee will immediately review all clinical records for documentation of 60 day summaries. If a 60 day summa is not present in the clinical reco a 60 day summary will be completed by the RN case manager and sent to the PCP. The Administrator or designee we educate administration/management, all clinicians on policy: Plan of Care Coordination of Client Services To prevent this deficiency in the future, the DON or designee will monitor/audit all clinical documentation weekly to ensure that 60 day summaries are completed and sent to the physician at least every 60 days.the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 11 % of all clinical records will be audited quarterly for evidence a 100% compliance is met to ensure that this deficiency will n reoccur.	ry ord vill e I e I fter	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	A. BUILD B. WING		NSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE & DISABLED HOM	E HEALTH CARE LLC	1	0500 C	DDRESS, CITY, STATE, ZIP CO ROSSPOINTE BLVD, APOLIS, IN 46256	D	-	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
	 /60 day summary i of 1/14/17 to 3/14. 3/9/17 failed to intime a week, and the psychosocial condi- and outcome of care The clincial record visit note for 3/28, diagnosis of "acute spontaneous ruptur drum" and amoxice missed visit note for notified by office into today and unable to physician's order of machine, tubing, Mercord failed to inter- summary for the care 5/13/17. The clinical record conference/60 day certification period notes dated 10/6/1 nursing services and daily and were ord dated 11/08/17 into services were beintivity of the services of the physical or psychological or psychol	d evidenced 2 case conference notes for the certification period /17. The notes dated 2/16/17 and clude skilled nurse services 1 he patient's current physical or lition and patient's response to re/services provided. d included a physicians office /17 that reported a new e otitis media of right ear with re of tympanic membrane (ear cillin to treat the infection. A for 3/29/17 reported, "RN that patient was seen in ER to be seen for SNV." A dated 4/19/17 included suction Yonkers and nasal suction please provide training and y and caregiver." The clinical clude a case conference/ 60 day ertification period of 3/15/17 to d evidenced 2 case r summary notes for the d of 9/11/17 to 11/9/17. The 7 failed to include skilled nd reported HHA services were dered 5 times a week. The note correctly reported skilled nursing ig provided 5 days a week (SN ed 1-2 times a week) and vices were "no change." The lude the patient's current bosocial condition and patient's atcome of care/services			Education completed 1	1/11/2018.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The clinical record evidenced 2 case conference/ 60 day summary notes for the certification period of 11/10/17 to 1/8/18. The notes dated 12/4/17 and 1/4/18 both stated, "continue plan of care as developed. No acute changes noted at this time. The notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. The clinical record evidenced a skilled nurse note dated 2/19/18 that reported, "per mother, patient fell off bed yesterday." The clinical record evidenced 2 case conference/ 60 day summary notes for the certification period of 1/9/18 to 3/9/18. The notes were dated 2/55/18 and 3/5/18 and both stated, "Continue plan of care as developed. No distress noted. No acute changes noted." There was no mention of the fall and the notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. An interview with the Administrator was conducted on 9/26/18 at 3:47 PM. He/she reported the 60 day summary is included on the case conference note on the agency document titled, " [agency name] Case Conference and 60 day Summary." The administrator reported the summary is not included on the Plan of Care and had no further documentation to be provided. N 0533 410 IAC 17-13-2 Nursing Plan of Care Bldg. 00 Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home Event ID: 106K11 Facility ID: 013593 Page 167 of 206 If continuation sheet State Form

11/27/2018

PRINTED:	11/27/2018
FORM API	PROVED
OMB NO. (938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	A. BUIL B. WING	3 		(X3) DATE COMPL 10/02 /	ETED
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC			ss, city, state, zip cod SPOINTE BLVD, IS, IN 46256	•	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		CRO	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIAT	TE	(X5) COMPLETIO
TAG	REGULATORY OF health aide services skilled service. (b) The nursing p following: (1) A plan of care identifying informat (2) The name of (3) Services to be (4) The frequenc (5) Medications, (6) Signed and d personnel providi (7) Supervisory v (8) Sixty (60) day (9) The discharge (10) The signatur who developed the Based on record re failed to ensure the documentation of c (Home Health Aide patient's skin condi irritation to a stage patient's receiving a (Patient #2) in a sai provide all services Care) for 4 of 4 patient	R LSC IDENTIFYING INFORMATION des in the absence of a alan of care must contain the a and appropriate patient ation. the patient's physician. e provided. y and duration of visits. diet, and activities. ated clinical notes from all ng services. risits. y summaries. e note. e of the registered nurse he plan. view and interview, the SN clinical record included coordination with the HHA e) regarding a change in the tion that progressed from 3 pressure ulcer for 1 of 4 home health aide services mple of 4 and the HHA failed to s outlined in the POC (Plan Of ient receiving HHA services		TAG TAG N 53 desig all cl of ca Imm man confi for p and care note	3 The Administrator or gnee will immediately revia inical records for coordina are between SN/HHA. ediately all RN case agers will be required to erence with the HHA weel atients they case manage document this coordinatio through a communication in the clinical record.	ew tion kly n of	DATE
	Findings Include:	nd 5) in a sample of 4 records.		adm	DON or designee will edu inistration/management, a cians on policy: Coordination of Client		
	and stated, "Home under the supervisi physician. The plar comprehensive ass provided by the cli	"Plan of Care" was reviewed care services are furnished on and direction of the client's n of care is based on a essment and information ent/family and health team of essional staff shall promptly		of Ca	Home Health Aide ervision Care Planning/ Coordina	tion	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULT A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 10/02/	ETED	
	PROVIDER OR SUPPLIE & DISABLED HOM	E HEALTH CARE LLC	1	STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
AGING (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C alert the physician need to alter the p 2. An agency poli Client Services" w personnel furnishi liaison to assure th effectively and sup the Plan of Care. T care conferences, 1 care plans, and wr 3. An agency poli Supervision" was shall provide Hom the direction and s when personal car ordered by the phy Supervisor or desi the HHA direction Care Plan. 4. The clinical rec	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION to any changes that suggest a lan of care" icy titled, "Coordination of vas reviewed and stated: "All ng services shall maintain a hat their efforts are coordinated pport the objective outlined in This may be done through formal maintaining complete, current itten and verbal interaction. icy titled, "Home Health Aide reviewed and stated, " Agency he Health Aide Services under supervision of a RN/ Therapist te services are indicated and ysician 1. The Nursing gnated RN/Therapist will give h for client care by way of the ord of patient # 1 with a SOC	PR	NDIAN/ ID EFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY) educated on: "What to Report to RN, Case Manager" Home Health Aide Documentation To prevent this deficiency in t future, the RN case managers be required to review all HHA documentation and perform weekly conference with HHA' all the patients they case mar RN case manager will also re the aide care plan with the assigned home health aide put the home health aide providin services to the patient and res the home health aide care pla with the home health aide at I every 60 days or when there change in the patients' condit the Administrator or designee be responsible for active clinic record audits until 100%	he s will s for nage. view rior to ig view in east is a ion. will cal	(X5) COMPLETION DATE	
	the following find The POC for the c 9/15/16, included a week. The HHA during week 1- 2 the certification pe as ordered. The POC for the c 11/14/16, included times a week for a ADL's. The HHA	ertification period of 7/18/16 to orders for HHA services 6 times provided services 5 times and 3 times during week 6 of eriod and failed to conduct visits ertification period of 9/16/16 to d orders for HHA services 6 issistance with IADL's and services were provided 3 times the certification period and failed			ompliance is met then 10 % of all linical records will be audited uarterly for evidence after 100% ompliance is met to ensure that his deficiency will not reoccur.			

