CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED		
		157538	B. WI	NG _		01/19/	2018	
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD			
PROCAF	RE HOME HEALTH	SERVICES	8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE	
G 0000								
Bldg. 00	This survey was a revisit of a federal/s	G 0	000					
	Federal and State d	eficiencies were cited.						
	Survey Date: 1/16/	/18 - 1/19/18						
	Facility #: 003042							
	Provider #: 157538	3						
	Active Patient #: 4	9						
	Discharge Patient #	t: 167						
G 0121 Bldg. 00	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on record review and observation the home health agency failed to ensure infection control procedures were followed in 1 of 1 home health		G 0121		G121. The Director of Nursing (DON) reviewed th policies titled "8.4 Infection		02/14/2018	
	agency. The findings include	le:			Control/Maintenance of Environment and Equipme for reeducation and			
	1. The agency policy dated 11/05/01 titled "8.4 Infection Control/Maintenance Of Environment Equipment" stated " Policy ProCare Home Health care staff members implement infection control and maintenance procedures for environment and equipment as appropriate.				clarification of procedures. The DON took a video training (01-22-18) on Infection Control/Maintenance of			

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

Purpose To control spread of infection To

TITLE

Environment and Equipment

(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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/19/2018		
	OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410				
(X4) I PREFI TAC	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	ΓE	(X5) COMPLETION DATE
	communicable/infe individual from ma equipment Procedu agency staff memb and maintenance propatients, staff, and equipment. Patient include, but are not Frequent hand was members before an patient care according to ProCarprocedure. Appropriate to ProCarprocedure according to ProCarprocedure. Appropriate to ProCarprocedure according agency policy and the Health staff members include, but are not frequent hand was members: Before a patient care Before a patient care Before apatient care Before apatient care according to bathroom control include; contissue or appropriate sneezing and washing open sores and/or cobandages; use persent Environmental and procedures include following: Maintait for example, by maintai	from transmission of ctious diseases To protect Ifunctioning or non-functioning are ProCare Home Health ers implement infection control cocedures with regard to their environment and infection control procedures Ilimited to the following: hing by home health care staff d after provision of direct ing to ProCare Home Health procedure. Appropriate skin dressing techniques re's agency policy and priate patient skin care re Home Health agency policy propriate handling and roducts Maintenance of Foley to ProCare Home Health procedure ProCare Home ers infection control procedures Ilimited to the following ting by home health care staff and after provision of direct the working in kitchen After contaminated materials After Other actions for infection twering nose and mouth with the item when coughing or to any hands afterwards; covering to hands afterwards; covering to hands with clean to hands with			and in-serviced the field son following the procedur on Infection Control. The staff also took a Video training on 1/23/18. The conformal of unexpired medications and maintaining a clean a sterile environment were reiterated and emphasized. A random hon visit was made (02-14-18) on a nursing field staff and compliant was assured. The DON or her clinical designee will review all nursing progress notes weekly to assure compliant with Infection Control measures. The DON will be responsifor ensuring that this deficiency does not recurrent.	es field use and ne a nce	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		r /	JILDING	instruction 00	(X3) DATE (COMPL 01/19/	ETED		
	RE HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ottles before disposal in						
		garbage cans, dirty pails and						
		soapy water Disposing of						
		y: draining off liquid before paper or plastic-lined pails						
		n paper and placing outside in						
		or down apartment incinerator						
	_	atting hard or stringy foods in						
		than in garbage disposal						
		of the bathroom, especially						
	-	se Keeping clean and dirty						
items separate Using sterile items that are not								
outdated Keeping the patient environment clean,								
neat and orderly Regularly cleaning patient								
	supplies such as con	mmodes, bedpans, urinals,						
	suction machines ar	nd measuring containers.						
	Equipment mainten	ance procedures include but						
	are not limited to th	ne following: Inspecting						
		o weeks to ensure it is						
		tained. Keeping equipment						
		ma functioning capacity.						
		patient's family; and home						
		rs regarding appropriate use of						
		uipment only for its intended						
		bjecting it to abusive use.						
		olth staff members provide ents regarding infection control						
	-	ents regarding infection control environment and equipment						
		ures as appropriate. ProCare						
		stered Nurses: Monitor						
	_	ad maintenance of environment						
		conducting patient home						
		ment monitored infection						
		nance of environment an						
	equipment on an ob	oservation"						
		home visit on 1/17/18 at 11:00						
	-	, start of care 12/28/17,						
	_	12/28/17 - 2/25/18 evidenced						
	employee C provid	ing wound care. Employee C						

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/19/2018	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX CRO TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 0133 Bldg. 00	to patient #2. Emple cleansing patient #2 bottle of normal sal label was observed bottle employee C to a pharmacy, date of by date of 01/2017. handwritten time or bottle that indicated This practice failed guidelines and the aprocedures on infect 484.14(c) ADMINISTRATOF The administrator supervising physic required under paorganizes and directions; maintain the governing bod personnel, and the Based on record revadministrator failed agency's ongoing further findings included 1. The agency job of "Administrator" standministrator standministrator standministrator failed agency is ongoing further findings included 1. The agency job of "Administrator" standministrator standministr	who may also be the sian or registered nurse ragraph (d) of this section, ects the agency's ongoing as ongoing liaison among y, the group of professional estaff. The wand interview the to organize and direct the notions in 1 of 1 agency. The description titled are "Position Summary: a, and coordinates activities of gency and its staff. Reports and the Board of Directors. Spistered Nurse, Physician, or	G 0	133	G133. The Administrator reviewed the Home Healt Agency's policies on Titled "Administrator" for reeducation and clarificat (01-22-18). The important of knowing the scope of Agency services was not so also was ensuring the Physicians' signatures are obtained on all plans of codocuments and orders.	cy ol ion ce ed, e	01/22/2018

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/19/2018				
	OF PROVIDER OR SUPPLIEI		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	ΓE	(X5) COMPLETION DATE	
IAG	business managemes supervisory or admi written and oral corskills Essential Fur Accountability: Pla administration of the Conditions of partice regulations under the Directors and the acadministrative policithe Home Health Actimproved work mesachievement of objectordinates and interpreted activities through redepartment supervice. Assurance and Perferogram Interpreted Board of Directors, supervisory staff to policies Develops measurement of Agethe annual program budget in cooperationand Board of Directors and Board of Directors Determines organized fixes areas of responsations of all estimates and staff purchase of supplies local, state, and nate participates in meeting community Promositions and promotions to increase community Promositions of the supplies and staff purchase of supplies local, state, and nate participates in meeting community Promositions and promotions to increase community Promositions of the supplies and nate participates in increase community Promositions with the agencies to increase community Promositions and participates in meeting and promotions and promotion	ent Minimum of two (2) years inistrative experience Effective mmunication and interpersonal		IAU	This will be monitored with the review of this Policy for the next two quarters and then yearly during our Professional Advisory Committee meetings in October/November annual The Board of Directors, the Administrator is responsite for monitoring this correct action to ensure that this deficiency does not recurred.	or I ally. ne ole tive	DATE	

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Event ID:

NT6X12 Facility ID: 003042

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r '	LE CONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G <u>00</u>	COMPLETED				
		157538	B. WING		01/19/2018				
NAME OF F	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP COD					
PROCAR	RE HOME HEALTH	SERVICES		8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI					
TAG		R LSC IDENTIFYING INFORMATION	TAC		DATE				
	~ ~	federal and state regulations Handles patients complaints							
		es unresolved problems							
		upervisors If not appointed							
		ectors, appoints a qualified							
	-	the administrator's absence							
		oment and implementation of a							
	_	on program to meet identified							
	-	ps an open, positive rapport							
	-	sources affiliated with home							
		Maintains high visibility and							
	availability while in the office via telephone to								
	physicians, referral sources, community resources, patients, and staff"								
	resources, patients,	and starr							
	2. Clinical record re	eview on 1/18/18 evidenced							
		only home health aide services.							
	-	e interview on 1/16/18 at 11:05							
		tor indicated that they did not							
		health only aide services. The							
		to ensure he/she was aware of							
	all the services the a	agency currently provided.							
		n 1/19/18 evidenced patient #4							
	_	d to have the physician sign							
	-	ne administrator failed to							
	ensure he/she obtain	~ -							
		n all patients serviced by the							
	home health agency	··							
G 0134	484.14(c)	_							
Dida oo	ADMINISTRATOR								
Bldg. 00		, who may also be the							
		cian or registered nurse ragraph (d) of this section,							
		personnel and ensures							
		ucation and evaluations.							
		view and interview the	G 0134	G134. The Administrato	r and 01/23/2018				
	administrator failed	to ensure all staff had		Director of Nursing (DOI					
	adequate education	for all population of patients		reviewed the policies title	•				
			1	Lieviewed the bolicies titl	cu				

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157538	B. W	ING		01/19/	/2018
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ROADWAY STREET STE F2A		
DDOCAE	RE HOME HEALTH	SEDVICES			LLVILLE, IN 46410		
FROCA	TE HOWE HEALTH	JERVICES		MEKKI	LEVILLE, IN 404 IO		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the agency serviced	l in 1 of 1 agency.			"3.1 Referral and		
					Acceptance of Patients"	and	
	The findings includ	le:			"5.1. Inservice Education		
	1 The agency noti	cy dated 10/15/05 titled "3.1			Programs" for reeducatio	n	
		otance Of Patients" stated "			and clarification of		
		ave procedures for the receipt,			procedures. The		
	processing, and evaluation of persons referred for				Administrator and the DC	NI	
		fied staff may take referral				/1 N	
		of all persons referred for			in-serviced all Field on		
	service will be maintained. Persons rejected will				caring for the Pediatric		
	be noted along with the reason for rejection.				patient. The staff were		
	Persons residing outside of the service area or in				issued handouts and test	ed	
	need of services not provided by the Agency will				on the in-service given. A	Al .	
		cting the appropriate			staff were expected to ha	ve	
	-	ceipt of a referral, an			a passing grade of 80%		
		gistered Nurse or Physical					
		only cases) will be made to			before starting or continuing		
		care can be adequately and			to care for pediatric patie		
		home, to assess the patient			and this was accomplished	ed	
		ensure that the patient meets ria. Patients will be evaluated			(01-23-18).		
		priate staff member within 24 -			This will be monitored wit	:h	
		or discharge from a facility			the review of Agency		
		Patients will be assigned to			policies and procedures		
		f members by a registered			yearly during our		
		supervision of the registered			Professional Advisory		
		geographical location, clinical			1		
		, and the qualifications and			Committee meetings in		
	availability of staff.				October/November annu	•	
					The Administrator and Do	NC	
		ency policy titled "5.1 Inservice			are responsible for		
		s" stated " Policy The home			monitoring this corrective		
		provides in-service education			action to ensure that this		
	programs for home health care staff members.				deficiency does not recur	•	
	Purpose 1. To increase home health care staff					•	
	member competency in a specific area of practice						
	To provide home health care staff members with current health care information. Procedure 1.						
The Director of Nursing of Home Health Care							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	plans an [sic] in-ser calendar which coul assessment 2) Orga 2. Posts in-service of designated areas one program offerings of required to attend a education hours per Nursing or the Adm completes and files Program Summary members document education programs program Attendance In-service/ Continuinal Samuel Receives skilled nurse care. ProCare has fin-services were procare for pediatric particular supervisor withey were in the propediatric training to	vice education program Id include: 1) Needs and anizational/Program objectives education program calendar in e month in advance of the B. Home Health Aides are minimum of 12 in-service year. 4. The Director of anistrator of Home Health Care an In-service Education form. 5. Home health care staff their participation in in-service on an In-service Education e form and an Individual ang Education Record form" on 1/17/18 evidenced patient #8 coatient with ProCare home as a pediatric patient that sing care and home health aide ailed to ensure that pediatric ovided to their employees that tients. 2:50 p.m. the administrator and were interviewed and indicated cess of providing in-service						
G 0143		OF PATIENT SERVICES						
Bldg. 00	liaison to ensure the coordinated effect objectives outlined Based on record revinterview the home coordinate services	shing services maintain nat their efforts are lively and support the d in the plan of care. It is not servation and health agency failed to lively age	G 0143	G143. The Administrator Director of Nursing (DON reviewed the policy titled "3.16 Case Conferences"	J)			

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		157538	B. W	ING		01/19/2	2018
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ROADWAY STREET STE F2A		
PROCAR	RE HOME HEALTH	SERVICES			LLVILLE, IN 46410		
	Г		1		,	-	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ГЕ	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	7E1 (* 1: : 1 1				reeducation on coordinat	ing	
	The findings includ	e:			services provided by all		
	1 The undeted age	may maliay titlad "2 16 Casa			Healthcare Providers in tl	ne	
		ency policy titled "3.16 Case I "The purpose of case			patients Home. All field s	taff	
		Determine the adequacy of the			was in-serviced by the Do	I	
		nd appropriateness of			on 02-08-18 on the		
		Assure coordination of				_	
		goal directed activity on the			importance of identifying		
		eare staff member Evaluate			Healthcare providers; typ		
	1 ~	l plans for future care Provide			disciplines with frequenci	es	
assistance to team members having difficulty planning care for specific problem cases Refer				and documenting and			
				coordinating services with	ı l		
	cases that require further study to the clinical				them.		
	record review comr	nittee Case conferences shall			The DON or her clinical		
	be held regularly to	review problem cases and to					
	review the plan of t	reatment for appropriateness			designee will review all		
	1	ontinued services. Such			progress notes weekly to		
		e documented separately or in			assure compliance with		
		and should be held on each			Care Coordination. Also,		
	_	of admission; prior to the date			during the monthly case		
		nt is due for the review at least			conference meetings,		
		prior to discharge. However, if			Coordination of Care will	he	
	_	case-specific conference would					
		rofessional disciplines			emphasized.	9.1.	
		patient's care should have			The DON will be respons	ibie	
	1 ^ -	nference. For personnel			for ensuring that this		
		patient's care but unable to			deficiency does not recur	.	
		ce, a telephone conference d. Documentation of the					
		the responsibility of the					
		pervisor, or other professional					
	as instructed by the						
		l include a summary of					
		-					
	progress, assessment of the need for continued care, plans and discharge goals All staff delivering patient care services is encouraged to have at least weekly contact with their Case						
		eded. Any conference related					
	to an individual patient may be documented as a						

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157538	B. W	ING		01/19/	/2018
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2					
DDOCAE		SEDVICES			ROADWAY STREET STE F2A		
PROCARE HOME HEALTH SERVICES				IVIERRII	LVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
	case conference"						
	Clinical record r	review on 1/19/18 for patient #1					
	evidenced an agenc	y document titled "OASIS-C2					
	START OF CARE'	" that was dated 12/19/17 and					
	electronically signe	d by employee C. This					
	document had an ar	rea subtitled "Coordination of					
	Care" that stated "	. Name: [agency #26]					
	Regarding: Homen	naker Services 9 Hours/Week".					
	The home health ag	gency failed to provide any					
	documentation that	evidenced coordination of					
	care with agency #2	26. During an interview on					
	1/19/18 at 1:35 p. n	n. the administrator indicated					
	that they are not do	cumenting coordination of					
	care. The administr	rator also indicated that if					
	everything is going	ok they don't write anything					
	down.						
		review on 1/18/18 for patient #2					
	1	ey document titled "OASIS-C2					
		" dated 11/25/17 and					
		d by employee C. This					
		rea subtitled "Coordination of					
		. Regarding: HHA [home					
	_	s 5 days/week. This document					
		hat agency was providing					
		ervices and failed to evidence					
	any coordination of	care with other agency.					
		review on 1/19/18 for patient #4					
		ny coordination of care with					
		y care physician. The agency					
		ome Health Certification And					
		d 11/30/17 and electronically					
	1 2 2 1 1	e L indicated the patient's					
		ian #BB, which was a					
	hospitalist affiliated	l with agency #29. This					
physician only practices inside the facility with							
admitted patients. The home health agency failed							
	to identify the patie	ent's primary physician.					
	I		1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		ì	JILDING	instruction 00	(X3) DATE (COMPL 01/19/	ETED			
		ROVIDER OR SUPPLIER E HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
		start of care 7/23/17 1/18/18, evidenced Health Care Certific electronically signe with no physician sign an area subtitled "2 Treatment (Specify Amount/Frequency, Coordination of Car [Home Health Aide [Skilled Nursing] for failed to provide any show coordination of care agencies that p During an interview employee C indicate agency #26 because that agency that the with both agencies sign different conding reference to the reference to the reference to the revidenced and agency "NON-OASIS STA and electronically sign document had an artindicated the patien dialysis type is "Ho statement that read dialysis daily with I visit on 1/19/18 obs dialysis machine in	/Duration)" that stated " re with agency #26 (HHA re with agency #27 (SN or wound care)". The agency y clinical documentation to of care with the other health rovided care to their patient. y on 1/19/18 at 2:16 p.m., ed that "the patient likes e there is a home health aide at patient really likes. We speak and there have been no of sure if that has been ing the same interview "agency #28 does that, they inpanies for different reasons" multiple health care agencies atient. eview on 1/19/18 for patient #6						

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Event ID:

NT6X12 Facility ID: 003042

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PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538			A. BUILDING B. WING	00	COMPLETED 01/19/2018	
	ROVIDER OR SUPPLIER		8300 BI	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A		
PROCAR	RE HOME HEALTH	SERVICES	MERRII	LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	Monday - Friday from Patient #6 was unaway provided the in-horn interview with the fathe/she indicated he/company name. Obsome patient #6 dining on the label; upon as services they provide indicated they offer aide hours and that the employing agency #4 the clinical supervisional 1/19/18 at 1:42 p.m. indicated that their second indicated that their second indicated that their second indicated that their supervisor indicated name of the compart home hemodialysis.	e he/she gets home dialysis he interview the clinical he/she did not remember the ty that provided the patient The agency failed to the home hemodialysis				
G 0157 Bldg. 00	SUPER Patients are acceptasis of a reasonal patient's medical,	The particular of the state of				
	Based on record rev failed to meet the pa clinical charts review The findings include 1. The agency police	iew the home health agency stient's therapy needs in 1 of 7 wed. (#1)	G 0157	G157. The Administrator Director of Nursing (DON reviewed the policies title "3.1 Referral and Acceptance of Patients" a "9.4 Therapy Services" for reeducation and clarificat) d and r	

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Event ID:

NT6X12 Facility ID: 003042

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PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		157538	B. W	ING		01/19/2	2018
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				ROADWAY STREET STE F2A		
DDOCAD	RE HOME HEALTH	SEDVICES			LLVILLE, IN 46410		
TROCAN	CETIONIE HEAETH	<u> </u>		MILIXIXII			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ave procedures for the receipt,			of the procedures. The n	eed	
		luation of persons referred for			to meet the medical, nurs	sina.	
		fied staff may take referral			rehabilitation and social	J,	
		of all persons referred for					
		tained. Persons rejected will			needs of the patient was		
		the reason for rejection.			emphasized. The DON w		
		tside of the service area or in			review all new referrals to)	
		provided by the Agency will			ensure that the agency ca	an	
		eting the appropriate			provide the requested		
	_	ceipt of a referral, an			services directly or by		
		istered Nurse of Physical			contract. The DON will		
		only cases) will be made to					
		are can adequately and safely			contact the patient's		
		ome, to assess the patient care			physician when the agend	су	
		that the patient meets the			cannot meet the patient's		
		Patients will be evaluated by a			needs and arrange for the	e l	
		staff member within 24 - 48			patient to be transferred t		
		discharge from a facility			another agency.		
	-	Patients will be assigned to members by a registered					
		upervision of the registered			To assure that this deficie	ency	
		geographical location, clinical			is corrected, the DON or		
		and the qualifications and			Assistant Director of Nurs	sing	
	availability of staff				(ADON) will review all ne	w	
	avanaonity of starr.				referrals to ensure that th	e l	
	2. The agency police	ey dated 10/19/06 titled "9.4			agency can provide the	-	
		tated " A copy of the			l = '	, l	
		Therapy Referral Form will be			requested services direct	ıy	
		/Therapist providing therapy			or by contract.	_	
		the Therapy Referral Form			The Administrator and D0	ON	
		ong with the M.D. [medical			will be responsible for		
		Nursing Supervisor will			ensuring that this deficier	ncy I	
	_	Therapist providing therapy			does not recur.	, l	
		y inform them of the referral.					
	The Nursing Superv	risor will fax a copy of the					
	verbal order and ref	erral. The Therapist will visit					
	the patient within 48	8-72 hours. The Director of					
Nursing will be notified if the family requested an							
	evaluation other tha	n the above stated time frame.					
	After the assessmen	t, the Therapist will Contact					