State Form

Facility ID: 013593

If continuation sheet Page 169 of 206

PRINTED: 11/27/2018 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULT A. BUILI B. WING	DING	STRUCTION 00	CON	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	s 1 1					
(X4) ID PREFIX		7 STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		D EFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO	ECTION ULD BE	(X5) COMPLETIO	
TAG		DR LSC IDENTIFYING INFORMATION		AG	CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	DATE	
	5/13/17, included for assistance. The evidence documer during weeks 4-9 of The POC for the c 7/12/17 included of 5 days a week. The evidence documer weeks 1 and 2. The during weeks 4-8 a certification period							
	9/10/17 included of 5 days a week. The during week 1 and	ertification period of 7/13/17 to orders for HHA 9 hours a day for e HHA conducted 3 visits 16 visits during weeks 2-9 of the d and failed to provide visits 5 rdered.						
	11/9/17 included of 5 days a week. Th weeks 1-6, 2 visit weeks 8 and 9 of t	ertification period of 9/11/17 to orders for HHA 9 hours a day for e HHA provided 6 visits during s during week 7, 4 visits during he certification period. The vided visits as ordered.						
	1/8/18, included of 5 days a week. The during weeks 5-9	ertification period of 11/10/17 to orders for HHA 9 hours a day for e HHA provided visits 6 times during the certification period. o provide visits as ordered.						
	3/9/18 included or a week. The HHA 1/9/18 to 1/12/18 1/11/18. The HHA	ertification period of 1/9/18 to ders HHA 9 hours a day, 5 days provided visits 4 times a week with 14-hour visits on 1/9/18 and a provided visits 5 times a week with 14-hour visits on 1/16/18						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	CON	(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLI	ER E HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256						
ave to					,				
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE	р	ID REFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETIC		
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IAU		HHA provided visits 6 times a		IAU			DATE		
		8 to 3/9/18. The HHA failed to							
		rdered. The HHA failed to							
	provide visits as o								
	The POC for the c	certification period of 3/10/18 to							
		rders for HHA 9 hours a day, 5							
		ssistance with IADL's and							
		provided 6 visits during week 1,							
	2, 3, 4, 6, 8, and 3 provide visits as o	visits week 9. The HHA failed to ordered.							
	The POC for the c	certification period of 5/9/18 to							
	7/7/18 included or	rders for HHA 9 hours a day, 5							
	days a week for as	ssistance with IADL's and							
	ADL's. The patier	nt was in the hospital from							
		The HHA conducted a 14-hour							
		d a 10-hour visit $5/12/18$. The							
	-	visits a week from 5/13/18 to							
		ts weekly from 5/17/18 to 7/7/18.							
		o provide visits as ordered.							
		certification period of 7/8/18 to							
		rders for HHA 9 hours a day, 5							
	5	HHA provided 6 visits during							
		sits during week 9 of the d. The HHA provided 14-hour							
	· ·	d. The HHA provided 14-hour /10/18, 7/12/18. The HHA failed							
	to provide visits a								
		solucied.							
	The POC for the c	certification period of 9/6/18 to							
		orders for HHA 9 hours a day, 5							
	days a week. The	HHA provided 3 visits during							
		its during week 2 and 3 of the							
	-	d. The HHA provided 14-hour							
		/11/8.9/13/18, 9/18/18, and							
		our visits on 9/9/18 and 9/16/18.							
	The HHA failed to	o provide services as ordered.							
	5. The clinical red	cord for Patient # 2, with a start							

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE of care date of 9/28/15, with a diagnosis to include Cerebral Palsy and Functional limitations to include Paralysis, Bowel and Bladder Incontinence, Endurance and Ambulation. The plans of care for the certification periods of 3/15/18 to 5/13/18 included orders for HHA (Home Health Aide) for 8 hours daily for, 5 visits weekly for assistance with IADL's and ADL's. The clinical record was reviewed with the following findings: A HHA visit note dated 3/29/18 stated, "Skin in the crack of [pt's name] butt (buttocks) is slightly irritated. A SN visit was conducted on 4/11/18 (13 days later). The SN note stated, "Educated about pressure relief due to impaired mobility voices an understanding. Patient states that she has wound center appointment on 4/19/18 due to opened area to crack of buttocks. Unable to assess wound due to patient sitting in wheelchair and unable to transfer via hoyer to assess wound because patient did not want to be transferred back." A document in the clinical record dated 4/12/18 at 11:00 AM and titled, "[hospital name] office visit," included a new diagnosis for Stage 3 pressure ulcer of the buttock. The administrator was interviewed on 9/26/18at 2:45 PM. The administrator reported there was no documentation that the aide and nurse communicated about the patient's irritated area that progressed to a stage 3 pressure ulcer in the clinical record. The administrator was asked about the process for the home health aide notes to be reviewed by an RN. The administrator reported, "The HHA visits are audited every 60 days by [director of nursing services name]. 106K11 Facility ID: 013593 Page 172 of 206 Event ID: State Form If continuation sheet

11/27/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Review of the plan of care for the certification period of 7/14/18 to 9/11/18, with services to include HHA 8 hours a day 5 days a week for assistance with IADL's and ADL's was reviewed with the following findings: The HHA provided visits 6 days in week 4 of the certification period ranging from 3 to 11 hours a day for a weekly total of 46 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 4 days in week 5 of the certification period ranging from 8-9 hours a day for a weekly total of 33 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 4 days in week 7 of the certification period ranging from 7-8 hours a day for a weekly total of 31 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 6 days in week 8 of the certification period ranging for 7 hours daily for a weekly total of 42 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 3 days in week 9 of the certification period ranging from 4 to 11 hours for a weekly total of 22 hours. The HHA failed to perform the visits as ordered. 6. The clinical record of Patient # 4 with a SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include HHA 3 hours a day for 4 days a week was reviewed with the following findings: For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits 106K11 Facility ID: 013593 Page 173 of 206 Event ID: State Form If continuation sheet

11/27/2018

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681			TRUCTION 00	(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	ST 10 IN)			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PRE		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETIO
TAG	during week 1, 1 v	PR LSC IDENTIFYING INFORMATION risit during week 2, 1 visit during ring week 5, 6, 7 and 2 visits	TA	G	DEFICIENCY)		DATE
	the HHA failed to	on period of 9/9/18 to 11/17/18, conduct visits as ordered as following missed visits: 3 visits and 3.					
	9/25/18 at 3:45 PM been 2-3 weeks sin than 1 day a week hit or miss I can't a	conducted with Patient # 4 on A. The patient reported it had nce he/she had a HHA more . The patient reported, "It's been get any answers out of the office nd doesn't do any good I'm tt of mind."					
	administrator on 1	conducted with the 0/1/18 at 4:30 PM and he/she no further documentation to be					
	date of 6/19/16 wi	cord of Patient # 5 with a SOC th services to include HHA 5) hours week was reviewed with ings:					
	8/17/16, the HHA during weeks 3 an	ation period of 6/19/16 to failed to provide 2 hours of care d 4, 10 hours of care during rs of care during weeks 8 and 9.					
	10/16/16, there we clinical record for weeks 7, 8, and 9 the clinical record	ation period of 8/18/16 to ere no HHA visit notes in the weeks 1, 2, 3, 4, 5, 6. During there were no HHA visit notes in , except four (4), 2-hour HHA vices on (9/29/16, 9/30/16, /16)					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, NAPOLIS, IN 46256		
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N 0537 Bldg. 00	 12/14/16 the HHA during week 1, 18 during week 3 and visit on 12/6/18, th for the certification An interview was Administrator on 1 absence of HHA m orders to change th reported he/she wa during that time pe no additional infor 410 IAC 17-14-1 Scope of Service Rule 1 Sec. 1(a) shall provide nur nurse or a licens accordance with follows: Based on record r (Skilled Nurse) fai on the POC (Plan records reviewed of services in a samp Findings Include: A policy titled, "P stated, "Home card the supervision an physician. The pla comprehensive ass provided by the cl members The p 	conducted with the 10/1/18 at 1:58 PM regarding the tootes and if there were any he POC. The Administrator as not working at the agency eriod. He/she reported there was mation to be provided. (a) es The home health agency sing services by a registered ed practical nurse in the medical plan of care as eview and interview, the SN iled to provide services outlined Of Care) for 1 of 4 (Patient #1) of patients receiving SN	N 0.	537	N 537 The Administrator or designed immediately review all clinical records with SN services are provided. If there is evidenced the POC is not being followed DON will call the PCP for a v order to update the plan of cal and the POC will be updated the clinical record and sent to PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON call the patient and offer to tr them to an agency that can provide all services in the PC patient agrees to be transferr another agency the DON will	l being that d the erbal are in o the o twill ansfer	11/30/201