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Event ID:

NT6X12 Facility ID: 003042

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	the Case Manager/I communicate the fire Therapist will submare Home Health within Home Health Service initial assessment to The agency will receive therapy schedule ear problems, contact the Supervisor immediate each patient receive [occupational therapiservices will be conditional therapiservices will be conditional therapiser will report to discharge of Therapist will report Nursing" 2. Clinical record restart of care 12/19/12-2/16/18, evidence "Patient Profile" that required for patient OT [occupational therapy]. Only Provided to patient OT [occupational therapy]. Only Provided to patient OT [occupational therapy]. Only Provided to patient Therapy of the paperwork had "Referrals/Respons #AA, have PT/OT/Stysarthria" This HHC [home health of OT or ST ever be failed to evidence a	DON [director of nursing] to ndings and plan. The nit initial assessment to ProCare not 24-48 hrs [hours]. ProCare ces will submit the submitted to the physician for signature. The process of the patient of the physician for signature. The Director of Nurses/Clinical attely. A case conference for ng PT [physical therapy], OT py], and ST [speech therapy] ducted at least every thirty the assigned Case Manager and aide] (if applicable) will be in conference will be scheduled for each patient. The Physical the directly to the Director of the view on 1/19/18 for patient #1, 17, certification period 12/19//17 dan agency document titled at indicated the services #1 was PT [physical therapy], nerapy] and ST [speech was evidenced as being #1 by the home health agency.			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/19 /	ETED
	ROVIDER OR SUPPLIEF			8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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
	evidenced an agence START OF CARE' electronically signed document had an art Limitations" that has speech, contracture The same document supported the need follows: a. The agency START OF CARE' M1230 (M1230) S Expression of Lang language) that had to Code "03" stated "3 expressing basic ideassistance or guessis single words/short public b. The agency START OF CARE' "(M1740) Cognitive symptoms that are of week (Reported or apply.)" with a "x" decision-making: factivities of daily lappropriately stop at through actions". c. The agency START OF CARE' "(M1810) Current including undergarifront-opening shirts zippers/buttons/sna	document titled "OASIS-C2" had an area subtitled e, behavioral, and psychiatric demonstrated at least once a Observed): (Mark all that marked by "2 - Impaired ailure to perform usual (I)ADLs iving], inability to activities, jeopardized safety document titled "OASIS-C2" had an area subtitled ability to dress upper body					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/19 /	ETED
	PROVIDER OR SUPPLIER		8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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
	must help the patier clothing." An area Ability to Dress Lo without dressing aid slacks, socks or nyl of "03" placed in be Patient depends ent dress lower body." Bathing: Current a safely. Excludes grashing hands, and a code of "05" place - Unable to use the in bathing self in be with assistance or self. The agency START OF CARE "(M1870) Feeding feed self meals and refers only to the present of the set-up, or intermitted liquid/pureed/ground e. The agency START OF CARE "(M1880) Current and Light Meals (e.g., codelivered meals safe placed in box. Codelivered and light meals." f. The agency START OF CARE "The	nt put on upper body subtitled "(M1820) Current wer Body safely (with or ds) including undergarments, ons, shoes." that had a code ox. Code "03" stated "3 - irely upon another person to An area subtitled "(M1830) bility to wash entire body rooming (washing face, I shampooing hair)." that had ed in box. Code "05" stated "5 shower/tub, able to participate ed/sink/bedside chair/commode upervision." I document titled "OASIS-C2 I had an area subtitled or Eating: Current ability to snacks safely. Note: This rocess of eating, chewing, and eparing the food to be eaten." 01" placed in box. Code "01" feed self but requires meal ent assistance/supervision, or a				
		e phone safely, including				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157538	B. WI	NG		01/19/	2018
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
G 0158	dialing numbers, an telephone to commu "04" placed in box. to answer the teleph assisted with equipres. Clinical record reskilled nurse initial/titled "OASIS-C2 St 12/19/17 and electro. This document asse C evidenced the need occupational therapy ordered by the physical and failed to mee place of residence.	d effectively using the inicate." that had a code of Code "04" stated "4 - Unable one at all but can listen if					
G 0158 Bldg. 00	SUPER Care follows a write established and per	tten plan of care eriodically reviewed by a e, osteopathy, or podiatric					
	Based on record reversal failed to follow the periodically reviewed clinical charts review that the findings included the findings i	riew the home health agency plan of care established and ed by the physician in 6 of 7 wed. (#1, #2, #3, #4, #5, #6, #7) e: cy dated 10/15/05 titled "3.9 n/Patient Plan Of Care" stated el Home Health services are general supervision of a a plan of care that is odically reviewed by the appropriate application of the nt's condition. Purpose To	G 0	158	G158. The Administrator Director of Nursing (DON reviewed the policies title "3.1 Referral and Acceptance of Patients" a "3.9 Medical Supervision" reeducation and clarificat of procedures. The DON in-serviced the skilled sta on following the Physician orders (including disciplin requested, with frequenci performing only ordered) d and ' for ion ff ns' es	02/08/2018

PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538		JILDING	instruction 00	(X3) DATE SURVEY COMPLETED 01/19/2018		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	ΓE	(X5) COMPLETION DATE	
	approved ProCare I Procedure ProCare I Procedure ProCare furnished to patient supervision of a phyplan of care establishy the physician to of the services to the patient plan of care physician in consult Health staff an intermolated includes the follow of care Physician in patient plan of care of care Any other aby the physician and ProCare Home Heath written record by the agency based on the following Policy and Orders 3. Is incorprecord. 4. Is review in consultation with interdisciplinary teats the severity of the at least every 60 data care are documented plans of modification or ally, are reduced thome Health Regist countersigned by the as possible, following Telephone orders, plans Changes in out of range paramere reported immediate supervising RN [regist a physician refers a care that cannot be	Home Health services. Home Health services are seed. Home Health services application seed. Health services application. He seed to a service of the service of the service of the service of patient plan service of the service of patient plan service of the service of patient plan service of the ser			tasks, providing instruction (for example; caregiver/patient instruction employing non-pharmaceutical pain relief modalities, filling the medication box, patient positioning and reposition etc.) in accordance with the plan of care. Also, staff is notify the patient's physicians of missed visit when they cannot be made up. To assure the physician orders and plan of care a being followed, the DON her clinical designee will review all progress notes weekly as part of the week quality assurance processensure compliance. The DON will be respons for ensuring that this deficiency does not recurrent.	ons ening he to eside re or ekly s to ible		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	COMPLETED	
		157538	B. W	ING		01/19/	/2018	
			<u> </u>	CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER	8						
DDOCAD	DE LIOME LIEALTH	CED/ICEC			ROADWAY STREET STE F2A			
PROCAR	RE HOME HEALTH	SERVICES		MEKKII	LVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	approve any additio	ons or modifications in the						
	original plan of care	e. ProCare Home Health staff						
		inform the physician of						
		at a need to alter the patient						
	plan of care"	•						
	•							
	2. Record review o	n 1/19/18 of patient #1, start of						
		fication period 12/19/17 -						
		an agency document titled						
		ification And Plan Of Care"						
	dated 1/10/18 and s	igned by the physician. This						
	document had an ar	rea subtitled "21. Orders for						
	Discipline and Trea	tments (Specify						
	_	/Duration)" that stated "SN						
		uency: 1W9 [once a week for 9						
		eal therapy] Frequency: 2W4 [2						
		weeks]. Homebound Status:						
	_	ele & taxing effort to leave						
		e assistance of another to get						
	-	; Unable to safely leave home						
	unassisted; SN to in							
		pain relief measures, including						
		es, massage, stretching,						
		t/cold packs. SN to report to						
		experiences pain level greater						
		tions not effective, patient						
	-	ain medications, pain affecting						
		atient's normal activities. SN to						
	assess if the Caregiv							
		e indication for each						
	_							
		l therapist to evaluate and						
	-	ment. SN to instruct the						
	_	t agency to report any fall with						
		jury and to call 911 for fall						
		injury or causing severe pain						
		e physician signed plan of care						
		d by the skilled nurse as						
	follows:							
	.	1/10/10						
	a. Record revi	ew on 1/19/18 evidenced an						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE : COMPL 01/19/	ETED
	PROVIDER OR SUPPLIER			8300 BR	DDRESS, CITY, STATE, ZIP COD COADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
IAU	agency document the nurse]/LPN [licensed 12/27/17 and electron This document had Care" that indicated was 109 mg/dl [mil was performed by the patient's left finger. Care did not order for blood sugar checks nurse failed to follow the second review evidence the skilled on nonpharmacological including relaxation stretching, position to assess if the Care understanding of the medication, and fair contact the agency without minor injuring resulting is serious or immobility as diplan of care. 3. Record review of care 11/25/17, certifor 1/23/18, evidenced "Home Health Certifor dated 12/11/17 and document had an antiposition in the property of the serious of the s	tled "LVN [licensed vocational ed practical nurse] Visit" dated onically signed by employee E. an area subtitled "Diabetic I patient #1's a.m. blood sugar ligram/deciliter] that the check he skilled nurse on the The physician signed plan of or the skilled nurse to perform on patient #1. The skilled ow the plan of care. iew on 1/19/18 failed to I nurse instructed the patient gic pain relief measures, a techniques, massage, ing, and hot/cold packs, failed egiver can verbalize an e indication for each led to instruct the caregiver to to report any fall with or y and to call 911 for fall injury or causing severe pain rected on the physician signed on 1/18/18 of patient #2, start of fication period 11/25/17 - an agency document titled iffication And Plan Of Care" signed by the physician. This rea subtitled "21. Orders for		IAU			DATE

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		157538	B. W	ING		01/19/	/2018
NA 75 05 5	ADOLUBED OF STATE		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				ROADWAY STREET STE F2A		
	RE HOME HEALTH	SERVICES	•	MERRIL	LVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		skin for breakdown every					
		instruct on seizure disorder					
	signs & symptoms a seizure activity. SN	and appropriate actions during					
		contact agency to report any					
	_	minor injury and to call 911 for					
		ous injury or causing sever					
	-	SN to assess caregiver filling					
		etermine if caregiver is					
		SN to determine if the					
		identify the correct dose,					
	route, and frequency	y of each medication. Patient					
	refused Physical Th	erapy services at this time."					
	The physician signe	ed plan of care failed to be					
	followed by the skil	led nurse as follows:					
	ъ .	1/10/10 6					
		ew on 1/18/18 for patient #2					
		visit the week of 12/31/17 -					
	_	nterview on 1/18/18 at 3:23 p.m. ed the skilled nurse couldn't					
		certain time the family					
	-	as no evidence that another					
	-	ged or that the physician was					
		sed visit. The skilled nurse					
		physician signed plan of care.					
	 b. Record revi 	ew on 1/18/18 for patient #2					
	failed to evidence th	ne nurse assess/instructed on					
	seizure disorder sign	ns and symptoms and					
	appropriate actions	during seizure activity,					
	_	ver filling the medication box					
		caregiver is preparing correctly,					
		caregiver is able to identify					
		te, and frequency of each					
		ed nurse visits dated 11/30/17,					
		2/22/17, 12/28/17 and 1/10/18.					
		iled to follow the physician					
	signed plan of care.						
	c. Record revi	ew on 1/18/18 for patient #2					

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 $NT6X12 \qquad {\tt Facility\ ID:} \quad 003042$

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED		
		157538	B. W	ING		01/19/2	2018		
				CTDFFT A	DDDEGG CITY CTATE ZID COD				
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD				
DDOCAD		SEDVICES			ROADWAY STREET STE F2A				
PROCAR	RE HOME HEALTH	SERVICES		MEKKII	LVILLE, IN 46410				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE		
	failed to evidence th	ne nurse instructed the							
	caregiver on turning	g/repositioning every 2 hours							
	on the skilled nurse	visits dated 11/30/17, 12/7/17,							
		and 1/10/18 as ordered on the							
	physician signed pla	an of care.							
		n 1/19/18 of patient #3, start of							
		fication period 12/28/17 -							
		an agency document titled							
		ification And Plan Of Care"							
		igned by the physician. This							
		ea subtitled "21. Orders for							
	Discipline and Trea								
		/Duration)" that stated "SN							
		once a week for 1 week], 2W4 [2							
		weeks], 1W5 [once a week for 5							
		ne health aide] Frequency:							
		bound Status: Exhibits							
		ng effort to leave home;							
	_	nce of another to get up and							
	-	le to safely leave home							
	unassisted; SN to a	n medications and current pain							
	_	y every visit. SN to instruct							
		macologic pain relief							
	-	relaxation techniques,							
	-	, positioning, and hot/cold							
		ct the Patient on methods to							
	•	shear. SN to perform/instruct							
		ollows: clean with NaCl							
		pply Medihoney cover with							
		ess skin for breakdown every							
		nue wound care when							
		ed. SN to assess patient for							
		N to instruct patient to wear							
	-	en ambulating. SN to instruct							
		ribed assistive device when							
		instruct patient to change							
	_	IHA to assist with ADL's							
		iving] & IADL's [instrumental							
		C1 L	1						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538		LDING	nstruction <u>00</u>	(X3) DATE COMPL 01/19/	ETED
	PROVIDER OR SUPPLIER			8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	P	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ving] per HHA care plan. SN					
		ling medication box to					
		is preparing correctly. SN to					
		tient is able to identify the					
		and frequency of each					
		assess if the Patient can					
		tanding of the indication for hysical therapist to evaluate					
		treatment." The physician					
		failed to be followed as					
	evidenced by:	ranca to be followed as					
	a. Record rev	iew on 1/19/18 for patient #3					
	evidenced the skille	ed nurse had an extra visit					
	during the week of	1/7/18 - 1/13/18. No extra visit					
	order was evidence	d in the clinical record and no					
	prn [as needed] visi	its were ordered on the plan of					
		erview on 1/19/18 at 1:55 p.m.					
		ed he/she would have to write					
		ra visit made to patient #3. The					
		to follow the physician signed					
		led to obtain a physician order					
	for the extra visit.						
	b. Record rev	iew on 1/19/18 for patient #3					
	failed to evidence the	he skilled nurse to instruct the					
	patient on nonphari	macologic pain relief measures					
	on the skilled nurse	visits dated 1/2/18 and 1/5/18					
	as ordered on the pl	hysician signed plan of care.					
	c. Record rev	iew on 1/19/18 for patient #3					
		he skilled nurse instructed the					
		per footwear when ambulating,					
		nt to use prescribed assistive					
	_	ating, assessed the patient					
		pox to determine if the patient					
	was preparing corre	ectly, determined if the patient					
		ne correct dose, route, and					
		nedication and assessed if the					
	patient can verbaliz	te an understanding of the					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2/ LLVILLE, IN 46410	4
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE
PREFIX TAG	indication for each in indicate indi	medication on the skilled (2/18, 1/5/18, 1/8/18, 1/10/18) red on the physician signed in 1/19/18 for patient #4 failed cian signed plan of care. You on 1/19/18 at 2:10 p.m. the indicated that the agency never an of care from the physician. In the indicated that the agency never an of care from the physician. In the indicated was titled "Coram where it is greatly a pharmacist on scriber signature evidenced. In 1/19/18 for patient #5 failed cian signed plan of care for 11/20/17 - 1/18/18. Record dence any physician signed from the Health services for this skilled nursing care was retification period on 11/24/17 (27/17 by employee E, 11/29/17 (17 by employee E, 11/29/17 (17 by employee J, 12/4/17 by 7 by employee E, 12/12/17 by 13/17 by employee J. In 1/19/18 for patient #6, start of attion period 1/9/18 - 3/9/18 ent titled "Home Health lan Of Care". This document it "21. Orders for Discipline"	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE COMPLETION DATE
	Amount/Frequency. Frequency: 24visits [occupational therapy Status: Exhibits con	Duration)" that stated "SN s. PT Frequency: 6 visits. OT by]: 3 visits. Homebound ansiderable & taxing effort to the assistance of another to			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	get up and move sa home unassisted; U medical restriction([below knee amputa and effectiveness of pain management the instruct patient to take becomes severe to a SN to instruct patient relief measures, incomassage, stretching packs. SN to report experiences pain less medications not effect tolerate pain medications not effect tolerate pain medications not effect tolerate pain medications. SN to instruct methods to reduce from patient/Caregiver of hours. SN to instruct the Patient/prominences. SN to care as follows: SN area with wound clear and tape 3XW [3 times for breakdown ever Patient/Caregiver of infection to report to increased temp > 10 drainage, foul odor, significant changes care when wound(s wound for S&S [signifection, healing stomplications. SN insulin as follows: HS [at bedtime]. Pace cream applied after skin breakdown. Significant changes.	fely; Unable to safely leave Unable to leave home due to s); Other: Bilateral BKA ation]; SN to assess pain level fi pain medications and current herapy every visit. SN to dee pain mediation before pain herapy every visit. SN to dee pain mediation before pain herapy every visit. SN to dee pain mediation before pain herapy every visit. SN to dee pain mediation techniques, herapy every visit. SN to herapy every visit. SN to herapy every visit. In to n nonpharmacologic pain herapy every visit. In the one nonpharmacologic pain herapy every every every every every every every every every herapy every e	TAG	DEFICIENCY	DATE

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 157538		l í	UILDING	NSTRUCTION 00	(X3) DATE COMPI 01/19		
NAME OF	PROVIDER OR SUPPLIE	3	•		NDDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F		
PROCAI	RE HOME HEALTH	SERVICES		MERRILLVILLE, IN 46410			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION diet. SN to determine if the		TAG	BETTELEXCTT		DATE
		identify the correct dose,					
	_	y of each medication. SN to					
		ver can verbalize an					
		e indication for each					
	_	assess the Caregiver					
		table medications to determine					
	if proper technique is utilized. SN to instruct the						
	Caregiver on precautions for high risk						
	medications, such as, hypoglycemics,						
	anticoagulants/antiplatelets, narcotics. Physical						
	therapist to evaluate and submit plan of treatment.						
	Occupational therapist to evaluate and submit						
	plan of treatment. Physical therapy to evaluate.						
		py to evaluate. SN to instruct					
		er to contact agency to report					
	1 -	hout minor injury and to call					
		g in serious injury or causing					
		obility." The skilled nurse and					
	care this was evide	pist failed to follow the plan of					
	care this was evide.	nced by.					
		iew on 1/19/18 for patient #6					
		ed nurse failed to instruct the					
		pad all bony prominences,					
	_	caregiver on signs/symptoms					
		to report to physician, to					
		emp > 100.5, chills, increase in					
	_	, redness, pain and any other					
		, instruct the patient/caregiver					
		diet, determine if the caregiver					
		ne correct dose, route, and medication, assess if the					
		llize an understanding of the					
	1	medication, assess the					
		ering injectable medications to					
	1	technique was utilized, instruct					
		ecautions for high risk					
	medications, such a						
	· ·	platelets, narcotics and to					
	1		1				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018	
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	report any fall with call 911 for fall resu causing severe pain the plan of care for 1/11/18 and 1/12/18 b. Record reviewidence the occupa	ew on 1/19/18 failed to ational therapist evaluated or treatment as ordered on the			
	8. Clinical record r start of care 2/22/20 12/13/17 - 2/10/18, "Home Health Care Care", electronically physician on 12/27/subtitled "Section 2 Treatments (Specify Amount/Frequency: 2W1 [2] [3 times a week for Wednesdays 4hrs [1] hrs/visit Homebou considerable & taxi Requires the assistat move safely; Unab unassisted; HHA to per HHA care plan. changes to SN".	eview on 1/19/18 for patient #7, 1/16, certification period evidenced a document titled Certification And Plan Of y signed and dated by 18. This document had an area 1. Orders for Discipline and (//Duration)" that stated "HHA times a week for 1 week], 3W8 8 weeks]. Mondays and hours]/visit; Fridays 2			
	agency document d Home Health Service signed and dated by evidenced the follow Out: 01:00 p.m." The	ew on 1/19/18 evidenced an ated 12/13/17, titled "ProCare ces HHA Visit", electronically employee B on 12/13/2017, wing: "Time In 10:00 a.m. Time are agency failed to present wing that the home health aide			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157538	B. W	ING		01/19/	2018
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ROADWAY STREET STE F2A		
PROCAF	RE HOME HEALTH	SERVICES			LLVILLE, IN 46410		
				I WIE I WI			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	completed the 4 hor	ur visit as ordered.					
	b) Record review on 1/19/18 evidenced an						
		ated 12/26/17, titled "ProCare					
		cesHHA Visit", electronically					
		/ employee B on 12/26/2017,					
	evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present						
		wing that the home health aide					
	completed the 4 hour visit as ordered. The agency						
	also failed to present documentation indicating physician orders for home health aide to complete						
	the visit on a Tuesday.						
	the visit on a Tuesday.						
	c) Record review on 1/19/18 evidenced an						
		ated 12/27/17, titled "ProCare					
		ces HHA Visit", electronically					
		/ employee B on 12/27/2017,					
		wing: "Time In 12:00 p.m. Time					
		he agency failed to present					
		wing that the home health aide					
	completed the 4 hor						
	d) Record revi	ew on 1/19/18 evidenced an					
	agency documented	d dated 1/2/2018, titled					
	"ProCare Home He	alth Services HHA Visit",					
	electronically signe	d and dated by employee B on					
	1/2/2018. The agen	cy failed to present					
	documentation indi-	cating physician orders for					
	home health aide to	complete the visit on a					
	Tuesday.						
	· /	ew on 1/19/18 evidenced an					
		ated 1/10/2018, titled "ProCare					
		ces HHA Visit", electronically					
		/ employee B on 1/10/2018,					
		wing: "Time In 12:00 p.m. Time					
		he agency failed to present					
		wing that the home health aide					
	completed the 4 hor	ur visit as ordered.					