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE updated as necessary, but at least every sixty (60) facilitate a transfer to an agency of days ...2. The plan of care shall be completed in the patients choice and full to include: c. Type, frequency, and duration of documentation of conversation all visits/services ... k. Specific dietary or with patient will be recorded in the nutritional requirements or restrictions. 1. patients clinical record. Medications, treatments, and procedures ... p. Treatment goals... 9. At the time of certification The Administrator or designee will and recertification, a written summary of the educate client's current status and the services being administration/management, all provided are submitted with the plan of care for clinicians on policy: review. The summary shall include but is not limited to: changes in clients physical or Plan of Care psychosocial condition, client response to care/services and outcome of care and services ... To prevent this deficiency in the 10. Professional staff shall promptly alert the future, the DON will monitor the physician to any changes that suggest a need to services of all clients weekly alter the plan of care" through audits of services provided and any trends will be addressed The clinical record of patient # 1 with a SOC (start weekly with the administrator. of care) date of 7/18/16 was reviewed with the following findings: Education completed on 11/08/2018 The POC for the certification period of 7/18/16 to 9/15/16 included orders for skilled nurse 5 times a week for G-Tube feedings while the mother is at work. The SN failed to provide services until 8/9/16 (21 days) after the SOC. An OASIS assessment conducted 9/13/16 stated: "SN to administer feedings on time daily 5 days a week while [parent] is working." The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while mother was at work. The agency failed to provide SN visits 10/27/16, 10/28/18, 11/1/16 to 11/5/16 and 11/8/16 to 11/10/16. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist family in finding a Event ID: 106K11 Facility ID: 013593 Page 176 of 206 If continuation sheet State Form

11/27/2018

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	-	10500 0	DDRESS, CITY, STATE, ZIP CROSSPOINTE BLVD, APOLIS, IN 46256		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
	has declined this of coming home at ne until nursing staff An OASIS assess reported the follow one time daily 5 da working." The PC 11/15/16 to 1/13/1 a week. The SN c visits ordered on th period and failed t The POC for the c 3/14/17 included c G-tube feedings ea	at this time family ffer. Currently [parent] is boon to feed daughter via G-Tube available." nent conducted 11/11/16 ving: "SN to administer feedings ays a week while [parent] is DC for the certification period of 7 included orders for SN 5 times onducted a total of 4 of the 45 ne POC for the certification o provide G-Tube feedings. ertification period of 1/14/17 to orders for SN 1 time a week for ach visit. The SN conducted a the certification period and with					
	feedings were give The POC for the c 9/10/17 included c G-tube feedings. T weeks 2-3 and 5-9	e SN visit 2/8/17 no G-Tube en by the nurse. ertification period of 7/13/17 to orders for SN 5 times a week for 'he SN provided 1 visit during of the certification period and visits per week as ordered for					
	11/9/17 included of tube G-tube feedin during weeks 1, 4, week 2 and 1 visit certification period G-Tube feedings a A SN note dated 9	ertification period of 9/11/17 to orders for SN 5 times a week for gs. The SN provided 2 visits 5, 6, 7 and 8, 0 visits during during week 9 of the 1. The SN failed to provide s ordered. /11/17 stated, "continues to o cover G-Tube feedings while					
		Will discuss with leadership. is time his/her family has been					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP C CROSSPOINTE BLVD, VAPOLIS, IN 46256	COD	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETIC
TAG		OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE
	able to cover the o not been a daily R	ther days of the week there has N."				
	1/8/18 included or tube G-tube feedin change the SN free and week 9 of the provided 2 visits of during weeks 1 an G-Tube feedings a provide visits 5 tir The POC for the c 3/9/18 included or tube G-tube educa The SN provided	ertification period of 11/10/17 to ders for SN 5 times a week for ngs. Orders were present to quency to 1 visit during weeks 7 certification period. The SN luring weeks 2-6. No SN visits d 8. The SN failed to provide as ordered and follow the POC to mes weekly on weeks 1-6 and 8. ertification period of 1/9/18 to ders for SN 5 times a week for tion, monitoring and feedings. visits 1 time during week 1 and 2 as 2-9 of the certification period.				
	The SN failed to p as ordered 5 times	veckly on the POC.				
	5/8/18 included or G-Tube education SN provided 1 vis	ders for SN 2 times a week for , monitoring and feedings. The sit during week 9 of the d and failed to provide G-Tube				
	7/7/18 included or G-Tube education patient was in the and in a long-term 6/13/18 with a dia skin grafts. The S of the certification	ertification period of 5/9/18 to ders for SN 2 times a week for , monitoring and feedings. The hospital from 5/17/18 to 6/1/18 a acute care facility from 6/1/18 to gnosis of 3rd-degree burns and N provided 1 visit during week 1 a period and failed to provide as ordered on the POC.				
		conducted with the Parent of 4/18 at 10: 00 AM. The Parent				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMPLETE	(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPL		10500	ADDRESS, CITY, STATE, ZIP CROSSPOINTE BLVD, IAPOLIS, IN 46256			
· /	RY STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE CC	(X5) OMPLETIC	
reported that he/s patient's full-time patient's sibling of in the role of a H the home daily th patient bolus G-t reported when th (7/18/16) the fee by a nurse of the full-time nurse le of 2016 and soor sending a nurse of reported he/she v working on gettin parent reported h patient's nurses a needed a nurse 5 concern had not parent reported a nurse was not ne him/her that Meo authorization for An interview wa sibling and full-t The sibling repon G-Tube feedings for work. The tul changed to late a home and then at since he/she was within his/her sco feedings. He/she nurse for 2/1/2 y agency would ge a week. The siblin the PA visits for	OR LSC IDENTIFYING INFORMATION she worked 5-6 days a week. The e HHA for the agency, the can not administer tube feedings HA. Without a nurse to come to be parent had to change the ube feeding schedule. The parent e patient had been admitted on dings had been given in midday agency. The parent reported the off the agency around November after the agency stopped is days a week. The parent was told that the agency was ng a replacement nurse. The e/she had reported to the nd to the agency that he/she days a week, but the staffing been addressed or resolved. The nurse had told him/her that a cessary and another nurse told licaid had denied the prior a nurse 5 times a week. s conducted with Patient # 1's time HHA on 9/25/18 at 1:50 PM. ted the parent administered the for Patient #1 before he/she left be feeding schedule had been fternoon when the parent came bedtime. The sibling reported working as a HHA it was not ope of practice to give the tube reported they have not had a ears and have been told the t a nurse for the feedings 5 days ng reported she/he had been denied.	TAG	DEFICIENCY)		DATE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE C A. BUILDING B. WING	construction (x 00	3) DATE SURVEY COMPLETED 10/02/2018
NAME OF PROVIDER OR SUPPL AGING & DISABLED HOI		10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, NAPOLIS, IN 46256	
PREFIX (EACH DEFIC TAG REGULATORY	RY STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION s asked if there was a complaint	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
 needs 5 days a w the parent is at w the complaints h the complaint lo, he/she had not b needed this servi aware of the mis the POC for SN reported there w provided. N 0541 410 IAC 17-14- Scope of Servic Rule 14 Sec. 14 Services are lim purposes of pra setting, the reg following: (B) Regularly r needs. Based on record failed to comple every 60 days for records reviewed Findings Include An agency polic Reassessment/U Assessment" wa Comprehensive revised as often due to major dec status. Assessme collection for all clients Reasse 	a) (1)(B) Except where ited to therapy only, for ictice in the home health stered nurse shall do the eevaluate the patient's nursing review and interview the agency e the comprehensive assessment r 1 of 7 (Patient #1) clinical	N 0541	N 541 The Administrator or designee will immediately review all clinical records for comprehensive reassessments is the last 5 days of certification period. Any clinical record found be out of compliance with the 5-day window the RN responsib for the assessment will be counselled individually by the DON. The DON or designee will educa administration/management, all clinicians on policy: Client Reassessment/ Update of Comprehensive Assessment	in to le