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i '		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/19/2018	
		157538	B. W.	ING		01/19/	2018
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
G 0159 Bldg. 00	agency document da Home Health Service signed and dated by evidenced the follow Out: 02:00 p.m." The documentation show completed the 4 hour 484.18(a) PLAN OF CARE The plan of care do	eveloped in consultation					
	with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on record review the home health agency failed to ensure all plans of care contained pertinent patient diagnosis and all equipment patient required to maintain health in 1 of 7 clinical charts reviewed. (#6) The findings include:		G 0	159	G159. Director of Nursing (DON) reviewed the police titled "3.9 Medical Supervision/Patient Plan Care" for reeducation and clarification of procedures The DON in-serviced the skilled staff on the	of d	02/08/2018
	Medical Supervision " Policy ProCare furnished under the physician, based on established and peri physician to ensure	ey dated 10/15/05 titled "3.9 m/Patient Plan Of Care" stated of Home Health services are general supervision of a a plan of care that is odically reviewed by the appropriate application of the nt's condition. Purpose To			importance of ensuring the all pertinent patient information including diagnosis, all equipment acaptured in the plan of call as a standard of	are	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A	
PROCAR	RE HOME HEALTH	SERVICES		LLVILLE, IN 46410	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE DATE
TAG	ensure the provision approved ProCare I Procedure ProCare I Procedure ProCare furnished to patient supervision of a phyplan of care establis by the physician to of the services to the patient plan of care: physician in consult Health staff an inter Includes the following care is written Type services and equipmed diagnosis Patient in functional limitation potential Type of in Frequency of needed medication Patient permitted Patient in therapy services. He Medical supplies/apsafety measures to pure Instructions for time Review of patient procedures for time appropriate items 2 and made available agency or is prepared ProCare Home Heap physicians verbal or Procedures re: Tele incorporated into the reviewed by the atternorm the severity of the supplier of the severity of the suppropriate items 2 and the severity of the severity of the suppropriate items 2 and made available agency or is prepared ProCare Home Heap physicians verbal or Procedures re: Tele incorporated into the reviewed by the atternorm the suppropriate items 2 and the severity of the suppropriate items 3 and 5	In of quality and legally Home Health services. Home Health services are s: Under the general visician Based on a patient ched and periodically reviewed ensure appropriate application e patient's condition. The 1. Is developed by a cation with ProCare Home disciplinary team members. Ing: Date the patient plan of e of ProCare Home Health ment required Patient as Patient rehabilitation cursing services needed d nursing services Patient special diet Patient activities reatment Rehabilitation and come health aide services opliances necessary Any crotect against patient injury ely patient discharge or referral lan of care Physician initial of patient plan of care Date plan of care Any other . Is written by the physician to the ProCare Home Health ed as a written record by the lith agency based on the reders following Policy and ephone Orders 3. Is e patient clinical record. 4. Is	TAG	professional practice. The DON or her clinical designee will review each Plan of Care for completeness before may to the physician for signature. The DON will be responsifor ensuring that this deficiency does not recur	h iiling sible
	care are documente	d through written and signed			

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018	
	ROVIDER OR SUPPLIER		8300 BI	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	orally, are reduced thome Health Regis countersigned by the as possible, following Telephone orders, the plans Changes if out of range paramereported immediate supervising RN [regation and provided immediates aphysician refers a care that cannot be evaluation visit, the approve any addition original plan of care members promptly changes that suggest plan of care" 2. Clinical record restart of care 1/9/18, 3/9/18 evidenced an "Physician Face To 1/12/18 and signed document stated" diagnosis, or conditation home healthcare for failure on Dialysis amputation] Due to disease] And Ischer [illegible writing] Corelated to the needed help c [with] Home management] PT/Co. 3. Clinical record reprimary diagnosis of evidenced an agency Health Certification or the property of the providence of	e attending physician as soon and Policy and Procedure re: Medical orders and Patient care an vital signs, other significant atters and events must be by through the hierarchy to gistered nurse] or physician If patient under a patient plan of completed until after an physician is consulted to ans or modifications in the by ProCare Home Health staff inform the physician of a need to alter the patient eview on 1/19/18 for patient #6, certification period 1/9/18 - a agency document titled Face Encounter" dated by the physician. This The primary medical reason, ion related to the reason for the encounter was: Renal B [bilateral] BKA [below knee PAD [peripheral arterial mia Sacral Wound gait Other Conditions/Diagnoses d home care: Wound Care Dialysis Med mgt [medication				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
G 0165	This document had 10-CM Other Pertingual 10-C	an area subtitled "13. ICD- nent Diagnoses" that stated [traumatic] amp [amputation] at tween] kn [knee] and ankl v [lower] leg, subs Complete tw kn and ankl, I [left] low leg, , oropharyngeal phase d Pressure ulcer of sacral Type 2 diabetes mellitus ons" This plan of care list patient #6's renal failure in ceives dialysis at home 5 days v failed to ensure identification ertinent health conditions. eview on 1/19/18 for patient #6 y document titled "Home And Plan Of Care" undated igned by employee C. This ea subtitled "14. DME uipment and Supplies" that d, Wheelchair, hoyer lift, lcohol pads, Chux/Underpads, Dressing Supplies, Gauze Pads, eers, Sharps Container, sterile gloves, Silver Alginate eer". The home health agency ee of home hemodialysis atte fluids the patient had in the care failed to contain all the	IAU		DATE		
Bldg. 00	CONFORMANCE ORDERS Drugs and treatme agency staff only a	WITH PHYSICIAN ents are administered by as ordered by the					
		riew and interview the home to ensure physician orders	G 0165	G165. Director of Nursing (DON) reviewed the police	· I		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		157538	B. WI			01/19/	
				_	_		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ROADWAY STREET STE F2A		
PROCAR	RE HOME HEALTH	SERVICES		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were obtained before administering medications				titled "3.9 Medical		
	and/or treatments in	2 of 7 clinical records			Supervision/Patient Plan	of	
	reviewed. (#4, #5)				Care" for reeducation and		
	The findings includ	e:			clarification of procedures	5 .	
					The DON in-serviced the		
		cy dated 10/15/05 titled "3.9			skilled staff on adhering t		
	-	n/Patient Plan Of Care" stated			the Physicians' orders an	d	
	" Policy ProCare Home Health services are				Plan of Care. Also all ord	ers	
	furnished under the general supervision of a physician, based on a plan of care that is				must be signed before be	eina	
	established and periodically reviewed by the				carried out and no	9	
	physician to ensure appropriate application of the				intervention should be		
	services to the patient's condition. Purpose To						
	ensure the provision of quality and legally				carried without the		
	_	Home Health services.			Physicians' orders.		
		Home Health services are			The DON or her clinical		
		s: Under the general			designee will review the		
		ysician Based on a patient			clinical notes weekly to		
		shed and periodically reviewed			ensure the orders and		
	_	ensure appropriate application			treatment plans are being	,	
		e patient's condition. The					
		1. Is developed by a			followed. Also 10% of clir		
	_	tation with ProCare Home			records will be selected a	ınd	
	Health staff and into	erdisciplinary team members.			reviewed quarterly for		
	2. Is written by	the physician and made			evidence that physician's		
		Care Home Health agency or is			orders are being followed		
	prepared as a writte	n record by the ProCare Home			The DON will be respons		
		d on the physicians verbal					
	_	licy and Procedures re:			to ensure that this deficie	псу	
	_	3. Is incorporated into the			does not recur.		
	_	rd. 4. Is reviewed by the					
		in consultation with the home					
		rdisciplinary team members at					
	such intervals as the severity of the patient illness						
	requires, but at least every 60 days. Changes in						
	the plan of care are documented through written						
	and signed plans of modifications or, if the						
		ed orally, are reduced to					
	writing, signed by a	ProCare Home Health					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538			JILDING	instruction 00	(X3) DATE (COMPL 01/19/	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	attending physician following Policy ar orders, Medical orders, Medical orders, Medical orders, Medical order for the intraversal (1/28/18, failed to evorder titled "Condument titled "Condument titled "Condument or signed physician or administration of the clinical record #4. at 2:04 p.m. the clin Daptomycin was not medication reconcil a. Clinical receividenced an agency Health Certification 11/30/17 and electron This document had Medications: Dose (C)hanged (U)ncha 750mg [milligrams intravenous (IV) N' to be signed by a plon 1/19/18 at 1:57 pindicated he/she woorders. The home I	and countersigned by the as soon as possible, ad Procedure re: Telephone ders and Patient care plans" In 1/19/18 for patient #4 start of fication period 11/30/17 - vidence a physician signed enous administration of iotic] or Daptomycin derview did evidence a foram Prescriber Order" igned only by a pharmacist. Ince of a physician signature any another documented der for the intravenous de antibiotics evidenced in During an interview on 1/19/19 dical supervisor indicated that but listed on the agency diation. Ford review on 1/19/18 by document titled "Home on And Plan Of Care" dated denoically signed by employee L. an area subtitled "10. Frequency/Route (N)ew dermody that listed "Vancomycin dermody that listed "Vanc					
		on 1/19/18 for patient #5, start of fication period 11/20/17 -					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ	JLTIPLE CO ILDING	ONSTRUCTION 00	(X3) DATE S COMPLE	
		157538	B. WI			01/19/2	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
G 0170	1/18/18 evidenced the enemas on the paties for the skilled nurse evidenced in the clipperformed enemas of 11/24/17, 11/27/17, 12/8/17, 12/11/17 at failed to obtain a pherforming treatment 484.30	the skilled nurse performed nt. No physician signed order to perform enemas was nical record. The skilled nurse on the following visits dated: 11/29/17, 12/4/17, 12/6/17, nd 12/13/17. The skilled nurse ysician order before nts on patient #5.					
Bldg. 00	accordance with the Based on record revision follow the plan of complysician in 4 of 7 of #2, #3, #6) The findings including for following for the findings including for the findings in the following for the first form for the first form for the following for the following for the following for the form for the	s skilled nursing services in ne plan of care. riew the skilled nurse failed to are established by the clinical charts reviewed. (#1,	G 0	170	G170. Director of Nursing (DON) reviewed the policititled "3.9 Medical Supervision/Patient Plan Care" for reeducation and clarification of procedures. The DON in-serviced the skilled staff on adhering the Plan of Care; no intervention should be carried without the Physicians' orders. Order must be obtained for missivists that are not made used and all instructions to patients/caregivers must given in accordance to the treatment plan. The DON or her clinical designee will review the clinical notes weekly to ensure the orders and	of d ss.	02/08/2018

PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		157538	B. W	ING		01/19/	2018	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER				ROADWAY STREET STE F2A			
PROCAR	RE HOME HEALTH	SERVICES			LLVILLE, IN 46410			
			1	<u> </u>	,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
		ng: Review of patient plan			treatment plans are being	J		
		nitial documenting review of			followed. Also 10% of clir	nical		
		Date of review of patient plan			records will be selected a	nd		
	-	ppropriate items 2. Is written			reviewed quarterly for			
		d made available to the			evidence that physician's			
		Ith agency or is prepared as a e ProCare Home Health			· ·			
	-	e physicians verbal orders			orders are being followed			
		d Procedures re: Telephone			The DON will be respons			
		orated into the patient clinical			to ensure that this deficie	ncy		
	•	ved by the attending physician			does not recur.			
		the home health staff and						
		m members at such intervals						
		e patient illness requires, but						
		ys. Changes in the plan of						
		d through written and signed						
	plans of modification	ons or, if changes are requested						
	_	to writing, signed by a ProCare						
	Home Health Regis	tered Nurse, and						
	countersigned by the	e attending physician as soon						
	as possible, following	ng Policy and Procedure re:						
		Medical orders and Patient care						
		n vital signs, other significant						
		eters and events must be						
	-	ly through the hierarchy to						
		gistered nurse] or physician If						
		patient under a patient plan of						
		completed until after an						
		physician is consulted to						
	* *	ns or modifications in the						
		e. ProCare Home Health staff						
		inform the physician of t a need to alter the patient						
	plan of care"	i a need to after the patient						
	pian or care							
	2. Clinical record re	eview on 1/19/18 of patient #1,						
		7, certification period 12/19/17						
		d an agency document titled						
	· ·	ification And Plan Of Care"						
		igned by the physician. This						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 BI	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	document had an ar Discipline and Trea Amount/Frequency. [skilled nurse] Freq weeks]. PT [physic times weekly for 4 of Exhibits considerab home; Requires the up and move safely unassisted; SN to in nonpharmacologic prelaxation technique positioning, and hot physician if patient than 5, pain medica unable to tolerate parability to perform physician if the Caregivent of the Caregivent of the Caregivent of the Caregivent of the contact or without minor in resulting in serious or immobility." The failed to be followed evidenced by: a. Clinical receividenced an agence [licensed vocational practical nurse] Viselectronically signed document had an arthat indicated patier 109 mg/dl [milligraperformed by the skinger. The physici order for the skilled	ea subtitled "21. Orders for timents (Specify (Duration)" that stated "SN uency: 1W9 [once a week for 9 al therapy] Frequency: 2W4 [2 weeks]. Homebound Status: le & taxing effort to leave assistance of another to get (Unable to safely leave home instruct patient on pain relief measures, including es, massage, stretching, (cold packs. SN to report to experiences pain level greater tions not effective, patient in medications, pain affecting atient's normal activities. SN to			

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		T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/19/2018	
		ROVIDER OR SUPPLIER			8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) PREI	FIX	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		evidence the skilled on nonpharmacolog including relaxation stretching, positionit to assess if the Care understanding of the medication, and fail contact the agency twithout minor injur resulting is serious or immobility as displan of care. 3. Clinical record restart of care 11/25/12 - 1/23/18, evidence "Home Health Certidated 12/11/17 and document had an are Discipline and Trea Amount/Frequency. 1W10 Homebound Status: taxing effort to leave leave home unassisted due to medical restreation. SN to assessions & symptoms as seizure activity. SN Patient/Caregiver to fall with or without fall resulting in serion immobility, mediation box to desire the care and the content of the content of the care in the	lew on 1/19/18 failed to nurse instructed the patient gic pain relief measures, a techniques, massage, ing, and hot/cold packs, failed giver can verbalize an elinication for each led to instruct the caregiver to go report any fall with or y and to call 911 for fall injury or causing severe pain rected on the physician signed review on 1/18/18 of patient #2, 7, certification period 11/25/17 dan agency document titled iffication And Plan Of Care" signed by the physician. This ea subtitled "21. Orders for tements (Specify //Duration)" that stated "SN fonce weekly for 10 weeks]. Exhibits considerable & the home; Unable to safely the diffication (s); SN to instruct in turning/repositioning every 2 to skin for breakdown every instruct on seizure disorder and appropriate actions during					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	r í	ILDING	nstruction <u>00</u>	(X3) DATE (COMPL 01/19/	ETED
	PROVIDER OR SUPPLIEF			8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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
	route, and frequenc refused Physical Th The physician signs	y of each medication. Patient nerapy services at this time." ed plan of care failed to be lled nurse as evidenced by:					
	patient #2 evidence 12/31/17 - 1/6/18. at 3:23 p.m. employ couldn't see the pati requested. There w visit time was arran notified for the mis-	ord review on 1/18/18 for d a missed visit the week of During an interview on 1/18/18 yee C indicated the skilled nurse itent at a certain time the family was no evidence that another aged or that the physician was sed visit. The skilled nurse physician signed plan of care.					
	b. Record reversal failed to evidence the seizure disorder sign appropriate actions assessed the caregive to determine if the cand determine if the the correct dose round medication on skills 12/7/17, 12/14/17,	iew on 1/18/18 for patient #2 the nurse assess/instructed on ns and symptoms and during seizure activity, ver filling the medication box caregiver is preparing correctly, te caregiver is able to identify the, and frequency of each ed nurse visits dated 11/30/17, 12/22/17, 12/28/17 and 1/10/18. tiled to follow the physician					
	failed to evidence the caregiver on turning on the skilled nurse	he nurse instructed the g/repositioning every 2 hours e visits dated 11/30/17, 12/7/17, and 1/10/18 as ordered on the an of care.					
	start of care 12/28/1 - 2/25/18, evidence	review on 1/19/18 of patient #3, 17, certification period 12/28/17 d an agency document titled ification And Plan Of Care"					

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 BI	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	dated 1/10/18 and s document had an ar Discipline and Trea Amount/Frequency. Frequency: 1W1 [c times a week for 4 weeks]. HHA [hon 1W1, 2W4. Homel considerable & taxi Requires the assista move safely; Unab unassisted; SN to a effectiveness of paimanagement therap patient on nonpharmeasures, including massage, stretching packs. SN to instrureduce friction and on wound care as for [sodium chloride] a Allevyn. SN to assivist. May disconting wound(s) have heal diet compliance. SI proper footwear where patient to use prescriptions slowly. Here [activities of daily I activities of daily I acti	/Duration)" that stated "SN once a week for 1 week], 2W4 [2 weeks], 1W5 [once a week for 5 ne health aide] Frequency: bound Status: Exhibits ong effort to leave home; once of another to get up and le to safely leave home	TAG	DEFICIENCY	DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	ì í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/19/	ETED
	PROVIDER OR SUPPLIER			8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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
IMO	evidenced by:	CESC IDENTIFY THE INTO ON ONLY MICH.		1710			DATE
	patient #3 evidence visit during the wee visit order was evid and no prn [as need plan of care. Durin 1:55 p.m. employee to write an order fo #3. The skilled nur physician signed pl a physician order fo b. Clinical rec patient #3 failed to instruct the patient relief measures on the	cord review on 1/19/18 for evidence the skilled nurse to on nonpharmacologic pain the skilled nurse visits dated s ordered on the physician					
	patient #3 failed to instructed the patient when ambulating, i prescribed assistive assessed the patient determine if the patient determined in the	pord review on 1/19/18 for evidence the skilled nurse into the war proper footwear instructed the patient to use it device when ambulating, it filling medication box to client was preparing correctly, attent is able to identify the and frequency of each essed if the patient can tanding of the indication for in the skilled nurse visits dated 18, 1/10/18 and 1/12/18 as sician signed plan of care.					
	start of care 1/9/18,	certification period 1/9/18 - document titled "Home Health					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
PROCAR	RE HOME HEALTH	SERVICES		ROADWAY STREET STE F2A LLVILLE, IN 46410	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		lan Of Care". This document			
		d "21. Orders for Discipline			
	and Treatments (Sp	-			
		/Duration)" that stated "SN			
		s. PT Frequency: 6 visits. OT			
		by]: 3 visits. Homebound			
		nsiderable & taxing effort to			
	_	res the assistance of another to			
		fely; Unable to safely leave Inable to leave home due to			
		s); Other: Bilateral BKA			
		ation]; SN to assess pain level			
	and effectiveness of pain medications and current pain management therapy every visit. SN to instruct patient to take pain mediation before pain				
	_	chieve better pain control.			
		nt on nonpharmacologic pain			
	-	luding relaxation techniques,			
		, positioning, and hot/cold			
		to physician if patient			
	_	vel greater than 5, pain			
		ective, patient unable to			
	tolerate pain mediat	ions, pain affecting ability to			
	_	ormal activities. SN to instruct			
	Patient/Caregiver or	n turning/repositioning every 2			
	hours. SN to instru	ct the Patient/Caregiver on			
	methods to reduce f	riction and shear. SN to			
		Caregiver to pad all bony			
	_	perform/instruct on wound			
		to cleanse wound to sacral			
		eanser and apply Silver			
		ped and packed with gauze			
		nes weekly]. SN to assess skin			
		y visit. SN to instruct the			
	•	n signs/symptoms of wound			
	_	o physician, to include			
	_	00.5, chills, increase in			
		redness, pain and any other			
	_	May discontinue wound) have healed. SN to assess			
	care when wound(s	mave neared. Sin to assess			