	R MEDICARE & MEDI		(VA) \ 0.11	CONCERNICETION	OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681			(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 10/02/2018
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, NAPOLIS, IN 46256	
(X4) ID PREFIX	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG N 0542 Bldg. 00	of care within the including day sixty The clincial record of care) date of 7/2 certification period clinical record evid reassessment that was 5 days after the recertification rease before the end of the period. The administrator 2:50 PM regarding complete the assess reported he/she did had been conducted documentation to 410 IAC 17-14-1 Scope of Service	d of Patient #1 with a SOC (start 18/16 was reviewed. During the d of 11/15/16 to 1/13/17, the denced a recertification was completed on 1/18/17. This he certification period. The ssessment failed to be completed he 60 days of the certification was interviewed on 9/27/18 at g the failure of the nurse to ssment timely. The administrator d not know why the assessment ed late and there was no further be provided. (a)(1)(C)	TAG	To prevent this deficiency in the future, the DON or designee we review upcoming Re-certification weekly at case conference to ensure RN's complete re-certifications in the last five days of the certification period Administrator or designee will responsible for active clinical record audits until 100% compliance is met then 10 % of clinical records will be audited quarterly for evidence after 10 compliance is met to ensure the this deficiency will not reoccur. Education completed on 11/11/2018.	rill ons , the be of all 0% nat
	services are limit purposes of praces setting, the regis following: (C) Initiate the p revisions. Based on observat interview, the RN accurately comple frequency and dur for 4 of 7 (Patients requirements for 2 medications and the	ied to therapy only, for tice in the home health tered nurse shall do the lan of care and necessary ion, record review and (Registered Nurse) failed to te the plan of care to include the ation of visits to be conducted $s \neq 1, 2, 4, 5$), the nutritional c = 0, 7 (Patient #1, 3), all reatments for 3 of 7 (Patient # 1, able goals for 1 of 7 (Patient # 1)	N 0542	N 542 The Administrator or designee will immediately revia all clinical records for accurate and complete plan of care, including frequency, and durat of visits, nutritional requirements, medications, treatments with measurable go and current and past findings. clinical records found to have a POC that is not updated, the D	ion bals, Any a

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/02/2018
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP CO CROSSPOINTE BLVD, IAPOLIS, IN 46256	D
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O Findings Include: 1. A policy titled, and stated, "Home under the supervis physician. The pla comprehensive ass provided by the cli members The pl to ensure that clier updated as necessa days2. The plan full to include: c. 7 all visits/services . nutritional requiren Medications, treath	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION "Plan of Care" was reviewed care services are furnished on and direction of the client's n of care is based on a essment and information ent/family and health team an will be consistently reviewed t needs are met and will be ry, but at least every sixty (60) of care shall be completed in Type, frequency, and duration of . k. Specific dietary or ments or restrictions. 1. ments, and procedures p. . other appropriate items 9.	ID PREFIX TAG	PROVIDERS PLAN OF CORRI (EACH CORRECTIVE ACTION SHIC CROSS-REFERENCED TO THE AP DEFICIENCY) will call PCP for a verba update the plan of care, physician order will be v reflecting the update an PCP for signature. The DON or designee w all clinicians on policy: Plan of Care polic Home Health Adm Service Agreement To prevent this deficience future, The DON will rev plan of care for accurac sending to PCP for sign Administrator or designee	DULD BE IPROPRIATE COMPLETI DATE I order to then a vritten d sent to
	written summary of the services being the plan of care for include, but is not physical or psycho response to care/se and services 10. promptly alert the suggest a need to a 2. The clinical reco	fication and recertification , a f the client's current status and provided are submitted with r review. The summary shall limited to: changes in clients social condition, client rvices and outcome of care Professional staff shall physician to any changes that lter the plan of care"		responsible for active cl record audits until 100% compliance is met then clinical records will be a quarterly for evidence a compliance is met to en this deficiency will not re Education completed or 11/11/2018.	5 10 % of all udited fter 100% sure that eoccur.
	the following findi The POC for the c 9/15/16, included week and HHA set failed to include th nurse) and failed to	of 7/18/16 was reviewed with ngs: ertification period of 7/18/16 to orders for skilled nurse 5 times a vices 6 times a week. The POC e duration for the SN (skilled o include the HHA (Home and duration and services to be			

AND PLAN OF CORRECTION IDEN					(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10	500 CI	DDRESS, CITY, STATE, ZIP COI ROSSPOINTE BLVD, POLIS, IN 46256)	
(X4) ID PREFIX		7 STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	II PRE		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TA		CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
	11/14/16, included and HHA services to include the SN duration. The POC for the c	ertification period of 9/16/16 to d orders for SN 5 times a week 6 times a week. The POC failed duration or HHA time and ertification period of 11/15/16 to orders for SN 5 times a week and					
	HHA 6 times a we	ek. The POC failed to include HHA time and duration.					
	3/14/17, included HHA 6 times a we	ertification period of 1/14/17 to orders for SN 1 time a week and eek. The POC failed to include HHA time and duration.					
	5/13/17, included HHA 6 times a we	ertification period of 3/15/17 to orders for SN 1 time a week and eek. The POC failed to include HHA time and duration. POC.					
	7/12/17, included HHA 9 hours a da	ertification period of 5/14/17 to orders for SN 1 time a week and y for 5 days a week. The POC uration of the SN and HHA					
	9/101/7, included HHA 9 hours a da	ertification period of 7/13/17 to orders for SN 5 times a week and y. The POC failed to include N and HHA services.					
	11/9/17, included HHA 9 hours a da	ertification period of 9/11/17 to orders for SN 5 times a week and y for 5 days a week. The POC uration for the SN and HHA					
		ertification period of 11/10/17 to rders for SN 5 times a week and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 1/9/18 to 3/9/18, included orders for SN 5 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 3/10/18 to 5/8/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 5/9/18 to 7/7/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 7/8/18 to 9/5/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC included orders for Two Cal HN (a nutritional supplement) oral 240 ml bolus every 6 hours. During an interview conducted with the patient's family member on 9/24/18 at 10:00 AM, he/she reported the following was the accurate G-Tube feeding: Two Cal HN 480 ml bolus at 6 or 7 Event ID: 106K11 Facility ID: 013593 Page 184 of 206 State Form If continuation sheet