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DENTIFICATION NUMBER IN WING NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES SIRVER ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410 STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410 STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410 STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410 STATE TAG WOUND for S&S [signs and symptoms] of infection, healing status, wound deterioration, and complications. SN to prefill syringes with Levemir insulin as follows: Dunits to be taken Q [every] HS [at bedrime]. Planet to have incontinence cream applied after each diaper change to prevent skin breakdown. SN to instruct the Caregiver is able to it dentify the correct dose, route, and frequency of each medication. SN to assess if the Caregiver can vehalize an understanding of the indication for each medication. SN consess the Caregiver administering injectable medications to determine if proper technique is utilized. SN to instruct the Caregiver on peculiance of the indication of the can be sufficient to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Occupational therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapist to evaluate and submit plan of treatment. Physical therapis to evaluate a	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERILLVILLE, IN 46410 OX3 ID SUMMARY STATEMENT OF DEFICIENCE (RACH DEFICIENCY MUST BE PRECEDED BY BILL TAG RIGLIATORY OR ISS ISIGNS and symptoms) of infection, healing status, wound deterioration, and complications. SN to prefil syringes with Levenir insulin as follows: I Quint to be taken Q [every] HS [at bedtime]. Patient to have incontinence cream applied after each diaper change to prevent skin breakdown. SN to instruct Patient/Caregiver on 2CM [gram] Na: Foodimaj ADA [American diabetic association] diet. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medications. SN to assess if the Caregiver can verbalize an understanding of the indication for each medication. SN to assess the Caregiver administering injectable medications to determine if proper technique is utilized. SN to instruct the Caregiver on precautions for high risk medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics. Physical therapist to evaluate and submit plan of treatment. Physical therapy to evaluate. Occupational therapis to evaluate and submit plan of reatment. Physical therapy to evaluate. Occupational therapy is to evaluate and submit plan of from fall resulting in servious injury or causing severe pain or immobility." The skilled nurse failed to follow the plan of care, this was evidenced by: a. Record review on 1/19/18 for patient #6 evidenced the skilled nurse failed to instruct the patient/Caregiver to pad all bony prominences, instruct the patient/Caregiver on signs/symptoms of wound infection to report to physician, to include increased termy > 10.05, child, increase in	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00		
PROCARE HOME HEALTH SERVICES (AS) ID SEMMARY STATEMENT OF DEFICIENCE PREFIX TAO MEDITATORY OR LISC IDENTIFYING INFORMATION REGULATORY OR LISC IDENTIFYING INFORMATION TAG MOUNT of TSAS Signs and symptoms of infection, healing status, wound deterioration, and complications. SN to prefill syringes with Levemir insulin as follows: 10 units to be taken Q [every] HS [at bedtime]. Patient to have incontinence cream applied after each diaper change to prevent skin breakdown. SN to instruct Patient/Caregiver on 2CoM [grant] Na* [sodium] ADA [American diabetic association] diet. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Caregiver and verbalize an understanding of the indication for each medication. SN to assess the Caregiver administering injectable medications to determine if proper technique is utilized. SN to instruct the Caregiver on precautions for high risk medications, such as hypoglycemics, anticoagulants/antiplatelets, narcotics. Physical therapis to evaluate and submit plan of treatment. Occupational therapis to evaluate and submit plan of retarment. Physical therapy to evaluate. SN to instruct the Patient/Caregiver to contact agency to report any fall with or without minor injury or causing severe pain or immobility. The skilled nurse failed to follow the plan of care, this was evidenced by: a. Record review on 1/19/18 for patient #6 evidenced the skilled nurse failed to instruct the patient/caregiver on agains/symptoms of wound infection for report to physician, to include increase temp 1 100 5, chills, increase in			157538	B. W	ING		01/19/	/2018
PROCARE HOME HEALTH SERVICES SIMMARY STATEMENT OF DEFICIENCE PRETIX TAO SIMMARY STATEMENT OF DEFICIENCE PRETIX TAO WIND FOR ILSC IDENTIFYING INFORMATION TAG WOUND FOR SERVING SERVING STATEMENT OF DEFICIENCE PRETIX TAO WOUND FOR ILSC IDENTIFYING INFORMATION TAG WOUND FOR SERVING SERVING SERVING SERVING STATEMENT OF THE PROPRETATE TAG WOUND FOR SERVING SE			<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP COD		
Description	NAME OF P	ROVIDER OR SUPPLIER	8					
PREFIX TAG WILLIATORY OR LSC IDENTIFYING PROPRATION DATE REGULATORY OR LSC IDENTIFYING PROPRATION DATE TAG Wound for S&S [Signs and symptoms] of infection, healing status, wound deterioration, and complications. SN to prefil syringes with Levemir insulin as follows: 10units to be taken Q [every] HS [at beddime]. Patient to have incontinence cream applied after each diaper change to prevent skin breakdown. SN to instruct Patient/Caregiver on 2GM [gram] Nar [sodium] ADA [American diabetic association] diet. SN to determine if the Caregiver is able to identify the correct dose, route, and frequency of each medication. SN to assess if the Caregiver can verbalize an understanding of the indication for each medication. Sn to assess of the Caregiver and verbalize an understanding of the indication for each medications, such as, hypoglycemics, anticoagulants/antiplatelets, narcotics. Physical therapist to evaluate and submit plan of treatment. Occupational therapy to evaluate. An evaluate and submit plan of treatment. Physical therapy to evaluate. Occupational therapy to evaluate. Occupational therapy to evaluate. SN to instruct the Patient/Caregiver to routhout minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility." The skilled nurse failed to follow the plan of care, this was evidenced by: a. Record review on 1/19/18 for patient #6 evidenced the skilled nurse failed to instruct the patient/caregiver to pare all bony prominences, instruct the patient/caregiver on signs/symptoms of wound infection to report to physician, to include increased temp > 100.5, chills, increase in	PROCAR	RE HOME HEALTH	SERVICES	_				
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is able to identify the correct dose, route, and			_					

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

Event ID:

 $NT6X12 \qquad {\tt Facility\ ID:} \quad 003042$

If continuation sheet Page 43 of 129

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300	ET ADDRESS, CITY, STATE, ZIP COD D BROADWAY STREET STE F RRILLVILLE, IN 46410	
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Facility ID: 003042

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		157538	B. W	ING		01/19/	2018
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			ROADWAY STREET STE F2A		
PROCAR	RE HOME HEALTH	SERVICES			LLVILLE, IN 46410		
	Г		1	1	,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		:::	DATE
		e patient's condition. The 1. Is developed by a			completeness before ma	iing	
		tation with ProCare Home			to the physician for		
		rdisciplinary team members.			signature.		
	Includes the following: Date the patient plan of care is written Type of ProCare Home Health				The DON will be respons	ible	
					for ensuring that this		
		nent required Patient			deficiency does not recur		
		nental status Patient				•	
	_	ns Patient rehabilitation					
		ursing services needed					
		ed nursing services Patient					
	medication Patient	special diet Patient activities					
	permitted Patient treatment Rehabilitation and						
	therapy services Ho	ome health aide services					
	Medical supplies/ap	opliances necessary Any					
		protect against patient injury					
		ely patient discharge or referral					
		lan of care Physician initial					
		v of patient plan of care Date					
	_	plan of care Any other					
		2. Is written by the physician					
		to the ProCare Home Health					
		ed as a written record by the					
		Ith agency based on the					
		rders following Policy and					
		ephone Orders 3. Is					
	reviewed by the atte	e patient clinical record. 4. Is					
		ne home health staff and numbers at such intervals					
		e patient illness requires, but					
	1	ys. Changes in the plan of					
		d through written and signed					
		ons or, if changes are requested					
	_	to writing, signed by a ProCare					
	1	C. C					
	Home Health Registered Nurse, and countersigned by the attending physician as soon						
		ng Policy and Procedure re:					
	_	Medical orders and Patient care					
	_	n vital signs, other significant					
	ı -		1				l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		157538	B. W	ING		01/19/	/2018
NAME OF 1	PROVIDER OR SUPPLIEI		_	STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
NAME OF	NO VIDER OR SUPPLIED				ROADWAY STREET STE F2A		
PROCAF	RE HOME HEALTH	SERVICES		MERRII	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		eters and events must be					
	_	ely through the hierarchy to					
	supervising RN [registered nurse] or physician If						
	a physician refers a patient under a patient plan of						
	care that cannot be completed until after an						
	evaluation visit, the physician is consulted to approve any additions or modifications in the						
	original plan of care. ProCare Home Health staff						
	members promptly inform the physician of changes that suggest a need to alter the patient						
	plan of care"						
	plan of care						
	2. Clinical record review on 1/19/18 for patient #6,						
	start of care 1/9/18, certification period 1/9/18 -						
		n agency document titled					
		Face Encounter" signed					
	1/12/18 and signed	by the physician. This					
	document stated "	. The primary medical reason,					
	diagnosis, or condi-	tion related to the reason for					
	home healthcare fo	r the encounter was: Renal					
	failure on Dialysis	B [bilateral] BKA [below knee					
		PAD [peripheral arterial					
	_	mia Sacral Wound gait					
	1 0 03	Other Conditions/Diagnoses					
		ed home care: Wound Care					
	_	Dialysis Med mgt [medication					
	management] PT/0	OT"					
	3. Clinical record i	review on 1/19/18 for patient #6,					
	primary diagnosis of	of osteomyelitis, unspecified,					
	1	y document titled "Home					
	Health Certification	n And Plan Of Care" with no					
		cally signed by employee C.					
		an area subtitled "13. ICD-					
		inent Diagnoses" that stated					
	"Complete traum [traumatic] amp [amputation] at						
	lev [level] betw [between] kn [knee] and ankl						
		w [lower] leg, subs Complete					
	_	etw kn and ankl, l [left] low leg,					
	subs Dysphagia	, oropharyngeal phase					1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING 00 COMPLE					
		157538	B. W	ING		01/19/	2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 0180	region, stage 4 without complicated document failed to which the patient re a week. The agenc of all the patient's p	d Pressure ulcer of sacral Type 2 diabetes mellitus ons" This plan of care list patient #6's renal failure in exceives dialysis at home 5 days y failed to ensure identification pertinent health conditions. LICENSED PRACTICAL					
Bldg. 00	NURSE The licensed practand progress note Based on record rev	tical nurse prepares clinical es. view the licensed practical	G 0	180	G180. Director of Nursing	3	02/08/2018
	complete upon each clinical records rev				(DON) reviewed the police titled "4.4 Charting" for reeducation and clarificate	;y	
	Charting" stated " given during each h on the appropriate of Documentation is n rendered. Purpose care services given permanent and come care observations, i Procedure Home h interdisciplinary tea patient home health rendered. Such does not limited to, the f year of home health health visits F. Additional patient a interventions I. Pa health care education	ency policy titled "4.4". Policy Home health services nome visit shall be documented disciplines visit note. In ade on the day the service is To document the home health to patients. To provide tinuous records of home health nterventions, and outcomes.	in-serviced the Nurse on the importance of complete documents of titled "4.4" on the importance of complete documents of professional practations, and outcomes. In a day the service is of professional practation form the home health of the document of t		documentation form musicompleted. Assessments patient's pain, respiratory cardiovascular, nutritional and neurological statuses etc. must be performed a	of ard All t be of f, I S and	

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PRINTED: 03/01/2018

	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						RM APPROVED IB NO. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	l í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018	
	PROVIDER OR SUPPLIE			8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410	1	
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF findings Home interdisciplinary to patient home health flow sheets, as app	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION health care staff and am members: A. Document h care information on patient propriate B. Dictate patient		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) and all the needed assessments are being done and recorded. The DON will be respon		(X5) COMPLETION DATE
	D. Dictate clearly entries following la	nformation whenever possible D. Document K. charting ast charting entry without or spaces in progress notes			to ensure that this defici does not recur.		
	start of care 7/23/1 1/18/18, evidenced titled "LVN [licens [licensed practical	review on 1/19/18 for patient #5, 7 certification period 11/20/17 - 1 multiple agency documents sed vocational nurse]/LPN nurse] Visit" that failed to be entirety. This was evidenced					
	Visit" dated 11/24/ employee J failed t respiratory, cardio	y document titled "LVN/LPN (17 and electronically signed by to provide evidence that the vascular or nutrition was e nursing visit. The clinical complete.					
	Visit" dated 11/27/ employee E failed respiratory was ass	y document titled "LVN/LPN /17 and electronically signed by to provide evidence that pain or sessed during the nursing visit. failed to be complete.					
	Visit" dated 11/29/ employee J failed t respiratory, cardio	y document titled "LVN/LPN /17 and electronically signed by to provide evidence that the wascular or nutrition was a nursing visit. The clinical					

notes failed to be complete.

d. The agency document titled "LVN/LPN Visit" dated 12/1/17 and electronically signed by

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/19/2018	
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A ILLVILLE, IN 46410	A
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	respiratory, cardiov	provide evidence that the ascular or nutrition was nursing visit. The clinical omplete.			
	Visit" dated 12/4/17 employee E failed t respiratory system v	document titled "LVN/LPN d and electronically signed by o provide evidence that the was assessed during the elinical notes failed to be			
	Visit" dated 12/6/17 employee J failed to respiratory, cardiov	document titled "LVN/LPN and electronically signed by provide evidence that the ascular or nutrition was nursing visit. The clinical amplete.			
	Visit" dated 12/8/17 employee J failed to respiratory, cardiov	document titled "LVN/LPN and electronically signed by provide evidence that the ascular or nutrition was nursing visit. The clinical amplete.			
	Visit" dated 12/11/1 employee E failed to pain and respiratory	document titled "LVN/LPN 7 and electronically signed by o provide evidence that the system was assessed during the clinical notes failed to be			
	Visit" dated 12/12/1 employee J failed to respiratory, cardiov nutrition was assess	document titled "LVN/LPN 7 and electronically signed by provide evidence that the ascular, gastrointestinal or ed during the nursing visit.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/19/2018			ETED		
	PROVIDER OR SUPPLIE		<u> </u>	8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410		
(X4) ID PREFIX	(EACH DEFICIEN	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 DEFICIENCY)	TE	(X5) COMPLETION
G 0225 Bldg. 00	j. The agency Visit" dated 12/13/ employee J failed t respiratory, cardion assessed during the notes failed to be c 484.36(c)(2) ASSIGNMENT & HEALTH AIDE The home health	r document titled "LVN/LPN 17 and electronically signed by o provide evidence that the vascular and nutrition was e nursing visit. The clinical omplete. DUTIES OF HOME aide provides services that e physician in the plan of		TAG	Dia ChiaCi I		DATE
	care and that the under state law. Based on record re failed to follow the clinical records rev. The findings included the findings	aide is permitted to perform view the home health aide nursing plan of care in 2 of 7 riewed. (#3, #7)	G 02	225	G225. The Director of Nursing (DON) in-service the home health aides or importance of complying with the patients' care plan only tasks assigned in the care plan should be carriout. No task should be performed that is not in the care plan. Also the set frequency for each task in be followed. The DON will designate a office staff to review the home health aides' notes weekly to ensure that the care plans are being followed. Also 10% of clir records will be selected a reviewed quarterly for evidence that the care plans are being followed.	n the fully ans; e ed ne must an ical and	02/13/2018

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		r í	JILDING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/19/2018		
	ROVIDER OR SUPPLIER E HOME HEALTH			8300 BF	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	and patient family o	at Refers appropriate patient questions and concerns to the lth Registered Nurse case			The DON will be respons to ensure that this deficie does not recur.		
	Home Health Aide Agency shall provide by appropriately question and superstherapist. The home supervised every 14 appropriate therapist requirements for confequired by federal health aide services to: Assisting the particle of the physician and appropriate Planning Assisting the particle of the physician and appropriate Planning certain the physician and appropriate planning certain the physician and appropriate planning certain appropriate planning as a supervised by the many change in the min pt's [patients] hou Documenting clinic conferences, staff min programs as indicated as a clinical record restart of care 12/28/18, evidenced "HHA [home health document was dated signed by employed area subtitled "Plan home health aide with duties as ordered by duties as ordered by	pproved, instructed and urse or therapist Reporting mental or physical condition or me situation to the supervisor al notes Participation in case meetings, and in-service					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		UILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/19 /	ETED		
		ROVIDER OR SUPPLIER		8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
PRI	l) ID EFIX 'AG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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
		included temperature and respirations; she hair care/comb hair assist with dressing with bed pan/urinal bowel movement, reambulation, make be housekeeping and reade/s failed to follows: a. Clinical recepation and dated 1/3/18, 1/2 Employee F failed to ordered on the nurse a bed bath on the pactorial and dated 1/3/18 and dated 1/3/18 and dated and ordered on the nurse a bed bath on the pactorial and dated and the pactorial and dated electronically signed documents evidence "HHA Visit" dated electronically signed documents evidence performed pericare nursing plan of care to follow the nursin c. Clinical recepation and the patient #3 evidence "HHA Visit" dated signed by employee the home health aid shave the patient, feassist patient with the patient with the bed	re, blood pressure, heart rate ower with chair, shampoo hair, oral care, skin care, shave, medication reminder, assist, incontinence care, record ange of motion, assist with hed, change linen, light heal set-up. The home health ow the nursing plan of care as ord agency documents titled onically signed by employee F (5/18, 1/10/18 and 1/12/18. To shampoo patient's hair as ing plan of care and performed attent instead of a shower with the nursing plan of care. Ford review on 1/19/18 for dagency documents titled 1/5/18, 1/10/18, 1/12/18 and dby employee F. These ed the home health aide that was not ordered on the the theorem of the care. Ford review on 1/19/18 for danagency document titled 1/12/18 and electronically to the form of the care. Ford review on 1/19/18 for danagency document titled 1/12/18 and electronically to the form of the care of the plant of the care of the day agency document titled 1/12/18 and electronically to the plant of the plant				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538			(X2) MULTIPI A. BUILDIN B. WING		nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/19/2018	
	PROVIDER OR SUPPLIER		830	0 BF	NDDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFI	X	(EACH CORRECTIVE ACTION SHOULD BE	тс	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
TAG	4. Clinical record r start of care 2/22/16/18, evidenced "HHA Care Plan" d electronically signe document had an ar which indicated the perform the following plan of care and regor weekly. The hor are shampoo hair ar health aide duties to vital signs which in pressure, heart rate, chair, hair care/compericare, nail care, a reminder, incontine movement, assist wassist with ambulatilight housekeeping	eview on 1/19/18 for patient #7, 6, certification period 12/13/17 - an agency document titled	TAG		DEFICIENCY		DATE
	patient #7 evidence "HHA Visit" dated signed by employee failed to evidence tl oral care, skin care, meal set-up as orde care. b. Clinical rec patient #7 evidence "HHA Visit" dated 12/20/17, 12/22/17 employee B. These evidence the home	ford review on 1/19/18 for d an agency document titled 12/13/17 and electronically e B. This agency document the home health aide provided nail care, incontinence care or red on the nursing plan of cord review on 1/19/18 for d agency documents titled 12/15/17, 12/18/17, 12/18/17, and electronically signed by a agency documents failed to health aide provided oral care, nice care and meal set-up as ing plan of care.					

, ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY							
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	<u>00</u>	COMPLETED 01/10/2018				
		157538			01/19/2018				
NAME OF P	PROVIDER OR SUPPLIER	8		ET ADDRESS, CITY, STATE, ZI D BROADWAY STREET					
PROCAR	RE HOME HEALTH	SERVICES		MERRILLVILLE, IN 46410					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF					
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY	HE APPROPRIATE				
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE				
	c Clinical rec	ord review on 1/19/18 for							
	patient #7 evidenced agency documents titled								
	-	ere electronically signed by							
	employee B. The n	ursing plan of care dated							
		the patient was to have his/her							
	_	ekly. Record review indicated							
		hair shampooed on 12/18/17							
		ve their hair shampooed again							
		s was 11 days between							
	the nursing plan of	me health aide failed to follow							
	the nursing plan of	care as ordered.							
	d. Clinical rec	ord review on 1/19/18 for							
		d agency documents titled							
	-	1/2/18 and 1/3/18 that were							
	electronically signe	d by employee B. These							
	agency documents t	failed to evidence the home							
	_	d the meal set-up as ordered							
	on the nursing plan	of care.							
	a Clinical roo	ord review on 1/19/18 for							
		d an agency document titled							
	-	1/6/18 and electronically							
		e B. This agency document							
		he home health aide provided							
		s ordered on the nursing plan							
	of care.								
	c (21: : 1	1							
		ord review on 1/19/18 for patient							
	_	y documents titled "HHA ally signed by employee B.							
		home health aide note was							
		vas no documentation of the							
		shampooed or the linen							
		ered weekly by the nursing							
	-	ast evidenced time the patients							
	hair was shampooed was a home health aide visit								
	-	his evidenced there have been							
		tient's hair not being							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157538	B. W	ING		01/19/	/2018
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	-		8300 BF	ROADWAY STREET STE F2A		
PROCAF	RE HOME HEALTH	SERVICES		MERRILLVILLE, IN 46410			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	-	tils to follow the nursing plan The last evidenced time the					
		en changed was 1/6/18; this					
	_	re been 9 days since the					
		een changed. This fails to					
	_	olan of care as ordered.					
	6 F						
G 0236	484.48						
	CLINICAL RECOF	RDS					
Bldg. 00	A clinical record co	ontaining pertinent past					
		gs in accordance with					
	accepted profession						
		ery patient receiving home					
		n addition to the plan of					
		ontains appropriate					
		ition; name of physician;					
		ment, and activity orders;					
	-	clinical and progress notes; y reports sent to the					
		n; and a discharge					
	summary.	n, and a discharge					
	•	riew and interview the home	G_0	236	G236. The Director of		02/13/2018
		to maintain clinical records in		230	Nursing (DON) reviewed	the	02/13/2010
		ofessional standards in 2 of 7					
	clinical charts revie				policy titled "4.13 Patient		
					Record Contents" for		
	The findings include	e:			reeducation and clarificat		
					of procedures. A check-o	ff	
		ey dated 10/15/05 titled "4.13			log has been created to		
		tents" stated " The agency			monitor physicians' order	'S	
		nical record for each patient,			and signatures on the		
		the time of the first visit. The			patient's plan of care.		
		pertinent past and current			l ·	ll bo	
		ocial, and other therapeutic			The DON or designee wil		
	_	atient's chart shall contain data nited to: Identifying date:			monitor the Clinical recor	as	
	-	of birth, sex, patient number			weekly and 10% will be		
		nber), health insurance claim			selected and reviewed		
		ng physicians name, address,			quarterly for evidence tha	at	
		he status of the patient upon			the physicians' orders are	<u> </u>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/19/2018		
	PROVIDER OR SUPPLIEF			8300 BF	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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
	discharge for the horeport), and the patin Medicare, Medicaid Pay A complete physical vital signs, height, other relevant infor secondary diagnosis permitted, and funct written orders as prattending physician the services are prograssessment of the hysafety factors the adactivities of daily lishome, if any, to assign providing services (clinical notes are videlivery, and incorpiedly factors with shall contain the paremotional status on date of discharge, emet, and plans for fithe discharge summals or retained in the 2. Clinical record restart of care 11/30/15 - 1/28/18, principal evidenced an agency Health Certification 11/20/17 and electroscent in the discharge summals or retained in the contains the paremotional status on date of discharge summals or retained in the contains the discharge summals or retained in the contains the paremotional status on date of discharge summals or retained in the contains the paremotional status on date of discharge summals or retained in the contains the paremotional status on date of discharge summals or retained in the contains the paremotion of the discharge summals or retained in the contains the paremotion of the physical records and plans for the discharge summals or retained in the contains the paremotion of the physical retains the paremotion of the paremotion o	elected to be needed. An ome environment including bility of the patient to perform ving Persons available in the ist with care Medication tion, allergies, effects, and side and over-the-counter drugs blan of care for all disciplines. Clinical and progress notes written the day of service borated into the chart at least charge summary shall be sent thin 30 days of discharge and tient's physical, mental and admission and at discharge, xtent to which the goals were follow-up or referral. A copy of nary sent to the physician is clinical record" RESCIDENTIFYING INFORMATION Pospital or institution (discharge with assessment including) weight, systems review, and mation. Private private with the prognosis and saturations available in the iservity of the patient to perform ving Persons available in the ist with care Medication tion, allergies, effects, and side and over-the-counter drugs blan of care for all disciplines. Clinical and progress notes written the day of service porated into the chart at least charge summary shall be sent thin 30 days of discharge and tient's physical, mental and admission and at discharge, xtent to which the goals were follow-up or referral. A copy of nary sent to the physician is clinical record" Peview on 1/19/18 for patient #4, 17, certification period 11/30/17 diagnosis bacterial infection, y document titled "Home and Plan Of Care" dated onically signed by employee L.			cross-referenced to the appropriate cross-referenced to the appropriate obtained and their signatures are on the patient's plan of care. The DON will be respons to ensure that this deficie does not recur.	ible	
	physician. The homobtain a physician s	ed to be signed by the he health agency failed to signature for the plan of care. The properties of the plan of care.					

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

Event ID:

NT6X12 Facility ID: 003042

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	NT OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED 01/19/2018			
	PROVIDER OR SUPPLIER			8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION
TAG		ndicated that they never got		TAG	DETELENCT		DATE
	start of care 7/23/17 1/18/18, evidenced Health Care Certific electronically signe electronic signature a date. On this same to ensure a physicia an interview on 1/1 stated "okay". 4. Clinical record r evidenced a docume Certification and Pl evidenced a start of was not signed or d separate agency doc to Face Encounter" evidenced a Start of agency document ti "Cert. [certification SOC [Start of Ca 11/21/2016". Dur 2:20 p.m., employe	eview on 1/17/18 for patient #5, 7, certification period 11/20/17 - a document titled "Home cation and Plan of Care", d by employee C. The of employee C did not include e document, the agency failed in signature and date. During 9/18 at 2:17 p.m., employee C eview on 1/17/18 for patient #5, ent titled "Home Health Care an of Care". This document care date of 07/23/2017 and ated by a physician. On a cument titled "Physician Face signed and dated on 3/30/17, f Care of 11/23/2016. A third titled "Patient Profile" stated [] Period: 11/23/2016 Referral Date ring an interview on 1/19/18 at e C stated "there must be a r because the start of care for 23/17".					
G 0337 Bldg. 00	include a review of is currently using a potential adverse including ineffective side effects, significant including includes a significant includes a significant includes a review of the includes a review	we assessment must of all medications the patient in order to identify any effects and drug reactions, we drug therapy, significant ficant drug interactions, rapy, and noncompliance					

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

Event ID: NT6X12 Facility ID: 003042

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157538	B. W	NG		01/19/	2018
		l .		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ROADWAY STREET STE F2A		
PROCAF	RE HOME HEALTH	SERVICES			LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG			DATE
		view, observation and interview	G 0	337	G337. The Director of		01/23/2018
		led to ensure all the patient's			Nursing (DON) reviewed	the	
		n the medication reconciliation			policy titled "4.13 Patient		
	clinical charts revie	ensive assessment in 2 of 6			Record Contents" for		
	cimical charts revie	wed. (#4, #0)			reeducation and clarificat	ion	
	The findings includ	e:			of procedures. Medication	n	
					reconciliation, review and	l	
		cy dated 10/15/05 titled "4.13			profile update was		
		tents" stated " The agency nical record for each patient,			completed for Clinical		
		the time of the first visit. The			Record #4, on 01-23-18.		
		pertinent past and current			Medication reconciliation		
		ocial, and other therapeutic			review and profile update	·	
	_	atient's chart shall contain data			•		
	_	mited to: A complete			was completed for Patier		
	physical assessment	t including: vital signs,			#6 on 01-23-18. The DOI		
		ems review, and other relevant			has provided education to		
	_	ecific written orders as			staff involved in providing		
		ed by the attending physician			skilled care to the patient		
	_	ile including action, allergies,			referred to in Record #4 a	and	
	over-the-counter dr	ects or prescribed and			patient #6. The DON		
	over-the-counter un	ugs			in-serviced the skilled sta	ıff	
	2. Record review o	n 1/19/18 of clinical record #4			on performing a		
		acy order for Daptomycin			comprehensive review of	all	
		[milligrams] IV [intravenous]			medications the patient is		
		s]. This medication failed to be			currently using to identify		
		's plan of care or medication			adverse effects, drug		
	reconciliation.				reactions, ineffective drug	,	
	3 Observation at a	home visit on 1/19/18 at 10:30			therapy and non-complia	-	
		start of care 1/9/18, certification			with drug therapy. Record		
	_	18 evidenced patient's home				•	
	*	her kitchen table. Comparison			the patient's medications		
	of patient's home m	edications against ProCare's			from discharge paperwor		
		iation evidenced the following			from another medical fac	Ility	
	medication discrepa	ancies:			as an alternative is		
					unacceptable.		
	a. Patient #6 h	nome prescription bottle			The DON or her clinical		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLE	
		157538	B. W	ING		01/19/2	2018
C. C				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t			ROADWAY STREET STE F2A		
PROCAR	RE HOME HEALTH	SERVICES		MERRII	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ne [for blood pressure] 0.1 mg			designee will review all s	tart	
		th three times a day. ProCare			of cares and recertification	ns	
		liation indicated: Clonidine 0.1			documentation weekly to		
	-	daily by mouth (PO). The			ensure compliance. Also		
	frequency on the ag	not congruent with patient's			10% of clinical records w	ill I	
	home prescription.	iot congruent with patient's			be selected and reviewed		
	nome prescription.						
	b. Vitamin D2	2 [supplement] 50,000 IU			quarterly for evidence that		
		1 capsule by mouth every			Medication reconciliation		
		This prescription was ordered			review and profile update	is	
		not been updated on the			being done.		
	agency medication	-			The DON will be respons	ible	
					to ensure that this deficie		
	c. Potassium (Cl [Chloride] [supplement]			does not recur.		
	micro 10 MEQ [mil	lliequivalents] ER [extended			does not recur.		
	_	tablet by mouth daily. This					
		be on the agency's medication					
	reconciliation.						
	d. Niferex [iro	on supplement] take 1 tablet by					
	_	prescription was ordered					
		t been updated on the agency					
	medication reconcil	iation.					
	. D	and a constant of the C					
		over-the-counter medication:					
	_) mg as needed for pain.					
		reconciliation indicated:					
		mg oral tablet 1 tab q 6 hours					
		e dosage of the medication in vas not congruent with the					
	_	cy's medication reconciliation.					
	dosage on the agent	s medication reconciliation.					
	f. Levemir [in	sulin] 10 units subcutaneously					
		er indicated he/she administers					
	at 9:00 p.m. every n	night. This medication failed to					
	be on the agency's medication reconciliation.						
		ing medication was on the					
	agency's medication	reconciliation but was not a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		lì í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/19/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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) COMPLETION DATE	
	Calcium Acetate, B	atient's home medications: enadryl and Hydrocodone. iew on 1/19/18 at 1:18 p.m. the						
	clinical supervisor i	ndicated he/she recorded the as from discharge paperwork						
N 0000								
Bldg. 00		ecertification, post-condition state licensed home health	N 0	000				
	Federal and State do	eficiencies were cited.						
	Survey Date: 1/16/	18 - 1/19/18						
	Facility #: 003042							
	Provider #: 157538	3						
	Active Patient #: 49	9						
	Discharge Patient #	: 167						
N 0444 Bldg. 00	a home health age present full time a in order to qualify administrator, who supervising physic required by subse following:	nagement An individual need not be ency employee or be the home health agency as its administrator. The ormay also be the cian or registered nurse ction (d), shall do the						

State Form Event ID: NT6X12 Facility ID: 003042 If continuation sheet Page 60 of 129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 157538 B. WING			(X3) DATE SURVEY COMPLETED 01/19/2018				
	PROVIDER OR SUPPLIER		_	8300 BI	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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
TAG	Based on record revadministrator failed agency's ongoing for the findings included. The findings included agency's ongoing for the findings included. The agency job of "Administrator" stated Administers, directs the Home Health A To: The President of Qualifications: Resease experienced health Demonstrated ability personnel Ability the professionals, emploor community Knowledge business managements and oral constitutions of a constitution of the Conditions of partice regulations under the Directors and the administrative policity the Home Health A improved work media administrative policity the Home Health A improved work media activities through redepartment supervices and Perferogram Interprets Board of Directors, assurance and Perferogram Interprets Board of Directors, supervisory staff to policies Develops of measurement of Agency in the program of Agency in the policies Develops of measurement of Agency in the program of Agency in the Agency in the program of Agency in the program of Agency in the Agency in the program of Agency in the program of Agency in the Agency in the program of Agency in the Agency in th	description titled ted "Position Summary: s, and coordinates activities of gency and its staff. Reports and the Board of Directors. gistered Nurse, Physician, or care Administrator ty to supervise and direct o interface with providers, oyees, and members of the edge of organization and ent Minimum of two (2) years inistrative experience Effective mmunication and interpersonal	NO	TAG	N444. The Administrator reviewed the Home Health Agency's policies on Policies on Policies and the Job Description Titled "Administrator" for reeducation and clarificate (01-22-18). The important of knowing the scope of Agency services was noted as on also was ensuring the Physicians' signatures are obtained on all plans of codocuments and orders. This will be monitored with the review of this Policy for the next two quarters and then yearly during our Professional Advisory Committee meetings in October/November annual The Board of Directors, the Administrator is responsite for monitoring this correct action to ensure that this deficiency does not recurred.	cy ion ce ed, e are th or d ally. ne ble tive	DATE 01/22/2018

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
NAME OF P	ROVIDER OR SUPPLIER	· {		ADDRESS, CITY, STATE, ZIP COD	
PROCAR	RE HOME HEALTH	SERVICES		BROADWAY STREET STE F2A ILLVILLE, IN 46410	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
		on with the Budget Committee			
		tors Approves monthly gns checks as needed, and			
		ial position of the Agency			
		the Agency activity for the			
		and Advisory Committee			
		ration lines of authority and			
		nsibility Approves hiring and			
	termination of all en	mployees Approves salary			
	increases and staff p	promotions Authorizes			
		s and equipment Contacts			
		ional associations and			
		ings, conventions, etc.			
	_	alth and health-related			
	_	e and improve services to the			
		tes education awareness to			
		res continuous compliance federal and state regulations			
		Handles patients complaints			
		es unresolved problems			
		upervisors If not appointed			
		rectors, appoints a qualified			
	_	the administrator's absence			
		oment and implementation of a			
	continuing educatio	on program to meet identified			
		ps an open, positive rapport			
	with community res	sources affiliated with home			
		Maintains high visibility and			
	_	the office via telephone to			
		sources, community			
	resources, patients,	and staff"			
	2 Clinical record r	eview on 1/18/18 evidenced			
		only home health aide services.			
	_	e interview on 1/16/18 at 11:05			
	_	tor indicated that they did not			
		nealth only aide services. The			
		to ensure he/she was aware of			
	all the services the a	agency currently provided.			
			1	i	1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018	
	PROVIDER OR SUPPLIER		8300 1	FADDRESS, CITY, STATE, ZIP COD BROADWAY STREET STE F2A RILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
N 0446 Bldg. 00	3. Record review of and Patient #5 failed the plan of care. The ensure he/she obtain orders/signatures or home health agency 410 IAC 17-12-1(d) Home health agency administration/ma Rule 12 410 IAC 1 Sec. 1(c)(3) The also be the supervice registered nurse reshall do the follow (3) Employ qualificate quate staff eduated administrator failed	n 1/19/18 evidenced patient #4 d to have the physician sign he administrator failed to hed physician hall patients serviced by the f. c)(3) hecy hagement 17-12-1(c)(3) hadministrator, who may fising physician or hequired by subsection (d), hing: hed personnel and ensure hed personnel and ensure he he he he he he he hing: he hing: he hing: he h	N 0446	N446. The Administrator Director of Nursing (DON reviewed the policies title "3.1 Referral and	and 01/23/2018
	Referral And Accep The Agency shall h processing, and eva service. Only quali information. A log service will be main be noted along with Persons residing ou need of services not be assisted in contar resources. Upon re- evaluation by a Reg Therapist (Therapy	ese by dated 10/15/05 titled "3.1 brance Of Patients" stated " ave procedures for the receipt, luation of persons referred for fied staff may take referral of all persons referred for attained. Persons rejected will the reason for rejection. It is de of the service area or in a provided by the Agency will be ting the appropriate ceipt of a referral, an instered Nurse or Physical only cases) will be made to are can be adequately and		Acceptance of Patients" "5.1. Inservice Education Programs" for reeducation and clarification of procedures. The Administrator and the DO in-serviced all Field on caring for the Pediatric patient. The staff were issued handouts and tes on the in-service given. A staff were expected to ha a passing grade of 80% before starting or continu- to care for pediatric patients.	n on ON ated All ave

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
		157538	B. WING		01/19/2018	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R		ROADWAY STREET STE F2A		
PROCAE	RE HOME HEALTH	SERVICES		LLVILLE, IN 46410		
INOCAL		OLIVIOLO	IVILIANI	LLVILL, IIV TOTIO		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		t home, to assess the patient		and this was accomplished	ed	
		ensure that the patient meets		(01-23-18).		
		ria. Patients will be evaluated		This will be monitored with	h l	
		opriate staff member within 24 -				
		l or discharge from a facility		the review of Agency		
	_	Patients will be assigned to		policies and procedures		
		ff members by a registered		yearly during our		
		supervision of the registered	1	Professional Advisory		
		geographical location, clinical		Committee meetings in		
	_	t, and the qualifications and		October/November annua	allv	
	availability of staff	"		The Administrator and Do	•	
	0 751 1 1	11 11517			JIN	
		ency policy titled "5.1 Inservice		are responsible for		
	_	ns" stated " Policy The home		monitoring this corrective		
		provides in-service education		action to ensure that this		
		health care staff members.		deficiency does not recur		
	_	rease home health care staff				
		cy in a specific area of practice the health care staff members				
	_	care information. Procedure 1.				
		rrsing of Home Health Care				
		rvice education program				
	_	ald include: 1) Needs and				
		ganizational/Program objectives				
	,	education program calendar in				
		ne month in advance of the	1			
	_	3. Home Health Aides are				
		minimum of 12 in-service				
	-	r year. 4. The Director of				
	_	ninistrator of Home Health Care				
		s an In-service Education				
	_	form. 5. Home health care staff				
		t their participation in in-service				
		s on an In-service Education				
	program Attendance	ce form and an Individual				
		ing Education Record form"	1			
	3. Record Review	on 1/17/18 evidenced patient #8				
	as a current, active	patient with ProCare home				
	health. Patient #8	is a pediatric patient that	1			
			<u> </u>	1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· 1	CONSTRUCTION	X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		157538	B. WING 01/19/2018				
	ROVIDER OR SUPPLIER		8300	T ADDRESS, CITY, STATE, ZIP COD BROADWAY STREET STE F2A RILLVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		sing care and home health aide					
		ailed to ensure that pediatric					
	_	ovided to their employees that					
		itients. During an interview on					
	_	n. the administrator and clinical I they are still in the process					
	_	rice pediatric training to their					
	staff.	ree pediatrie training to their					
	Starr.						
N 0458	410 IAC 17-12-1(f)					
	Home health ager	ncy					
Bldg. 00	administration/ma	nagement					
	, ,	Personnel practices for					
		e supported by written					
		byees caring for patients in					
		ubject to Indiana licensure,					
	_	gistration required to					
	•	ctive service. Personnel ees who deliver home					
		all be kept current and					
		mentation of orientation to					
	the job, including t						
	(1) Receipt of job	_					
	(2) Qualifications						
	(3) A copy of limi	ted criminal history					
	pursuant to IC 16-	27-2.					
	(4) A copy of cur	rent license, certification,					
	or registration.						
		mance evaluations.					
	_	record review the home	N 0458	N458. The Administrator	has 01/19/2018		
		to ensure a signed job		signed the signed job			
	(employee G)	ach employee's personnel file.		description and it is now	in		
	(employee G)			the Administrator's			
	The findings includ	e·		personnel file records.			
		- ·		Personnel files are			
	Personnel record	review on 1/18/18 evidenced a		monitored monthly by the	_		
	signed job descripti	on by employee G titled		personnel officer using a			
	"Assistant Adminis	trator" signed and dated by		·			
	employee G on 2/22	2/02, no other signed job	1	created for that purpose	to		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/19/2018	
	ROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD BROADWAY STREET STE F2A ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Employee G is the chome health agency personnel record fai administrator signed	l job description.		ensure that all personnel requirements are comple and up to date. The Administrator will be responsible for ensuring this deficiency does not recur.	te
N 0466 Bldg. 00	from the: (1) physical exams ubsection (h); and (2) tuberculosis efollow-ups required must be maintained and treated as corrected as provided. Based on record reversaled to ensure confiled in a separate for records reviewed. (1) The findings included 1. The agency police Employment Health Policy Home health expected to comply employment requires pertinent health professaff members 3 health information if 4. Completed employment employment employment employment employment information if 4. Completed employment employme	nagement The information obtained inations required by d valuations and clinical d by subsection (i) ed in separate medical files infidential medical records, d in subsection (k). iew the home health agency fidential medical records were older in 1 of 7 employee employee N)	N 0466	N466. The Administrator Personnel Staff reviewed Policy titled "6.5 Employr Health requirements" for reeducation and clarificat of the procedures. The importance of holding the employee medical information in the strictes confidence was acknowledged. The employee health informa are now separated from other employee personner records. This separation completed on 1/19/18.	Inent tion tion tion the