11/27/2018

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	r í	ILDING	NSTRUCTION 00	CON	te survey 1pleted 02/2018
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC				10500 C	DDRESS, CITY, STATE, ZIP C ROSSPOINTE BLVD, APOLIS, IN 46256	OD	
(X4) ID SUMMAR		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	COMPLETIO
TAG		PR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	9-10 PM daily dur home from work. accurate nutritiona	at 4:00 PM and 480 ml bolus at ing the time the mother is at The POC failed to include the il requirements.					
	Aquaphor Externa healing of skin) 1 hours, Mupirocin once a day. The or ointments would b	1 (for protection and moisture apply to healed areas every 12 External (antibacterial) 2 % 1 ders failed to specify where the be applied. An order for					
	per feeding tube e	ibiotic) HCL oral 500 mg 1 tab very 12 hours failed to be POC and had been discontinued					
	remain tolerable th goal was not speci for an assessment	POC stated, "Patient's pain will rroughout care period." The fic to include the Wong scale of a nonverbal patient and did rable outcomes for tolerable					
	Administrator on 9 POC findings. The	conducted with the 0/24/18 at 4:45 PM to review the e Administrator reported there sumentation to be provided.					
		ord of Patient # 2 with a SOC is reviewed with the following					
	9/11/18 and 9/12/1 include HHA 8 ho	ertification period of 7/14/18 to 8 to 11/10/18, with services to urs a day 5 days was reviewed. include a duration for the HHA					
		ertification period of 7/14/18 to the following order: "Silvadene					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681 NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC		N OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u>		<u>00</u> COMPI		e survey pleted 2/2018	
		10500	STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256				
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETIC	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE	
	apply to open area not any better call week continued or and failed to inclu for application. An interview was Administrator on 9 POC findings. The was no further doc 4. The clinical rec 7/25/18 was review The POC for the c 9/22/18 included of nutritional require no concentrated sy interviewed on 9/2	protective ointment) 1 % 2 x day 2 times per day for a week if physician." The order for one in the POC for 9/12/18 to 11/10/18 de the specific area of the body conducted with the 9/26/18 at 4:30 PM regarding the e Administrator reported there cumentation to be provided ord of Patient #3 with a SOC of wed with the following findings: ertification period of 7/25/18 to orders for the following ments: "No added salt, regular, weets" The patient was 26/18 9:48 AM and reported he ily fluid restriction and his diet					
	regarding his med during a home the for the certificatio included orders fo Levothyroxine So Synthroid) Oral 12 Synthroid (thyroid levothyroxine) Or mornings daily. Th was a duplicate. N neuropathy pain) I the patient reporte discontinued 2 mo acting diabetic ins 15-20 units daily b	conducted with the patient ications on 9/26/18 at 9:48 AM rapy visit observation. The POC n period of 7/25/18 to 9/22/18 r the following medications: dium (thyroid pill also know as 75 mcg 1 tablet daily and					

AND PLAN OF CORRECTION IDEN					(X3) DATE SURVEY COMPLETED 10/02/2018		
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	-	10500 C	DDRESS, CITY, STATE, ZIP COI CROSSPOINTE BLVD, APOLIS, IN 46256)	
	CID O (A D				,		(175)
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
		failed to include the specific					
	Administrator on 9 the findings for Pa reported they did 1 regarding the patie and fluid restriction in regards to the n	conducted with the 9/26/18 at 12:07 PM regarding titent # 3. The Administrator not have any information ents dialysis medication, diet ons. The administrator reported nedication findings, "I have do. There is no excuse for					
	9/28/18 that include restrictions: Sodiu and 1500 ml. The orders specific to a Sodium 1,000 units and 2,300 units to dialysis catheter) of Venofer (iron medic (intravenous push) (medication for an x 365 days. The F special nutritional	d from the dialysis facility on ded the following daily diet m 3 GM, Phosphorus 1200 mg fax also included the following the patients ESRD: Heparin ts/ml to arterial port 2,200 units venous port (of a central every treatment (3 times weekly), dication for anemia) 100 mg IVP every treatment x 5 and Micera temia) 200 mcg IVP every 2 week POC failed to include the patient's needs related ESRD (End Stage d failed to include the patient's en for ESRD.					
	5. The clincial record of Patient # 4 with a SOC date of 3/13/18 was reviewed with the following findings:						
	9/8/18 included an	ertification period of 7/11/18 to a order for HHA 3 hours day/ 4 POC failed to include the IA visits.					
		conducted with the $0/1/18$ at 4:30 PM and the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE administrator reported there was no further documentation to be provided. 6. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification periods of 6/19/16 to 8/17/16, 8/18/16 to 10/16/16 and 10/17/16 to 12/14/16 included an order for HHA 4 hours a day/ 5 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be provided. N 0545 410 IAC 17-14-1(a)(1)(F) Scope of Services Bldg. 00 Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. N 0545 N 545 The Administrator or 11/30/2018 Based on record review and interview, the SN designee will immediately review (skilled nurse) failed to ensure the clinical record all clinical records for coordination included documentation of coordination with the of care between SN/HHA. HHA (home health aide) regarding a change in the Immediately all RN case patient's skin condition that progressed from managers will be required to irritation to a stage 3 pressure ulcer for 1 of 4 conference with the HHA weekly patient's receiving home health aide services for patients they case manage, (Patient #2) in a sample of 4. and document this coordination of care through a communication Findings Include: note in the clinical record. The DON or designee will educate Page 188 of 206 Event ID: 106K11 Facility ID: 013593 If continuation sheet State Form

11/27/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	11/27/2018
FORM API	PROVED
OMB NO. 0	938-039

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	r í	ILDING	DNSTRUCTION C	x3) date survey completed 10/02/2018	
	PROVIDER OR SUPPLIE	R E HEALTH CARE LLC		10500 (ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, IAPOLIS, IN 46256		
X4) ID REFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	An agency policy t	itled, "Coordination of Client			administration/management, all		
	Services" was revie	ewed and stated: "All			clinicians on policy:		
	personnel furnishir	ng services shall maintain a			Coordination of Client		
	liaison to assure that	at their efforts are coordinated			Services		
	effectively and sup	port the objective outlined in			Home Health Aide		
	the Plan of Care. T	his may be done through formal			Supervision		
	care conferences, n	naintaining complete, current			Care Planning/ Coordinat	on	
	care plans, and wri	tten and verbal interaction.			of Care		
	An agency policy t	itled, "Home Health Aide			Home health aides will be		
	Supervision" was r	eviewed and stated, " Agency			educated on:		
	shall provide Home	e Health Aide Services under			"What to Report to RN,		
	the direction and su	pervision of a RN/ Therapist			Case Manager"		
	when personal care	e services are indicated and			Home Health Aide		
	ordered by the phys	sician 1. The Nursing			Documentation		
		gnated RN/Therapist will give					
		for client care by way of the			To prevent this deficiency in the	;	
	Care Plan.				future, the RN case managers v	vill	
					be required to review all HHA		
		for Patient # 2, with a start of			documentation and perform		
		5, with a diagnosis to include			weekly conference with HHA's		
	-	Functional limitations to			all the patients they case mana	-	
	include Paralysis, I				RN case manager will also revi	ew	
		rance and Ambulation. The			the aide care plan with the		
	~	e certification periods of			assigned home health aide prio	r to	
		5/14/18 to 7/13/18 and 7/14/18			the home health aide providing		
		l orders for HHA (Home Health			services to the patient and revie		
	,	aily for, 5 visits weekly. The			the home health aide care plan		
		reviewed with the following			with the home health aide at lea		
	findings:				every 60 days or when there is		
	A HHA visit note	lated 3/29/18 stated, "Skin in			change in the patients' condition the Administrator or designee w		
		ame] butt (buttocks) is slightly			be responsible for active clinica		
	irritated.	ane jour (ourocks) is slightly			record audits until 100%	'	
					compliance is met then 10 % of	all	
	A SN visit was con	ducted on 4/11/18 (13 days			clinical records will be audited		
		e stated, "Educated about			quarterly for evidence after 100	%	
		to impaired mobility voices an			compliance is met to ensure that		
	-	ient states that she has wound			this deficiency will not reoccur.	"``	
		t on $4/19/18$ due to opened area					

Event ID:

106K11 Facility ID: 013593

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	 (3) DATE SURVEY COMPLETED 10/02/2018
	PROVIDER OR SUPPLII & DISABLED HOM	ER IE HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, JAPOLIS, IN 46256	
X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	7 clinical records. An agency policy Services" was rev personnel furnishi liaison to assure the effectively and su the Plan of Care. care conferences, care plans, and wr PurposeTo ensu- between members ensure appropriate to clients To me needs or changes team to determi and /or future plan attending physicia of the client and ic services provided. as necessary to est and coordinated e disciplines involve the initial assessm (Registered Nurse findings of the ini Manager to ensure care orders. d. Cli caree. Need for community resour agencies and insti Care conferences conference summa "	alysis (Patient # 3) in a sample of titled, "Coordination of Client iewed and stated: "All ing services shall maintain a hat their efforts are coordinated pport the objective outlined in This may be done through formal maintaining complete, current ritten and verbal interaction. are services are coordinated s of the interdisciplinary team. To e, quality care is being provided odify the plan to reflect the identified by members of the ine the continuation of services as for care. To provide the an with an ongoing assessment dentify the client's response to . 1. Care conferences will be held tablish interchange, reporting, valuation between all ed in the client's care 3. After nent, the admitting RN e) or Therapist shall discuss the tial visit with the Clinical ea. Clarification of the plan of ent's need for skilled nursing to ther services and/or referral to recesG. Coordination with other tutions, if the need arises 6. will be determined on the care ary form or in the progress note		wound care. If coordination of care has not been established to DON or RN case manager will establish this coordination of care by calling the dialysis center or wound care center and request weekly updates on patients care The DON or designee will educ administration/management, all clinicians on policy: Coordination of Client Services To prevent this deficiency in the future, the DON will audit these clinical records weekly to ensur updates from these providers al present in the clinical record, if if present the DON will call the provider for an update and notif the RN case Manager of the update so the RN can update the POC if needed. The Administrator or designee to be responsible for active clinical record audits until 100% compliance is met then 10 % of clinical records will be audited quarterly for evidence after 100 compliance is met to ensure that this deficiency does nor reoccur Education completed on 11/11/2018.	re e. ate e e e e e o t u u u u u u u u u u u u u u u u u u

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	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION N OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 157681 B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018				
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	-	10500 CI	DDRESS, CITY, STATE, ZIP C ROSSPOINTE BLVD, POLIS, IN 46256	DD	
(V4) ID	SUMMAD	Z STATEMENT OF DEFICIENCIE		ID			(¥5)
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH		(X5) COMPLETIC
TAG	,	R LSC IDENTIFYING INFORMATION	1	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
IAU		For hemodialysis treatments 3		IAG			DAIL
		ed to his ESRD. In addition, the					
		e was getting medication for					
		iction and dietary restrictions					
	related to his ESR	-					
		D.					
	The clinical record	d of Patient #3 with a Start of					
		nd a POC (Plan of Care) for the					
		d of $7/25/18$ to $9/22/18$ included					
	-	owing nutritional requirements:					
		gular, no concentrated sweets."					
		include any medication orders					
		ent's dialysis 3 times weekly					
	T I 1	· · · · · · · · · · · · · · · · · · ·					
		was interviewed on 9/26/18 at					
	-	orted there was no					
		e agency had coordinated care					
		lysis facility or the Nephrologist.					
		reported they did not have any ling the patients dialysis					
		nd fluid restrictions. The					
		rted in regards to the					
	-	gs, "I have some education to					
	do. There is no ex	-					
		sked to call the dialysis facility					
		rent treatment orders for the					
	^	diet, fluid restriction, and					
		was obtained from [the dialysis					
		8 and included the following					
	-	the patient's ESRD: Heparin					
	· •	t blood clots) 1,000 units/ml to					
	- · ·	2,200 units and 2,300 units to					
		t (of the dialysis catheter) every					
		weekly), Venofer (iron					
		emia) 100 mg IVP (intravenous					
		hent x 5 and Micera (medication					
		ncg IVP every 2 week x 365 days.					
		a 1500 ml fluid restriction and					
	dietary restriction	to 3 gm sodium, and 1200 mg					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	A. BUILDING <u>00</u> C B. WING 1			x3) date survey completed 10/02/2018	
	PROVIDER OR SUPPLI	ER E HEALTH CARE LLC	1	STREET ADDRESS, CITY, STATE, ZIP 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY (Phosphorus daily.	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION The POC failed to include the on regimen for ESRD, diet and	PR	ID PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
N 0596 Bldg. 00	 410 IAC 17-14-1 Scope of Service Rule 14 Sec. 1(I, shall be respons patient contact, 1 home health aid, the requirements (1) The home h (A) have succe competency eva addresses each subsection (h) of Based on record r administrator faile included documer competed a comp before patient com records reviewed Findings Include: An agency policy reviewed and state established and m Special Instruction employee personr limited to B. En Competency testin specific competency testing a date of hire of 7. 7/13/16, was revise 	es) The home health agency ible for ensuring that, prior to the individuals who furnish e services on its behalf meet s of this section as follows: health aide shall: ssfully completed a luation program that of the subjects listed in f this rule; and eview and interview, the ed to ensure the personnel file nation that the home health aide etency evaluation program tact for 1 of 1 home health aide	N 059	 N 596 The Administration N 596 The Administration immediately alert HR hire any new HHA's. Administrator or designs eek a contract RN to HHA skills check off at competency. No new health aides will be hit contract is in place. At that were found not to check offs present in will be checked off by RN on skills. The Administrator or deducate administration/manage Director on policy: Personnel Reference To prevent this deficite future, the Administration designee will be respondent to the complexence 	Director not The perform and home red until my HHA's have skills employee file the contract designee will ement, HR ecords ency in the tor or onsible for rd audits until	11/30/201	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	È É		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/02/2018	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157681	A. BU B. WI	VILDING	00		
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
AGING 8	& DISABLED HOME	E HEALTH CARE LLC			CROSSPOINTE BLVD, IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		est competency and a skills			% of all employee records with		
	competency upon l	nire.			audited quarterly for evidence	e after	
	The administrator	was interviewed on 10/1/18 at			100% compliance is met to	llmat	
		ted he/she would search for the			ensure that this deficiency wi	li not	
	-	n. The administrator was			reoccur.		
	-	2/18 at 10:30 AM and reported					
		to locate the missing					
		personnel file of Employee E.				will be nce after o will not	
N 0606	410 IAC 17-14-1(n)					
	Scope of Service						
Bldg. 00	Rule 14 Sec. 1(n)	A registered nurse, or					
	therapist in thera	by only cases, shall make					
		he patient's residence and					
		ory visit at least every thirty					
		when the home health aide					
		ent, to observe the care, to					
		ips, and to determine					
	whether goals are	e being met.	N 0	606	N 606 The Administrator or		11/30/201
	Based on record re	IN U	000	designee will immediately rev		11/30/201	
	Registered Nurse (all clinical records for supervi			
	supervision to the			of HHA's every 30 days for	01011		
	every 30 days for I			patients receiving non-skilled			
	patient's receiving HHA only services (Patients #				nursing services. If there are		
	4 and 5) in a samp	le of 4 records.			clinical records in which		
					supervision of HHA is not		
	Findings Include:				completed every 30 days, the		
					case manager will be brough		
	U	cy titled, "Home Health Aide			immediately to be counseled	on	
	<u>^</u>	eviewed and stated, "Agency			supervisory regulations.		
	•	services under the direction			The Administrator or designe	ewill	
	-	a RN/Therapist when personal dicated and ordered by the			educate	all	
		luency of supervision will be in			administration/management, clinicians on policy:	all	
		are regulations, agency policy			onnicians on policy.		
	-	ederal requirements3.			Home Health aide		
		of HHA shall be according to			supervision		
		-					
	the following frequ	ency: a. When skilled services					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE are being provided to a client, a Registered To prevent this deficiency in the Nurse/Therapist must make a supervisory visit to future, the DON will monitor the client's residence at least every two (2) weeks supervisory visits to ensure skilled" supervisory visits are conducted every 30 days through weekly 2. The non-skilled clinical record of Patient #4 audits. The Administrator or with a SOC date of 3/13/18 was reviewed with the designee will be responsible for following findings: active clinical record audits until 100% compliance is met then 10 The POC for the certification period of 7/11/18 to % of all clinical records will be 9/8/18 included orders for SN monthly for aide audited quarterly for evidence after supervisory visit and HHA 3 hours a day for 4 100% compliance is met to days a week. The prior supervisory visit was ensure that this deficiency will not 7/6/18 and the next supervisory visit was 9/7/18. reoccur. The supervisory visit exceeded the state requirements of every 30 days by 31 days. 3. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification period of 6/19/16 to 8/17/16 included orders for HHA services 5 days a week for 20 hours week. HHA services were started on 6/20/16. The first supervisory visit was 7/21/16 which exceeded the 30 day state requirement by 3 days. The POC for the certification period of 8/18/16 to 10/16/16 included orders for HHA services 5 days a week for 20 hours week. The prior Supervisory visit was 8/17/16 and the next supervisory visit was 9/23/16. This exceeded the 30 day state requirement by 6 days. The POC for the certification period of 10/17/16 to 12/14/16 included orders for HHA services 5 days a week for 20 hours week. The prior supervisory visits were 10/13/16, 11/10/16 and there were no further supervisory visit done Event ID: 106K11 Facility ID: 013593 Page 195 of 206 State Form If continuation sheet