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 BI	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	11/16/17. Employe contained his/her ce background check, I description, orientat competency all in the health agency failed confidential records	ohysical exam, TB test, job ion, test and skills he same folder. The home to separate the employee's in a different folder.		Personnel Officer now monitors the personnel fil monthly to ensure that the employee medical information is held in the strictest confidence and separate from the other employee personnel records. The Administrator and Personnel Staff will review and monitor the Agency's Policy and Procedure year for ensuring that this deficiency does not recur	e w s arly
N 0484 Bldg. 00	services shall main communications to appropriately communications to appropriately communications to appropriately communication the object. The means of communication shall be document minutes of case of Based on record reviewels although agency failed documentation and record to ensure that complement one and objectives of the pattern records reviewed. (#	All personnel providing nation effective of assure that their efforts plement one another and tives of the patient's care. Inmunication and the results seed in the clinical record or onferences. It is with an interview the home to maintain effective communications in the clinical their efforts appropriately other and support the client's care in 1 of 7 clinical their effective communications in the clinical their efforts appropriately other and support the client's care in 1 of 7 clinical their effective communications in the clinical their efforts appropriately other and support the client's care in 1 of 7 clinical their effective communications in the clinical their effective care in 1 of 7 clinical their effective communications in the clinical their effective com	N 0484	N484. The Administrator Director of Nursing (DON developed a tool to log patients' hospitalization (Hospitalization Log) in o to document patients' hospitalizations and discharges to facilitate ar maintain effective	rder

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	to 1/18/18, evidence "OASIS-C2 Transfe Assessment Date of 12/13/17, electronic 12/14/17. Under the stated "Reason for I checked next to "19 procedure". During on 1/19/18 at 2:14 p#5 did have a physic admitted to the hosp employee C indicate hospital was going that he/she had hear #5 that he/she was p [skilled nursing faci on to state "as far as still in the hospital them otherwise". The documentation that of the patient to the patient was admitted the care of patient #2. Clinical record restart of care 7/23/17 1/18/18, evidenced Care Certification as signed by employee physician signature. Discipline and Trea instruct Patient/Care wound infection to increased temp > [g second agency documentation that of the patient was admitted that the care of patient #4 physician signature. Discipline and Trea instruct Patient/Care wound infection to increased temp > [g second agency documentation that of the patient was admitted that the patient was admitted to the patient was patient was admitted to the patient was admitted to the patient was patient was admitted to the patient was patient was admitted to the patient was admitted to the patient was patient was admitted to the patient was admitted to the patient was admitted to the patient was patient was admitted to the patient was	ed an agency document titled er Not Discharged" with an \$\frac{12}{13}/17\$ and a Visit Date of sally signed by employee C on exection "OASIS M2430" it Hospitalization" a box is - Scheduled treatment or an interview with employee C o.m., he/she stated that patient cian appointment and was oital. Upon further interview, ed that she "was not sure if the to discharge patient #5 and diffrom others seeing patient bossibly going to a SNF [lity]". Employee C continued is he/she knows patient #5 is because no one has notified the agency failed to provide communicated the discharge hospital, what hospital the discharge hospit		communications to all disciplines. The DON or the designe will review the hospitaliz log daily to ensure that a disciplines are aware of patient's hospitalization status. The DON will be respons to ensure this deficiency does not recur.	ation all the the sible

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157538	B. W	ING		01/19/	/2018
NAME OF B	DOWNER OF GUIDNIED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			8300 BF	ROADWAY STREET STE F2A		
PROCAR	E HOME HEALTH	SERVICES		MERRII	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		ure, pulse, O2 [oxygen]					
		perature assessments:					
	-	by employee C, 11/20/2017					
		E, 11/22/17 signed by					
		2017 signed by employee J,					
		by employee E, 11/29/2017 EJ, 12/01/2017 signed by					
		2017 signed by employee E,					
		employee J, 12/08/2017 signed					
		1/2017 signed by employee E,					
		employee J, and 12/13/2017					
	signed by employee J. During an interview on 1/19/2018 at 2:16 p.m. with employee C, she indicated that patient #5 refuses to have his/her vitals taken. The agency failed to provide						
	_	the patient refused vital sign					
		at it is is communicated in the					
	clinical record.						
N 0486	410 IAC 17-12-2(h	n)					
	Q A and performa						
Bldg. 00	•	The home health agency					
ŭ	` '	s services with other health					
		roviders serving the patient.					
	•	riew, observation and	N 0	486	N486. The Administrator	and	01/23/2018
	interview the home	health agency failed to			Director of Nursing (DON		
	coordinate services	with all health care providers			reviewed the policy titled	,	
	serving their patient	s in 5 of 7 clinical records				6	
	reviewed. (#1, #2, #	#4, #5, #6)			"3.16 Case Conferences"		
					clarification and reeducat	ion	
	The findings include	e:			on coordinating services		
	1 The undated age	ncy policy titled "3.16 Case			provided by all Healthcare	е	
		The purpose of case			Providers in the patient's		
		Determine the adequacy of the			home. All field staff were		
		d appropriateness of			in-serviced by the DON o	n	
		Assure coordination of			1/23/18 on the importance		
		goal directed activity on the			identifying all Healthcare	- - ·	
		are staff member Evaluate				00	
	-	I plans for future care Provide			providers; types, disciplin	⊌ 5,	
		•			with frequencies and		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	f /	JILDING	onstruction 00	(X3) DATE (COMPL 01/19/	ETED
	PROVIDER OR SUPPLIER			8300 BF	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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)	ΓE	(X5) COMPLETION DATE
TAG	assistance to team in planning care for special cases that require for record review commits be held regularly to review the plan of the and feasibility of conferences shall be the clinical record a patient at the time of the plan of treatment every 60 days and participating in the input at his [sic] conjumitation participating in the attend the conference ould be established conference shall be primary nurse or sure as instructed by the documentation shall progress, assessment care, plans and discipled delivering patient of the have at least weekly manager and as need to an individual pattern case conference" 2. Clinical record in evidenced an agency START OF CARE electronically signed document had an and Care" that stated " Regarding: Homer The home health agent and search agency in the home health agent and search agency in the home health agent agency in the home health agent agency in the home health agency in the health agency in the home health agency in the health agency in th	members having difficulty pecific problem cases Refer arther study to the clinical mittee Case conferences shall review problem cases and to reatment for appropriateness portinued services. Such the documented separately or in and should be held on each of admission; prior to the date and is due for the review at least prior to discharge. However, if case-specific conference would refessional disciplines patient's care should have inference. For personnel patient's care but unable to ce, a telephone conference di. Documentation of the the responsibility of the pervisor, or other professional supervisor. The l include a summary of the of the need for continued tharge goals All staff are services is encouraged to you contact with their Case and the conference related the ded. Any conference related the ded. Any conference related the ded. Any conference related the ded.		TAG	documenting and coordinating services with them. The DON or clinical designee will review all progress notes weekly to ensure compliance with Care Coordination. Also, during the monthly case conference meetings, Coordination of Care will emphasized. The DON will be respons for ensuring that this deficiency does not recur	be ible	DATE
	documentation that	evidenced coordination of					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIEF		8300 E	ADDRESS, CITY, STATE, ZIP CO BROADWAY STREET STE LILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION (X5) OULD BE PROPRIATE COMPLETION DATE
	care with agency #2 1/19/18 at 1:35 p.m that they are not docare. The administreverything was going anything down. 3. Clinical record revidenced an agency START OF CARE's electronically signed document had an arrow that stated " health aide] service failed to indicate with home health aide seany coordination of the patient's primary document titled "How Plan Of Care" dated signed by employed physician is physician only prace admitted patients. To identify the patients. State of the care of the patient of th			CROSS-REFERENCED TO THE AF DEFICIENCY)	
	1/18/18, evidenced Health Care Certific electronically signe with no physician s an area subtitled "2 Treatment (Specify	a document titled "Home cation And Plan Of Care", d by employee C and undated, ignature. This document had 1. Orders for Discipline and "Duration)" that stated "			
		re with agency #26 (HHA			

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	OF CORRECTION	IDENTIFICATION NUMBER 157538	A. BUILDING B. WING	00 00	COMPLETED 01/19/2018
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A	
PROCAR	RE HOME HEALTH	SERVICES		LLVILLE, IN 46410	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
TAG		services) and agency #27 (SN	IAU		DATE
		or wound care)". The agency			
	failed to provide any	y clinical documentation to			
	show coordination of	of care with the other health			
	-	rovided care to their patient.			
	_	on 1/19/18 at 2:16 p.m.,			
		ed that "the patient likes			
		there is a home health aide at			
		patient really likes. We speak			
	_	and there have been no			
	_	at sure if that has been ag the same interview			
		'agency #28 does that, they			
		npanies for different reasons"			
		nultiple health care agencies			
	that cared for one pa				
	6. Clinical record re	eview on 1/19/18 for patient #6			
	evidenced an agenc	_			
	1	RT OF CARE" dated 1/9/18			
	and electronically si	gned by employee C. This			
	document had an ar	ea subtitled "Dialysis" that			
	indicated the patient	t was on dialysis, that the			
	1	me dialysis Permacath and a			
		"Patient receives home			
		Dialysis nurse". During a home			
		ervation was made of a home			
		the patient's bedroom. During			
	_	atient #6 on 1/19/18 at 10:50			
		cated he/she received dialysis om a home dialysis nurse.			
		vare of the company that			
		ne dialysis. During an			
		amily member on 1/19/18,			
		she was not aware of the			
		servation was made of a folder			
	on patient #6 dining	room table with agency #30			
		sking the family member what			
		led for patient #6 he/she			
	indicated they offer	ed the patient free home health			

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AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538		(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 01/19 /	ETED	
	PROVIDER OR SUPPLIER			8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
N 0520 Bldg. 00	employing agency # the clinical supervision 1/19/18 at 1:42 p.m. indicated that their secondination because every day. During the supervisor indicated name of the company home hemodialysis. Coordinate care with company for patient Care Rule 13 Sec. 1(a) for care on the base expectation that the can be adequately agency in the patient Based on record revisited to meet the patient can be adequately agency in the patient Care The findings included 1. The agency policing Referral and Accept The Agency shall he processing, and eva service. Only quality information. A log service will be main be noted along with Persons residing our need of services not be assisted in contact resources. Upon receivaluation by a Regeneral and a legal contact resources. Upon receivaluation by a Regeneral service and the contact resources. Upon receivaluation by a Regeneral service revaluation service re	the he/she gets home dialysis the interview the clinical I he/she did not remember the my that provided the patient. The agency failed to in the home hemodialysis to #6. A) Patients shall be accepted sis of a reasonable me patient's health needs of met by the home health agency atient's therapy needs in 1 of 7 wed. (#1)	N 05.	20	N520. The Administrator Director of Nursing (DON reviewed the policies "3.1 Referral and Acceptance Patients" and "9.4 Therap Services" for reeducation and clarification of the procedures. The need to meet the medical, nursing rehabilitation and social needs of the patient was emphasized. The DON w now review all new referrato ensure that the agency can provide the requested services directly or by contract. The DON will	of of g, ill als	01/22/2018

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/19/2018	
	PROVIDER OR SUPPLIEF			8300 BF	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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)	ΓE	(X5) COMPLETION DATE
	performed [sic] at he needs, and to ensure admission criteria. nurse or appropriate hours of referral or whenever possible. the appropriate staff nurse or under the senurse according to needs of the patient availability of staff. 2. The agency polion Therapy Services of the Agency services. A copy of will be submitted addirector order. The contact the agency services and verbal. The Nursing Superverbal order and reference the patient within 4 Nursing will be not evaluation other that After the assessment the Case Manager/I communicate the firm the Health within Home Health within Home Health Services initial assessment to the agency will receive the patient received the p	care can adequately and safely amome, to assess the patient care to that the patient meets the Patients will be evaluated by a cestaff member within 24 - 48 discharge from a facility Patients will be assigned to fi members by a registered supervision of the registered geographical location, clinical and the qualifications and" cy dated 10/19/06 titled "9.4 stated " A copy of the earth Therapy Referral Form will be cy/Therapist providing therapy of the Therapy Referral Form dong with the M.D. [medical to earn Note of the ferral. The Therapist will visit 8-72 hours. The Director of diffied if the family requested and the above stated time frame. In the Therapist will Contact DON [director of nursing] to not indings and plan. The mit initial assessment to ProCare can 24-48 hrs [hours]. Pro			contact the patient's physician when the agence cannot meet the patient's needs directly or by contrand arrange for the patient be transferred to another agency. To assure that this deficite is corrected, the DON or Assistant Director of Nurs (ADON) will review all ne referrals to ensure that the agency can provide the requested services or by contract. The Administrator and DO will be responsible to ensure that this deficiency does in recur.	act nt to ency sing w e	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		A. BUILDIN B. WING		00 00	COMPL 01/19/	ETED	
	PROVIDER OR SUPPLIER		830	00 BRO	RESS, CITY, STATE, ZIP COD ADWAY STREET STE F2A /ILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	services will be con (60) [sic] days. The HHA [home health attendance. A case prior to discharge o Therapist will repor Nursing" 2. Clinical record r start of care 12/19/1 - 2/16/18, evidenced "Patient Profile" tha required for patient OT [occupational th therapy]. Only PT provided to patient: 3. Clinical record r evidenced faxed ho this paperwork had "Referrals/Response #AA, have PT/OT/S dysarthria" This	ducted at least every thirty e assigned Case Manager and aide] (if applicable) will be in conference will be scheduled if each patient. The Physical et directly to the Director of eview on 1/19/18 for patient #1, 7, certification period 12/19//17 d an agency document titled at indicated the services #1 was PT [physical therapy], herapy] and ST [speech was evidenced as being #1 by the home health agency. eview on 1/19/18 for patient #1 spital paperwork dated 1/16/18 an area subtitled et Letter" that stated "Per Dr. ST. Dx [diagnosis]: area was addressed to Procare			CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE .	
	HHC [home health of OT or ST ever be 4. Clinical record r evidenced an agenc START OF CARE' electronically signe document had an ar Limitations" that ha speech, contracture. The same document supported the need follows: a. The agency START OF CARE' M1230 (M1230) S	care]. There was no evidence					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	ROVIDER OR SUPPLIER		8300 E	ADDRESS, CITY, STATE, ZIP COI BROADWAY STREET STE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION he code "03" placed in a box.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION
	Code "03" stated "3 expressing basic ide	- Has severe difficulty eas; requires maximal ng by listener. Limited to			
	START OF CARE' "(M1740) Cognitive symptoms that are of week (Reported or of apply.)" with a "x" of decision-making: factivities of daily l	document titled "OASIS-C2 had an area subtitled e, behavioral, and psychiatric lemonstrated at least once a Observed): (Mark all that marked by "2 - Impaired ailure to perform usual (I)ADLs iving], inability to ctivities, jeopardized safety			
	START OF CARE" "(M1810) Current including undergarr front-opening shirts zippers/buttons/snapplaced in box. Cod must help the patier clothing." An area Ability to Dress Lowithout dressing aid slacks, socks or nylof "03" placed in both Patient depends ent dress lower body." Bathing: Current al safely. Excludes grant washing hands, and a code of "05" placed - Unable to use the	and blouses, managing os." that had a code of "02" e "02" stated "2 - Someone at put on upper body subtitled "(M1820) Current wer Body safely (with or ds) including undergarments, ons, shoes." that had a code ox. Code "03" stated "3 - irely upon another person to An area subtitled "(M1830) oility to wash entire body ooming (washing face, shampooing hair)." that had ed in box. Code "05" stated "5 shower/tub, able to participate d/sink/bedside chair/commode			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	JILDING	00	COMPL 01/19/	ETED	
	PROVIDER OR SUPPLIER			8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	d. The agency START OF CARE' "(M1870) Feeding of feed self meals and refers only to the property swallowing, not present that had a code of "stated "1 - Able to feed set-up, or intermitted liquid/pureed/ground e. The agency START OF CARE' "(M1880) Current of Light Meals (e.g., concluded in box. Codelivered meals safe placed in box. Codelivered meals." f. The agency START OF CARE' "(M1890) Ability to answer the dialing numbers, and telephone to community to answer the teleph assisted with equipment of the stilled in box. To answer the teleph assisted with equipment of the stilled in the stilled "OASIS-C2 Stilled" of	document titled "OASIS-C2 ' had an area subtitled or Eating: Current ability to snacks safely. Note: This occess of eating, chewing, and paring the food to be eaten." 01" placed in box. Code "01" eed self but requires meal ont assistance/supervision, or a dd meat diet." document titled "OASIS-C2 ' had an area subtitled Ability to Plan and Prepare ereal, sandwich) or reheat ely:" that had a code of "02" e "02" stated "2 - Unable to eals or reheat any delivered document titled "OASIS-C2 ' had an area subtitled O Use Telephone: Current e phone safely, including d effectively using the unicate." that had a code of Code "04" stated "4 - Unable tone at all but can listen if		TAG	DEFICIENCY)		DATE
	occupational therap ordered by the phys agency failed to pro	ed for the patient to have y and speech therapy as ician. The home health wide these services to patient et patient #1's needs in their					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	ULTIPLE CO JILDING	onstruction 00	(X3) DATE COMPL	
		157538	B. W	ING		01/19/	/2018
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	place of residence.						
N 0522 Bldg. 00	written medical pla	Medical care shall follow a an of care established and red by the physician,					
	dentist, chiropractor podiatrist, as follow Based on record rev	or, optometrist or ws: iew the skilled nurse failed to	N 0	522	N522. The Administrator		02/08/2018
	_	are establish by the physician arts reviewed. (#1, #2, #3, #6,			Director of Nursing (DON reviewed the Policy "3.9 Medical Supervision/Pation	ent	
	Medical Supervision " Policy ProCare furnished under the physician, based on established and peri physician to ensure services to the patie ensure the provision approved ProCare F Procedure ProCare furnished to patients supervision of a phy plan of care establis by the physician to of the services to the patient plan of care: physician in consult Health staff an inter Includes the followi of care Physician ir patient plan of care of care Any other a	e: ry dated 10/15/05 titled "3.9 n/Patient Plan Of Care" stated Home Health services are general supervision of a a plan of care that is odically reviewed by the appropriate application of the nt's condition. Purpose To of quality and legally Iome Health services. Home Health services are s: Under the general rsician Based on a patient hed and periodically reviewed the and periodically reviewed tensure appropriate application the patient's condition. The 1. Is developed by a ation with ProCare Home disciplinary team members. ng: Review of patient plan propriate items 2. Is written if made available to the			Plan of Care" for reeduca and clarification of procedures. The DON in-serviced the skilled state on following the Physician orders (including disciplin requested with frequencial performing only ordered tasks, providing instructions. e. caregiver/patient instructions on employing non-pharmacological pair relief modalities, filling the medication box, patient positioning and repositioning, etc. in accordance with the plan cares. Staff must notify the patient's physician of missivisits when they cannot be made up. To assure the physician	aff n's nes es), ons g n e	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	l í	ILDING	NSTRUCTION 00	(X3) DATE S COMPL 01/19/	ETED
	PROVIDER OR SUPPLIER		_	8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	written record by the agency based on the following Policy and Orders 3. Is incorprecord. 4. Is review in consultation with interdisciplinary tea as the severity of the at least every 60 days care are documented plans of modification or ally, are reduced thome Health Regist countersigned by the aspossible, following Telephone orders, Market Market Supervising RN [regist a physician refers a care that cannot be evaluation visit, the approve any addition original plan of care members promptly changes that suggest plan of care" 2. Clinical record restart of care 12/19/1 - 2/16/18, evidenced "Home Health Certificated 1/10/18 and sevice document had an area Discipline and Trea Amount/Frequency. [skilled nurse] Frequency.	e attending physician as soon ng Policy and Procedure re: Medical orders and Patient care n vital signs, other significant eters and events must be ly through the hierarchy to gistered nurse] or physician If patient under a patient plan of completed until after an physician is consulted to ns or modifications in the e. ProCare Home Health staff inform the physician of t a need to alter the patient eview on 1/19/18 of patient #1, 7, certification period 12/19/17 d an agency document titled ification And Plan Of Care" igned by the physician. This ea subtitled "21. Orders for			orders and plan of cares being followed, the DON clinical designee will revie all progress notes weekly part of the weekly quality assurance process to enscompliance. The DON will be respons for ensuring that this deficiency does not recur	or ew as sure ible	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SU COMPLET 01/19/20	ED
	RE HOME HEALTH		8300 B	ADDRESS, CITY, STATE, ZIP COD BROADWAY STREET STE ILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETION DATE
	Exhibits considerable home; Requires the up and move safely unassisted; SN to innonpharmacologic relaxation technique positioning, and hot physician if patient than 5, pain medica unable to tolerate prability to perform prassess if the Caregiunderstanding of the mediation. Physical submit plan of treat Caregiver to contact or without minor in resulting in serious or immobility." The failed to be followed evidenced by: a. Clinical receividenced an agence [licensed vocational practical nurse] Visual electronically signed document had an arthat indicated patient 109 mg/dl [milligrate performed by the skilled checks on patient # follow the plan of control of the skilled checks	pain relief measures, including es, massage, stretching, t/cold packs. SN to report to experiences pain level greater tions not effective, patient ain medications, pain affecting atient's normal activities. SN to ver can verbalize an e indication for each 1 therapist to evaluate and ment. SN to instruct the t agency to report any fall with jury and to call 911 for fall injury or causing severe pain e physician signed plan of care d by the skilled nurse as ord review on 1/19/18 y document titled "LVN I nurse]/LPN [licensed it" dated 12/27/17 and d by employee E. This ea subtitled "Diabetic Care" int #1's a.m. blood sugar was m/deciliter] that the check was cilled nurse on the patient's left an signed plan of care did not nurse to perform blood sugar 1. The skilled nurse failed to				
	evidence the skilled	nurse instructed the patient cic pain relief measures,				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300	FADDRESS, CITY, STATE, ZIP BROADWAY STREET S RILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION (X5) SHOULD BE COMPLETION EAPPROPRIATE DATE
	stretching, position to assess if the Care understanding of the medication, and fail contact the agency without minor injur resulting is serious or immobility as displan of care. 3. Clinical record restart of care 11/25/1-1/23/18, evidences "Home Health Certe dated 12/11/17 and document had an are Discipline and Treat Amount/Frequency: 1W10 Homebound Status: taxing effort to leave leave home unassisted uto medical restrements. SN to assessing the serious wisit. SN to assessing the serious serious serious to depreparing correctly. Caregiver to fall with or without fall resulting in serious pain or immobility. The physician signed refused Physical The The physician signed to medical resulting in serious and frequency refused Physical The The physician signed to the serious serious serious and frequency refused Physical The The physician signed to the serious serious serious and frequency refused Physical The The physician signed to the serious s	Duration)" that stated "SN conce weekly for 10 weeks]. Exhibits considerable & e home; Unable to safely ted; Unable to leave home viction(s); SN to instruct in turning/repositioning every 2 is skin for breakdown every instruct on seizure disorder and appropriate actions during			
	10110 Wed by the skil	ica naise as evidenced by.		1	

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	OF CORRECTION	IDENTIFICATION NUMBER 157538	A. BUILDING B. WING	00	COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2# LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	patient #2 evidenced 12/31/17 - 1/6/18. I at 3:23 p.m. employ couldn't see the patirequested. There we visit time was arrangenotified for the missifailed to follow the b. Record revisit time was arranged in the constant of the correct dose round determine if the skilled nurse fasigned plan of care. c. Record revision failed to evidence the caregiver on turning on the skilled nurse 12/14/17, 12/28/17 physician signed plan determined in the skilled nurse 12/14/17, 12/28/17 physician signed plan determined in the skilled nurse 12/14/17, 12/28/17 physician signed plan determined in the skilled nurse 12/14/17, 12/28/17 physician signed plan determined in the skilled nurse 12/14/17, 12/28/17 physician signed plan determined in the skilled nurse 12/14/17, 12/28/17 physician signed plan determined in the skilled nurse 12/14/17, 1	eview on 1/19/18 of patient #3, 7, certification period 12/28/17 d an agency document titled ification And Plan Of Care" igned by the physician. This ea subtitled "21. Orders for			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		r í	UILDING	nstruction <u>00</u>	(X3) DATE COMPI 01/19	LETED	
	PROVIDER OR SUPPLIE		•	8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F: LLVILLE, IN 46410	. 2A	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	ON O BE	COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
		weeks], 1W5 [once a week for 5					
		ne health aide] Frequency:					
	-	bound Status: Exhibits					
		ing effort to leave home;					
		ance of another to get up and					
	move safely; Unab	ole to safely leave home					
	unassisted; SN to a	assess pain eve and					
	effectiveness of pai	in medications and current pain					
	management therap	by every visit. SN to instruct					
	patient on nonphar	macologic pain relief					
	measures, including	g relaxation techniques,					
massage, stretching, positioning, and hot/cold							
	packs. SN to instruct the Patient on methods to						
	reduce friction and shear. SN to perform/instruct						
	on wound care as follows: clean with NaCl						
	-	apply Medihoney cover with					
		sess skin for breakdown every					
		nue wound care when					
		led. SN to assess patient for					
	_	N to instruct patient to wear					
		nen ambulating. SN to instruct					
		ribed assistive device when					
	_	instruct patient to change					
	1 ^	HHA to assist with ADL's					
	-	living] & IADL's [instrumental					
		iving] per HHA care plan. SN					
	^	ling medication box to tis preparing correctly. SN to					
		tient is able to identify the					
		and frequency of each					
		assess if the Patient can					
		standing of the indication for					
		Physical therapist to evaluate					
		treatment." The physician					
		failed to be followed as					
	evidenced by:						
	a. Clinical rec	cord review on 1/19/18 for					
	patient #3 evidence	ed the skilled nurse had an extra					
	visit during the wee	ek of 1/7/18 - 1/13/18. No extra					

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	OF CORRECTION	IDENTIFICATION NUMBER 157538	A. BUILDING B. WING	00 00	COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAU	visit order was evide and no prn [as needed plan of care. During 1:55 p.m. employee to write an order for #3. The skilled number physician signed plate a physician order for b. Clinical recepatient #3 failed to do instruct the patient or relief measures on the 1/2/18 and 1/5/18 assigned plan of care. c. Clinical recepatient #3 failed to do instructed the patient when ambulating, in prescribed assistive assessed the patient determine if the patient determined if the patient determi	enced in the clinical record ed] visits were ordered on the g an interview on 1/19/18 at C indicated he/she would have the extra visit made to patient se failed to follow the an of care and failed to obtain	IAG		DATE
	start of care 1/9/18, 3/9/18 evidenced a of Certification And Phad an area subtitled and Treatments (Speamount/Frequency/	eview on 1/19/18 for patient #6, certification period 1/9/18 - document titled "Home Health lan Of Care". This document d "21. Orders for Discipline ecify (Duration)" that stated "SN s. PT Frequency: 6 visits. OT			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/19/2018					
		ROVIDER OR SUPPLIER E HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410						
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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)	ΓE	(X5) COMPLETION DATE		
		Status: Exhibits colleave home; Require get up and move sathome unassisted; Umedical restriction [below knee amputa and effectiveness of pain management the instruct patient to tabecomes severe to a SN to instruct patient relief measures, incomassage, stretching packs. SN to report experiences pain lemedications not effet tolerate pain mediate perform patient's not Patient/Caregiver of hours. SN to instruct the Patient/prominences. SN to care as follows: SN area with wound clear Alginate to wound and tape 3XW [3 times for breakdown every Patient/Caregiver of infection to report to increased temp > 10 drainage, foul odor, significant changes, care when wound(s) wound for S&S [significations. SN insulin as follows:	py]: 3 visits. Homebound insiderable & taxing effort to res the assistance of another to fely; Unable to safely leave Unable to leave home due to si); Other: Bilateral BKA ation]; SN to assess pain level of pain medications and current increase every visit. SN to take pain medication before pain inchieve better pain control. In the on nonpharmacologic pain ludding relaxation techniques, in positioning, and hot/cold it to physician if patient evel greater than 5, pain elective, patient unable to this, pain affecting ability to formal activities. SN to instruct in turning/repositioning every 2 et the Patient/Caregiver on friction and shear. SN to Caregiver to pad all bony to perform/instruct on wound to cleanse wound to sacral eanser and apply Silver bed and packed with gauze mes weekly]. SN to assess skin y visit. SN to instruct the in signs/symptoms of wound to physician, to include 100.5, chills, increase in redness, pain and any other and the prefill syringes with Levemir 10 units to be taken Q [every] atient to have incontinence							

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
	cream applied after skin breakdown. Sl on 2GM [gram] Nadiabetic association Caregiver is able to route, and frequency assess if the Caregiver understanding of the medication. SN to administering inject if proper technique Caregiver on precaumedications, such a anticoagulants/antip therapist to evaluate Occupational therapism of treatment. If Occupational therapism of the Patient/Caregiver any fall with or with 911 for fall resulting severe pain or immediated to follow the evidenced by: a. Record review evidenced the skilled patient/caregiver to instruct the patient/of wound infection include increased ted drainage, foul odor, significant changes, on 2GM Na+ ADA is able to identify the frequency of each in caregiver can verbal indication for each caregiver administer.	each diaper change to prevent N to instruct Patient/Caregiver + [sodium] ADA [American] diet. SN to determine if the identify the correct dose, y of each medication. SN to wer can verbalize an e indication for each assess the Caregiver table medications to determine is utilized. SN to instruct the attions for high risk							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/19/2018				
		ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410						
	(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION		
	TAG	the caregiver on premedications, such a anticoagulants/antipinstruct the patient/creport any fall with call 911 for fall resucausing severe pain the plan of care for 1/11/18 and 1/12/18 6. Clinical record restart of care 2/22/20 12/13/17 - 2/10/18, "Home Health Care Care", electronically physician AA on 12 section titled "Section t	platelets, narcotics and to caregiver to contact agency to or without minor injury and to alting in serious injury or or immobility as ordered on the skilled nurse visits dated 3. eview on 1/19/18 for patient #7, 016, certification period evidenced a document titled evidenced a document titled evidenced and dated by 0.2/27/18. This document had a on 21. Orders for Discipline that stated "HHA [Home ency: 2W1 [twice a week for aree times a week for 8 weeks]. nesdays 4hrs [hours]/visit;		TAG	DEFICIENCY)		DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(x3) date survey completed 01/19/2018	
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD BROADWAY STREET STE F2/ ILLVILLE, IN 46410	A
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
	to complete the visi				
	"ProCare Home He electronically signe 12/27/2017, evidend 12:00 p.m. Time Ou to present documen	document dated 12/27/17, titled alth ServicesHHA Visit", d and dated by employee B on ced the following: "Time In at: 02:00 p.m." The agency failed tation showing that the home ed the 4 hour visit as ordered.			
	d. An agency documented dated 1/2/2018, titled "ProCare Home Health Services HHA Visit", electronically signed and dated by employee B on 1/2/2018. The agency failed to present documentation indicating physician orders for home health aide to complete the visit on a Tuesday. e. An agency document dated 1/10/2018, titled "ProCare Home Health ServicesHHA Visit", electronically signed and dated by employee B on 1/10/2018, evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered. f. An agency document dated 1/15/2018, titled "ProCare Home Health ServicesHHA Visit", electronically signed and dated by employee B on 1/15/2018, evidenced the following: "Time In 12:00 p.m. Time Out: 02:00 p.m." The agency failed to present documentation showing that the home health aide completed the 4 hour visit as ordered.				
N 0524	410 IAC 17-13-1(a	a)(1)			
Bldg. 00	plan of care shall:	(1) As follows, the medical			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DA			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		157538	B. W	ING		01/19	/2018
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	R			ROADWAY STREET STE F2A		
PROCA	RE HOME HEALTH	SERVICES			LLVILLE, IN 46410		
INOUAI		SERVICES		IVILIXIXI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	home health ager	ncy staff.					
	1 1 1	rvices to be provided if a					
	skilled service is I	peing provided.					
	(B) Cover all per	tinent diagnoses.					
	(C) Include the fo	ollowing:					
	(i) Mental statu						
	(ii) Types of se	rvices and equipment					
	required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted.						
	(viii) Nutritional re						
	` '	s and treatments.					
		measures to protect					
	against injury.						
	1 ' '	s for timely discharge or					
	referral.						
	1	dalities specifying length of					
	treatment.						
	(xiii) Any other ap		1	504	NEOT TO A L C C C		02/00/2010
		view the home health agency	NU	524	N524. The Administrator		02/08/2018
		medical plan of care contained oses, durable medical			Director of Nursing (DON	1)	
		replete and accurate medication			reviewed the Policy "3.9		
		of 7 clinical charts reviewed.			Medical Supervision/Pati	ent	
	(#4, #6)	or 7 chinical charts reviewed.			Plan of Care" for reeduca		
	("7, "0)				and clarification of		
	The findings include	le:					
	The imanigo metac	···			procedures. The DON		
	1. The agency poli	cy dated 10/15/05 titled "3.9			in-serviced the skilled sta		
	Medical Supervision/Patient Plan Of Care" stated " Policy ProCare Home Health services are furnished under the general supervision of a physician, based on a plan of care that is established and periodically reviewed by the physician to ensure appropriate application of the				on following the Physicia	n's	
					orders (including discipling	nes	
					requested with frequenci		
					performing only ordered	/,	
					1 '		
					tasks, providing instruction	אונ	
		ent's condition. Purpose To			i.e. caregiver/patient		
		n of quality and legally			instructions on employing	3	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	ľ í	JILDING	instruction 00	(X3) DATE COMPL 01/19/	ETED
	PROVIDER OR SUPPLIER		•	8300 BF	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
	Procedure ProCare furnished to patient supervision of a phyplan of care establishy the physician to of the services to the patient plan of care physician in consult Health staff an intermediate includes the follow care is written Typeservices and equipmediagnosis Patient in functional limitation potential Type of in Patient medication activities permitted Rehabilitation and the aide services Medinecessary Any safe against patient injurpatient discharge or plan of care Physic of patient plan of care Any of written by the physic of patient plan of care Any of written by the physic proCare Home Health written record by the agency based on the following Policy and Orders 3. Is incorprecord. 4. Is review in consultation with interdisciplinary teal as the severity of the at least every 60 day care are documenter plans of modification.	Home Health services. Home Health services are so Under the general sysician Based on a patient shed and periodically reviewed ensure appropriate application e patient's condition. The station with ProCare Home disciplinary team members. In growth and the patient plan of the of ProCare Home Health and trequired Patient ental status ental ental ental status ental			non-pharmacological pair relief modalities, filling the medication box, patient positioning and repositioning, etc. in accordance with the plan care. Staff to notify the patient's physician of mis visits when they cannot be made up. To assure the physician orders and plan of cares being followed, the DON clinical designee will revie all progress notes weekly part of the weekly quality assurance process to enscompliance. The DON will be respons for ensuring that this deficiency does not recur	of sed e are or ew as sure	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP C ROADWAY STREET ST LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) IOULD BE PPROPRIATE COMPLETION DATE
	as possible, followin Telephone orders, Marchanges in out of range parameter reported immediate supervising RN [regal physician refers a care that cannot be evaluation visit, the approve any addition original plan of care members promptly changes that suggest plan of care" 2. The agency policy plan of care members promptly changes that suggest plan of care" 2. The agency policy patient Record Conshall maintain a cliry which is initiated at record shall contain medical, nursing, so information. The princluding but not limphysical assessment height, weight, system information Sports prescribed and signed in Medication profit effects, and side effects, and side effects, and side effects over-the-counter drugs. Record review of evidenced a pharmation [antibiotic] 650 mg Q24 [every 24 hour plans and plans and plans are plans as a proper serious plans and plans are plans and plans are plans and plans are plans as a plans are plans and plans are plans are plans and plans are plans are plans and plans are plans and plans are plans are plans are plans and plans are plans are plans are plans are plans and plans are plans ar	e attending physician as soon ng Policy and Procedure re: Medical orders and Patient care n vital signs, other significant sters and events must be ly through the hierarchy to gistered nurse] or physician If patient under a patient plan of completed until after an physician is consulted to ns or modifications in the representation of t a need to alter the patient by dated 10/15/05 titled "4.13 tents" stated " The agency stical record for each patient, the time of the first visit. The pertinent past and current social, and other therapeutic attent's chart shall contain data mited to: A complete stincluding: vital signs, tems review, and other relevant tecific written orders as ed by the attending physician le including action, allergies, tects or prescribed and			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE				
1.40	4. Clinical record r start of care 1/9/18, 3/9/18 evidenced ar "Physician Face To 1/12/18 and signed document stated " diagnosis, or condit home healthcare for failure on Dialysis amputation] Due to disease] And Ischer [illegible writing] G related to the neede help c [with] Home management] PT/G 5. Clinical record r primary diagnosis of evidenced an agence Health Certification date and electronica This document had 10-CM Other Perti "Complete traum lev [level] betw [be [ankle], r [right] low traum amp at lev be subs Dysphagia Anemia, unspecifie region, stage 4 without complication document failed to which the patient rea week. The agency of all the patient's p 6. Clinical record r evidenced an agency Health Certification.	eview on 1/19/18 for patient #6, certification period 1/9/18 - n agency document titled Face Encounter" signed by the physician. This The primary medical reason, ion related to the reason for reference the encounter was: Renal B [bilateral] BKA [below knee PAD [peripheral arterial mia Sacral Wound gait Other Conditions/Diagnoses d home care: Wound Care Dialysis Med mgt [medication							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		157538	B. WI	NG		01/19/	/2018
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					ROADWAY STREET STE F2A		
PROCAF	RE HOME HEALTH	SERVICES		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		rea subtitled "14. DME					
		quipment and Supplies" that					
	_	d, Wheelchair, hoyer lift, alcohol pads, Chux/Underpads,					
		Dressing Supplies, Gauze Pads,					
		vers, Sharps Container,					
		sterile gloves, Silver Alginate					
		er". The home health agency					
	failed to list the type of home hemodialysis						
	machine and dialysate fluids the patient had in the						
	home. The plan of care failed to contain all the						
	DME's and supplies the patient utilized.						
	7. Observation at a	home visit on 1/19/18 at 10:30					
		start of care 1/9/18, certification					
	1 ~	18 evidenced patient's home					
		her kitchen table. Comparison					
		nedications against ProCare's					
		liation evidenced the following					
	medication discrepa	ancies:					
	a Patient #6 l	nome prescription bottle					
		ne [for blood pressure] 0.1 mg					
		on the three times a day. ProCare					
	' ' ' '	liation indicated: Clonidine 0.1					
	mg oral tablet 1 tab	daily by mouth (PO). The					
	frequency on the ag						
	reconciliation was a	not congruent with patient's					
	home prescription.						
	, ,	250000					
		2 [supplement] 50,000 IU					
		1 capsule by mouth every					
	week for 12 weeks. This prescription was ordered						
	on 1/17/18 and had not been updated on the						
	agency medication reconciliation.						
	c. Potassium Cl [Chloride] [supplement] micro 10 MEQ [milliequivalents] ER [extended						
	_	tablet by mouth daily. This					
	medication failed to	be on the agency's medication					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/19/2018			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F24 MERRILLVILLE, IN 46410			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	reconciliation.						
	mouth daily. This p	on supplement] take 1 tablet by orescription was ordered been updated on the agency iation.					
	e. Patient #6 over-the-counter medication: Acetaminophen 500 mg as needed for pain. ProCare medication reconciliation indicated: Acetaminophen 160 mg oral tablet 1 tab q 6 hours by mouth (PO). The dosage of the medication in the patient's home was not congruent with the dosage on the agency's medication reconciliation. f. Levemir [insulin] 10 units subcutaneously at bedtime, caregiver indicated he/she administers at 9:00 p.m. every night. This medication failed to be on the agency's medication reconciliation.						
	agency's medication medication in the pa	ng medication was on the n reconciliation but was not a atient's home medications: enadryl and Hydrocodone.					
	8. During an interview on 1/19/18 at 1:18 p.m. the clinical supervisor indicated he/she recorded the patient's medications from discharge paperwork received from another medical facility.						
N 0537	410 IAC 17-14-1(a	•					
Bldg. 00	Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on record review the skilled nurse failed to N 0537 N537 The Administrator and		and	02/08/2019			
	follow the plan of c	arts reviewed. (#1, #2, #3, #6)	N 0	35/	N537. The Administrator Director of Nursing (DON reviewed the Policy "3.9		02/08/2018