11/27/2018

· · · ·		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 10/02/2018	
	PROVIDER OR SUPPLIE	E HEALTH CARE LLC	10500	ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, NAPOLIS, IN 46256		
	CLD O (A D)	AT A TEMPAT OF DEFICIENCIE		, 1	(175)	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E (X5) COMPLETION DATE	
IAU	before the end of t	he certification period 12/14/16. 30 requirement by 4 days.	IAU		DATE	
	administrator on 1 and missed superv	vas conducted with the 0/1/18 at 4:30 PM regarding late isory visits. The administrator no further documentation to be				
N 0608	410 IAC 17-15-1	(a)(1-6)				
N 0608 Bldg. 00	pertinent past an accordance with standards shall b patient as follows (1) The medica appropriate ident (2) Name of the chiropractor, poo (3) Drug, dietal orders. (4) Signed and contributed to by Clinical notes sh is rendered and i (14) days. (5) Copies of s person responsit component of the	Il plan of care and ifying information. e physician, dentist, liatrist, or optometrist. ry, treatment, and activity dated clinical notes all assigned personnel. all be written the day service ncorporated within fourteen ummary reports sent to the ole for the medical e patient's care.				
	failed to accurately include the freque made for 4 of 7 (P nutritional require all medications an 1, 2, 3), and measu	eview and interviews the agency y complete the plan of care to ncy and duration of visits to be atients # 1, 2, 4, 5), the ments for 2 of 7 (Patient #1, 3), d treatments for 3 of 7 (Patient # urable goals for 1 of 7 (Patient #	N 0608	<i>N 608</i> The Administrator or designee will immediately revie all clinical records for accurate and complete plan of care, including frequency, and durate of visits, nutritional requirements,medications, treatments with measurable go and current and past findings.	on als,	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>			COMPI	
	or conduction	157681	B. WIN		<u></u>		/2018
			<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					CROSSPOINTE BLVD,		
AGING 8	& DISABLED HOMI	E HEALTH CARE LLC		INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	-	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	patient every 60 da	ays for 1 of 5 (Patient # 1)			clinical records found to have a	a	
	patients with servi	ces provided for more than 60			POC that is not updated, the D	ON	
	days, failed to ensu	ure the HHA (Home Health			will call PCP for a verbal order		
	-	on notes were completed and			update the plan of care, then a		
		nical record for 2 of 4 patient's			physician order will be written		
		rvices (Patient's #1 and 5) and			reflecting the update and sent	to	
	-	itten notice of the patient's			PCP for signature.		
		d in the clinical record for 1 of 1			The DON or designee will educe	cate	
	patient's (Patient' #			all clinicians on policy:	oute		
	records reviewed.						
					Plan of Care policy		
	Findings Include:				Home Health Admission		
	0				Service Agreement		
	1. An agency poli	cv titled. "Clinical					
		vas reviewed and stated,			To prevent this deficiency in th	e	
		ment each direct contact with			future, The DON will review ev		
		cumentation will be completed			plan of care for accuracy befor	-	
		iver and monitored by the			sending to PCP for signature.		
		I responsible for managing the			Administrator or designee will I		
		ose: To ensure that there is an			responsible for active clinical	0e	
	-	the services provided, client			record audits until 100%		
		ing need for care. To				fall	
				compliance is met then 10 % c clinical records will be audited	n all		
		nance with the Plan of Care,				20/	
		e plan and interdisciplinary			quarterly for evidence after 100		
		a separate note shall be			compliance is met to ensure th		
	· ·	n visit/shift and signed and			this deficiency will not reoccur.		
		priate professional. Actual time					
		lient visit will be included in					
		cumentation of services ordered					
	-	will be completed the day					
		d and incorporated into the					
	clinical record with	hin seven					
	2. A policy titled	"Plan of Care" was reviewed					
		care services are furnished					
	-	ion and direction of the client's					
	-	n of care is based on a					
		sessment and information					
		ient/family and health team					
		an will be consistently reviewed					
	members The pl	an will be consistently reviewed			1		1

NTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681			(X2) MUI A. BUII B. WIN		(X3) DA COM	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADI)D		
AGING		HEALTH CARE LLC			POLIS, IN 46256		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	Р	ID REFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	ECTION OULD BE	(X5) COMPLETIC
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	PROPRIATE	DATE
	updated as necessar days2. The plan of full to include: c. T all visits/services nutritional requirem Medications, treatm Treatment goalst. At the time of certif written summary of the services being p the plan of care for include, but is not 1 physical or psychos response to care/ser and services 10.7 promptly alert the p suggest a need to al 3. The clinical reco (start of care) date of the following findin The POC for the ce 9/15/16, included of week and HHA servicas failed to include the nurse) and failed to Health Aide) time a provided. The clinic case conference/ 60 The POC for the ce 11/14/16, included and HHA services 0 to include the SN d duration. The clinic	rtification period of 7/18/16 to rders for skilled nurse 5 times a vices 6 times a week. The POC e duration for the SN (skilled o include the HHA (Home and duration and services to be cal record failed to include a o day summary. rtification period of 9/16/16 to orders for SN 5 times a week 6 times a week. The POC failed uration or HHA time and cal record failed to include a o day summary.					
	The POC for the ce	rtification period of 11/15/16 to					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			COM	(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CO		(X5) COMPLETIO	
		NCY MUST BE PRECEDED BY FULL			CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE		
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCET		DATE	
	HHA 6 times a we the SN duration or	orders for SN 5 times a week and ek. The POC failed to include HHA time and duration. The ed to include a case conference/						
	The POC for the c 3/14/17, included HHA 6 times a we the SN duration or clinical record evid day summary note 1/14/17 to 3/14/17 3/9/17 failed to ind time a week, and t psychosocial cond	ertification period of 1/14/17 to orders for SN 1 time a week and ek. The POC failed to include HHA time and duration. The denced 2 case conference /60 s for the certification period of . The notes dated 2/16/17 and clude skilled nurse services 1 he patient's current physical or ition and patient's response to re/services provided						
	5/13/17, included HHA 6 times a we the SN duration or	ertification period of 3/15/17 to orders for SN 1 time a week and ek. The POC failed to include HHA time and duration. The ed to include a case conference/						
	7/12/17, included HHA 9 hours a da	ertification period of 5/14/17 to orders for SN 1 time a week and y for 5 days a week. The POC uration of the SN and HHA						
	9/10/17, included HHA 9 hours a da	ertification period of 7/13/17 to orders for SN 5 times a week and y. The POC failed to include N and HHA services.						
	11/9/17, included HHA 9 hours a da	ertification period of 9/11/17 to orders for SN 5 times a week and y for 5 days a week. The POC uration for the SN and HHA						

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157681	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			CO	(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC				STREET AL 10500 C INDIANA	COD			
(X4) ID PREFIX		Ý STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	conference/60 day certification period notes dated 10/6/1 nursing services and daily and were ord dated 11/08/17 ind services were bein visits were provide reported HHA ser- notes failed to incl physical or psycho response to and ou provided. The POC for the c 1/8/18, included o HHA 9 hours a da failed to include d services. The clini conference/ 60 day certification period notes dated 12/4/1 "continue plan of d changes noted at th include the patient psychosocial cond and outcome of ca The POC for the c 3/9/18, included o HHA 9 hours a da	cal record evidenced 2 case summary notes for the d of 9/11/17 to 11/9/17. The 7 failed to include skilled nd reported HHA services were lered 5 times a week. The note correctly reported skilled nursing g provided 5 days a week (SN ed 1-2 times a week) and vices were "no change." The ude the patient's current osocial condition and patient's treated for SN 5 times a week and y for 5 days a week. The POC uration for the SN and HHA cal record evidenced 2 case y summary notes for the d of 11/10/17 to 1/8/18. The 7 and 1/4/18 both stated, care as developed" . No acute his time. The notes failed to 's current physical or ition and patient's response to re/services provided. ertification period of 1/9/18 to rders for SN 5 times a week and y, 5 days a week. The POC uration for the SN and HHA						
	services. The clini nurse note dated 2 mother, patient fel clinical record evid day summary note 1/9/18 to 3/9/18. T	cal record evidenced a skilled /19/18 that reported, "per l off bed yesterday." The denced 2 case conference/ 60 s for the certification period of The notes were dated 2/55/18 and ated, "Continue plan of care as						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE developed. No distress noted. No acute changes noted." There was no mention of the fall and the notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. The POC for the certification period of 3/10/18 to 5/8/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services The POC for the certification period of 5/9/18 to 7/7/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 7/8/18 to 9/5/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services The POC included orders for Two Cal HN (a nutritional supplement) oral 240 ml bolus every 6 hours. During an interview conducted with the patient's mother on 9/24/18 at 10:00 AM he/she reported the following was the accurate G-Tube feeding: Two Cal HN 480 ml bolus at 6 or 7 AM, 240 ml bolus at 4:00 PM and 480 ml bolus at 9-10 PM daily during the time the mother is at home from work. The POC failed to include the accurate Event ID: 106K11 Facility ID: 013593 Page 201 of 206 State Form If continuation sheet

11/27/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE nutritional requirements. The POC included the following topical ointments: Aquaphor External (for protection and moisture healing of skin) 1 apply to healed areas every 12 hours, Mupirocin External (antibacterial) 2 % 1 once a day. The orders failed to specify where the ointments would be applied. An order for Ciprofloxacin (antibiotic) HCL oral 500 mg 1 tab per feeding tube every 12 hours failed to be omitted from the POC and had been discontinued on 6/21/18. A pain goal on the POC stated, "Patient's pain will remain tolerable throughout care period." The goal was not specific to include the Wong scale for an assessment of a nonverbal patient and did not include measurable outcomes for tolerable pain goals. The clinical record failed to evidence any HHA documentation notes from 4/2/17 to 5/21/17 in the clinical record. An interview was conducted with the Administrator on 9/24/18 at 4:45 PM to review the POC findings. The Administrator reported there was no further documentation to be provided 4. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings: The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits. The POC for the certification period of 7/14/18 to 106K11 Facility ID: 013593 Page 202 of 206 Event ID: State Form If continuation sheet

11/27/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 157681 B. WING 10/02/2018 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 9/11/18, included the following order: "Silvadene External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18 and failed to include the specific area of the body for application. 5. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings: The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits The POC for the certification period of 7/14/18 to 9/11/18, included the following order: "Silvadene External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18 and failed to include the specific area of the body for application. An interview was conducted with the Administrator on 9/26/18 at 4:30 PM regarding the POC findings. The Administrator reported there was no further documentation to be provided 6. The clinical record of Patient #3 with a SOC of 7/25/18 was reviewed with the following findings: The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets" The patient was interviewed on 9/26/18 9:48 AM and reported he 106K11 Facility ID: 013593 Page 203 of 206 Event ID: State Form If continuation sheet

11/27/2018

STATEMENT OF DEFICIENCIES X1) PROVIDEF AND PLAN OF CORRECTION IDENTIFICATI 157681		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			CO	(X3) DATE SURVEY COMPLETED 10/02/2018	
NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC				STREET A 10500 C INDIANA				
	1			L				
(X4) ID		Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION		PREFIX	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETIC	
TAG		ily fluid restriction and his diet		TAG	Dirichiter		DATE	
		diet. A fax was obtained from						
		ty] on 9/28/18 and included the						
		et restrictions: Sodium 3 GM,						
		mg and 1500 ml. The POC failed						
	~	ents special nutritional needs						
	· ·	d Stage Renal Disease).						
	An interview was	conducted with the patient						
		ications on 9/26/18 at 9:48 AM						
	U U	rapy visit observation. The POC						
		n period of 7/25/18 to 9/22/18						
		r the following medications:						
		dium (thyroid pill also know as						
		75 mcg 1 tablet daily and						
		l pill also know as						
		al 75 mcg 1 tablet in the						
		he patient reported the order Iortriptyline (for diabetic						
	-	HCL oral 10 mg 2 caps bedtime,						
		d this medication had been						
	· ·	onths ago. Insulin aspart (fast						
		ulin) subcutaneous 100 units/ml						
	-	before meals, using sliding scale						
	(insulin amount de	epends on the patient's blood						
	sugar). The order	failed to include the specific						
	sliding scale order	S.						
		conducted with the						
		9/26/18 at 12:07 PM regarding						
		atient # 3. The Administrator						
	-	not have any information						
		ents dialysis medication, diet						
		ons. The administrator reported						
	-	nedication findings, "I have do. There is no excuse for						
		ocumentation to be provided.						
		d from [the dialysis facility] on led the following orders specific						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 10/02/2018 157681 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 10500 CROSSPOINTE BLVD, AGING & DISABLED HOME HEALTH CARE LLC INDIANAPOLIS, IN 46256 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE to the patients ESRD: Heparin Sodium 1,000 units/ml to arterial port 2,200 units and 2,300 units to venous port (of a central dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The POC failed to include the patient's medication regimen for ESRD. 7. The clincial record of Patient # 4 with a SOC date of 3/13/18 was reviewed with the following findings: The POC for the certification period of 7/11/18 to 9/8/18 included an order for HHA 3 hours day/ 4 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided. 8. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification periods of 6/19/16 to 8/17/16, 8/18/16 to 10/16/16 and 10/17/16 to 12/14/16 included an order for HHA 4 hours a day/ 5 days a week. The POC failed to include the duration of the HHA visits. The clinical failed to evidence any HHA documentation notes from 8/10/16 to 9/29/16 in the clincial record The clinical record failed to evidence a contain a copy of the patient's rights. An interview was conducted with the Event ID: 106K11 Facility ID: 013593 Page 205 of 206 State Form If continuation sheet

11/27/2018

PRINTED: 11/27/2018 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157681		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 10/02/2018	
	NAME OF PROVIDER OR SUPPLIER AGING & DISABLED HOME HEALTH CARE LLC				ADDRESS, CITY, STATE, ZIP COD CROSSPOINTE BLVD, APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	POC. The Adminis working at the agen	D/1/18 at 1:58 PM regarding the trator reported he/she was not acy during that time period. eported there was no ion to be provided.					

State Form Event ID: 106K11 Facility ID: 013593 If continuation sheet Page 206 of 206