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157538	B. W	NG _		01/19/	2018
				STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ROADWAY STREET STE F2A		
DDOCAE	RE HOME HEALTH	SEDVICES			LLVILLE, IN 46410		
TROUAN	CETIONIE TIEAETTI			MILIXIXII			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Medical Supervision/Patie	ent	
	The findings includ	e:			Plan of Care" for reeduca	tion	
					and clarification of		
		cy dated 10/15/05 titled "3.9			procedures. The DON		
	-	n/Patient Plan Of Care" stated			•		
	-	e Home Health services are			in-serviced the skilled sta		
	furnished under the general supervision of a				on following the Physiciar	า'ร	
	physician, based on a plan of care that is				orders (including disciplin	es	
	established and periodically reviewed by the				requested with frequencie	es), l	
physician to ensure appropriate application of the					performing only ordered	,	
services to the patient's condition. Purpose To ensure the provision of quality and legally					tasks, providing instruction	ns	
approved ProCare Home Health services.							
Procedure ProCare Home Health services are				i.e. caregiver/patient			
		s: Under the general			instructions on employing		
	_	ysician Based on a patient			non-pharmacological pair	ו	
		shed and periodically reviewed			relief modalities, filling the	9	
	-	ensure appropriate application			medication box, patient		
		e patient's condition. The			positioning and		
		1. Is developed by a			repositioning, etc. in		
		tation with ProCare Home			l '	ot	
		rdisciplinary team members.			accordance with the plan	01	
		ing: Review of patient plan			care. Staff to notify the		
		nitial documenting review of			patient's physician of mis	sed	
		Date of review of patient plan			visits when they cannot b	e	
	of care Any other a	appropriate items 2. Is written			made up.		
	by the physician and	d made available to the			To assure the physician		
	ProCare Home Hea	Ith agency or is prepared as a			orders and plan of cares	are	
		e ProCare Home Health			being followed, the DON		
		e physicians verbal orders					
		d Procedures re: Telephone			clinical designee will revie		
		porated into the patient clinical			all progress notes weekly	as	
		wed by the attending physician			part of the weekly quality		
		the home health staff and			assurance process to ens	sure	
	interdisciplinary team members at such intervals as the severity of the patient illness requires, but at least every 60 days. Changes in the plan of				compliance.		
					The DON will be respons	ihla	
					·		
		d through written and signed			to ensure that this deficie	ncy	
	-	ons or, if changes are requested			does not recur.		
orally, are reduced to writing, signed by a ProCare							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018			
		ROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		Home Health Regis countersigned by the as possible, following Telephone orders, Manages in out of range paramereported immediates supervising RN [regates a physician refers a care that cannot be evaluation visit, the approve any addition original plan of care members promptly changes that suggest plan of care" 2. Clinical record restart of care 12/19/1 - 2/16/18, evidenced "Home Health Certificated 1/10/18 and stated 1/10/18 and stated 1/10/18 and stated 1/10/18 and Treated Tr	tered Nurse, and e attending physician as soon and Policy and Procedure re: Medical orders and Patient care in vital signs, other significant exters and events must be by through the hierarchy to gistered nurse] or physician If patient under a patient plan of completed until after an physician is consulted to ans or modifications in the c. ProCare Home Health staff inform the physician of t a need to alter the patient eview on 1/19/18 of patient #1, 7, certification period 12/19/17 d an agency document titled iffication And Plan Of Care" igned by the physician. This ea subtitled "21. Orders for truents (Specify (Duration)" that stated "SN uency: 1W9 [once a week for 9 al therapy] Frequency: 2W4 [2 weeks]. Homebound Status: le & taxing effort to leave assistance of another to get (Unable to safely leave home enstruct patient on pain relief measures, including es, massage, stretching, c/cold packs. SN to report to experiences pain level greater tions not effective, patient ain medications, pain affecting atient's normal activities. SN to				

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		157538	B. W	ING		01/19/	/2018	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	ROVIDER OR SUPPLIER	R			ROADWAY STREET STE F2A			
PROCAR	RE HOME HEALTH	SERVICES			LLVILLE, IN 46410			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCE)		DATE	
	-	e indication for each						
	mediation. Physical therapist to evaluate and submit plan of treatment. SN to instruct the							
	Caregiver to contact agency to report any fall with							
	-	jury and to call 911 for fall						
	· · · · · · · · · · · · · · · · · · ·	injury or causing severe pain						
	-	e physician signed plan of care						
	-	d by the skilled nurse as						
	evidenced by:							
	,							
	 a. Clinical rec 	ord review on 1/19/18						
	evidenced an agenc	y document titled "LVN						
	[licensed vocational	l nurse]/LPN [licensed						
	-	it" dated 12/27/17 and						
		d by employee E. This						
		rea subtitled "Diabetic Care"						
		nt #1's a.m. blood sugar was						
		m/deciliter] that the check was						
		cilled nurse on the patient's left						
		an signed plan of care did not						
		I nurse to perform blood sugar						
	_	1. The skilled nurse failed to						
	follow the plan of c	are.						
	h Decord ray	iew on 1/19/18 failed to						
		I nurse instructed the patient						
		gic pain relief measures,						
		techniques, massage,						
	- C	ing, and hot/cold packs, failed						
		egiver can verbalize an						
		e indication for each						
	_	led to instruct the caregiver to						
		to report any fall with or						
	without minor injury and to call 911 for fall							
	resulting is serious injury or causing severe pain							
	or immobility as directed on the physician signed							
	plan of care.							
		eview on 1/18/18 of patient #2,						
	start of care 11/25/1	17, certification period 11/25/17						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018	
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2 ILLVILLE, IN 46410	Α
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	- 1/23/18, evidence	d an agency document titled			
	"Home Health Cert	ification And Plan Of Care"			
		signed by the physician. This			
		ea subtitled "21. Orders for			
	Discipline and Trea				
		Duration)" that stated "SN			
		once weekly for 10 weeks].			
		Exhibits considerable &			
	-	e home; Unable to safely			
		ted; Unable to leave home			
		iction(s); SN to instruct n turning/repositioning every 2			
	_	skin for breakdown every			
		instruct on seizure disorder			
		and appropriate actions during			
	seizure activity. SN				
	-	contact agency to report any			
	_	minor injury and to call 911 for			
		ous injury or causing sever			
	_	SN to assess caregiver filling			
		etermine if caregiver is			
		SN to determine if the			
	Caregiver is able to	identify the correct dose,			
	route, and frequency	y of each medication. Patient			
	refused Physical Th	erapy services at this time."			
		ed plan of care failed to be			
	followed by the skil	led nurse as evidenced by:			
	a. Clinical rec	ord review on 1/18/18 for			
		d a missed visit the week of			
	_	During an interview on 1/18/18			
		ree C indicated the skilled nurse			
		ent at a certain time the family			
	_	as no evidence that another			
	_	ged or that the physician was			
		sed visit. The skilled nurse			
	failed to follow the	physician signed plan of care.			
	b. Record revi	ew on 1/18/18 for patient #2			
		ne nurse assess/instructed on			

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		A. BUILDING B. WING	COMPLETED 01/19/2018				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	appropriate actions assessed the caregive to determine if the cand determine if the the correct dose rou medication on skille 12/7/17, 12/14/17, 12 The skilled nurse fasigned plan of care.	ns and symptoms and during seizure activity, yer filling the medication box caregiver is preparing correctly, e caregiver is able to identify te, and frequency of each ed nurse visits dated 11/30/17, 12/22/17, 12/28/17 and 1/10/18. illed to follow the physician						
	caregiver on turning on the skilled nurse 12/14/17, 12/28/17 physician signed pla							
	start of care 12/28/1 - 2/25/18, evidenced "Home Health Cert dated 1/10/18 and s	eview on 1/19/18 of patient #3, 7, certification period 12/28/17 d an agency document titled iffication And Plan Of Care" igned by the physician. This ea subtitled "21. Orders for tments (Specify						
	Amount/Frequency. Frequency: 1W1 [c times a week for 4 v weeks]. HHA [hon 1W1, 2W4. Homel considerable & taxi Requires the assista move safely; Unab unassisted; SN to a effectiveness of pair	Duration)" that stated "SN once a week for 1 week], 2W4 [2 weeks], 1W5 [once a week for 5 ne health aide] Frequency: bound Status: Exhibits ng effort to leave home; nce of another to get up and le to safely leave home						
	patient on nonpharmeasures, including massage, stretching	macologic pain relief g relaxation techniques, , positioning, and hot/cold ct the Patient on methods to						

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		, ,	A. BUILDING 00 B. WING			COMPLETED 01/19/2018		
	PROVIDER OR SUPPLIER		83	00 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410			
(X4) ID PREFIX	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE	ID PREI	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION	
TAG	reduce friction and on wound care as for a solution in the sol	shear. SN to perform/instruct ollows: clean with NaCl pply Medihoney cover with ess skin for breakdown every nue wound care when ed. SN to assess patient for N to instruct patient to wear ten ambulating. SN to instruct ribed assistive device when instruct patient to change IHA to assist with ADL's iving] & IADL's [instrumental ving] per HHA care plan. SN ting medication box to it is preparing correctly. SN to tient is able to identify the and frequency of each assess if the Patient can tanding of the indication for thysical therapist to evaluate treatment." The physician failed to be followed as sord review on 1/19/18 for dependent of the skilled nurse had an extra extended in the clinical record end wists were ordered on the gan interview on 1/19/18 at the C indicated he/she would have refer the extra visit made to patient se failed to follow the an of care and failed to obtain or the extra visit. The physical therapist to evaluate the extra visit made to patient se failed to follow the an of care and failed to obtain or the extra visit.	TA	G	DEFICIENCY)		DATE	

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	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)				
TAG		s ordered on the physician	TAG	DETELLET	DATE			
	patient #3 failed to instructed the patient when ambulating, it prescribed assistive assessed the patient determine if the patient determined if the patient determined if the patient determined if the patient determined in the	ord review on 1/19/18 for evidence the skilled nurse at to wear proper footwear instructed the patient to use device when ambulating, filling medication box to ient was preparing correctly, attent is able to identify the and frequency of each essed if the patient can tanding of the indication for a the skilled nurse visits dated 18, 1/10/18 and 1/12/18 as sicician signed plan of care.						
	start of care 1/9/18, 3/9/18 evidenced a Certification And Phad an area subtitle and Treatments (Sp Amount/Frequency: 24visit [occupational thera Status: Exhibits coleave home; Requiget up and move sa home unassisted; Umedical restriction [below knee amputand effectiveness or pain management the instruct patient to tabecomes severe to a SN to instruct patie	eview on 1/19/18 for patient #6, certification period 1/9/18 - document titled "Home Health lan Of Care". This document d "21. Orders for Discipline ecify /Duration)" that stated "SN s. PT Frequency: 6 visits. OT py]: 3 visits. Homebound insiderable & taxing effort to res the assistance of another to fely; Unable to safely leave Unable to leave home due to ss); Other: Bilateral BKA ation]; SN to assess pain level of pain medications and current interapy every visit. SN to take pain mediation before pain archieve better pain control. Int on nonpharmacologic pain luding relaxation techniques,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538			JILDING	instruction 00	(X3) DATE (COMPL 01/19/	ETED			
		ROVIDER OR SUPPLIER E HOME HEALTH		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE	
	IAU	massage, stretching packs. SN to report experiences pain lever medications not effect tolerate pain mediate perform patient's not patient/Caregiver or hours. SN to instruct the Patient/Caregiver or instruct the Patient/prominences. SN to care as follows: SN area with wound clear Alginate to wound the and tape 3XW [3 times for breakdown ever Patient/Caregiver or infection to report to increased temp > 10 drainage, foul odor, significant changes care when wound(s) wound for S&S [signifection, healing stream applied after skin breakdown. SN insulin as follows: HS [at bedtime]. Pater skin breakdown. SN on 2GM [gram] Natiabetic association Caregiver is able to route, and frequency assess if the Caregiver understanding of the medication. SN to administering injection assessing the caregiver is administering injection.	p, positioning, and hot/cold to physician if patient wel greater than 5, pain ective, patient unable to promal activities. SN to instruct in turning/repositioning every 2 et the Patient/Caregiver on criction and shear. SN to Caregiver to pad all bony perform/instruct on wound to cleanse wound to sacral canser and apply Silver ped and packed with gauze mes weekly]. SN to assess skin y visit. SN to instruct the in signs/symptoms of wound to physician, to include 20.5, chills, increase in redness, pain and any other. May discontinue wound have healed. SN to assess gas and symptoms] of atus, wound deterioration, and to prefill syringes with Levemir 10 units to be taken Q [every] atient to have incontinence each diaper change to prevent N to instruct Patient/Caregiver + [sodium] ADA [American] diet. SN to determine if the identify the correct dose, y of each medication. SN to ver can verbalize an e indication for each assess the Caregiver table medications to determine is utilized. SN to instruct the ations for high risk		IAU			DATE	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 01/19/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE	
	therapist to evaluate Occupational therapplan of treatment. I Occupational therapplan of treatment and the Patient/Caregive any fall with or with 911 for fall resulting severe pain or immediated to follow the evidenced by: a. Record review evidenced the skilled patient/caregiver to instruct the patient/of wound infection include increased to drainage, foul odor, significant changes on 2GM Na+ ADA is able to identify the frequency of each incaregiver can verbal indication for each caregiver administed determine if proper the caregiver on premedications, such a anticoagulants/antipinstruct the patient/report any fall with call 911 for fall resucausing severe pain	olatelets, narcotics and to caregiver to contact agency to or without minor injury and to alting in serious injury or or immobility as ordered on the skilled nurse visits dated						
N 0541 Bldg. 00	410 IAC 17-14-1(a Scope of Services Rule 14 Sec. 1(a)							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157538	B. W	NG		01/19	/2018
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ROADWAY STREET STE F2A		
PROCAF	RE HOME HEALTH	SERVICES		MERRILLVILLE, IN 46410			
(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 APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		ed to therapy only, for					
	purposes of practice in the home health						
		ered nurse shall do the					
	following:	valvata the nationale number					
	(B) Regularly ree	valuate the patient's nursing					
		view the home health agency	N 0	5.4.1	NEW The Allies		01/22/2018
		atient's therapy needs in 1 of 7	IN U	341	N541. The Administrator		01/22/2018
	clinical charts revie	1.5			Director of Nursing (DON	,	
	cimical charts levic	(n1)			reviewed the policies "3.1		
	The findings include	le:			Referral and Acceptance	of	
	8			Patients" for reeducation		and	
	1. The agency policy dated 10/15/05 titled "3.1				clarification of the		
	Referral and Acceptance Of Patients" stated "				procedures. The need to		
	-	have procedures for the receipt,			'	~	
	processing, and eva	aluation of persons referred for			meet the medical, nursing	J,	
	service. Only quali	ified staff may take referral			rehabilitation and social		
	information. A log	of all persons referred for			needs of the patient was		
		ntained. Persons rejected will			emphasized. The DON w	rill	
		n the reason for rejection.			review all new referrals to)	
		atside of the service area or in			ensure that the agency c	an	
		t provided by the Agency will			provide the requested	-	
		ecting the appropriate			services directly or by		
	_	eceipt of a referral, an			1		
		gistered Nurse of Physical			contract. The DON will		
		only cases) will be made to care can adequately and safely			contact the patient's		
		nome, to assess the patient care			physician when the agen	су	
	1	e that the patient meets the			cannot meet the patient's	;	
		Patients will be evaluated by a			needs and arrange for the	е	
		e staff member within 24 - 48			patient to be transferred		
		discharge from a facility			another agency.		
		Patients will be assigned to			To assure that this deficient	ancv	
		f members by a registered				ысу	
		supervision of the registered			is corrected, the DON or		
		geographical location, clinical			Assistant Director of Nurs	_	
	needs of the patient	t, and the qualifications and			(ADON) will review all ne		
	availability of staff				referrals to ensure that th	e	
					agency can provide the		
	2. The agency poli	cy dated 10/19/06 titled "9.4			requested services direct	ly	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 01/19/2018			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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)	ΓE	(X5) COMPLETION DATE	
	Therapy Services" werbal order and the faxed to the Agency services. A copy of will be submitted a director] order. The contact the agency services and verbal The Nursing Superverbal order and retained the patient within 4 Nursing will be not evaluation other that After the assessment the Case Manager/I communicate the fit Therapist will submit Home Health within Home Health Services will see problems, contact to Supervisor immedicate the patient receiving a compational therapy schedule early sch	stated " A copy of the e Therapy Referral Form will be y/Therapist providing therapy of the Therapy Referral Form long with the M.D. [medical e Nursing Supervisor will Therapist providing therapy by inform them of the referral. Wisor will fax a copy of the ferral. The Therapist will visit 8-72 hours. The Director of iffed if the family requested an unthe above stated time frame. In the Therapist will Contact DON [director of nursing] to indings and plan. The initial assessment to ProCare in 24-48 hrs [hours]. ProCare in 24-48 hrs [hours]. ProCare in ces will submit the submitted to the physician for signature. Serive a copy of the patient inch Monday. If there are the Director of Nurses/Clinical ately. A case conference for ing PT [physical therapy], OT py], and ST [speech therapy] inducted at least every thirty the assigned Case Manager and aide] (if applicable) will be in conference will be scheduled if each patient. The Physical int directly to the Director of			or by contract. The Administrator and DO will be responsible to ensithat this deficiency does recur.	ure		
	start of care 12/19/3 - 2/16/18, evidence "Patient Profile" the required for patient	eview on 1/19/18 for patient #1, 17, certification period 12/19//17 d an agency document titled at indicated the services #1 was PT [physical therapy], nerapy] and ST [speech						

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STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157538	B. W	ING		01/19/	2018
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ROADWAY STREET STE F2A		l
PROCAR	RE HOME HEALTH	SERVICES			LVILLE, IN 46410		
TROUAN	L HOWL HEALTH			IVILIXIXIL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	173	was evidenced as being					
	provided to patient	#1 by the home health agency.					
		eview on 1/19/18 for patient #1					
		spital paperwork dated 1/16/18					
	this paperwork had						
	^	e Letter" that stated "Per Dr.					
	#AA, have PT/OT/S						
		area was addressed to Procare					
	_	care]. There was no evidence					
	of OT or ST ever be	eing provided.					
	4 Clinian 1	i 1/10/10 f					
		eview on 1/19/18 for patient #1					
		y document titled "OASIS-C2" dated 12/19/17 and					
		d by employee C. This					
		rea subtitled "Functional					
		id an "x" noted by endurance,					
		, incontinence and ambulation.					
	_	t listed multiple areas that					
		for OT and ST services as					
	follows:	ioi or and sr services as					
		document titled "OASIS-C2					
		' had an area subtitled Oasis					
		peech and Oral (Verbal)					
		uage (in patient's own					
		the code "03" placed in a box.					
		- Has severe difficulty					
		eas; requires maximal					
		ng by listener. Limited to					
	single words/short						
	b. The agency	document titled "OASIS-C2					
		' had an area subtitled					
	"(M1740) Cognitive	e, behavioral, and psychiatric					
		demonstrated at least once a					
	week (Reported or	Observed): (Mark all that					
		marked by "2 - Impaired					
		ailure to perform usual (I)ADLs					
	[activities of daily l	iving], inability to					

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		A. BUILE B. WING		00	COMPL 01/19/	ETED
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD COADWAY STREET STE F2A		
PROCAR	RE HOME HEALTH	SERVICES	N	1ERRIL	LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRI	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		Ë	(X5) COMPLETION DATE
	appropriately stop a through actions".						
	START OF CARE' "(M1810) Current as including undergard front-opening shirts zippers/buttons/snapplaced in box. Code must help the patient clothing." An area Ability to Dress Lowithout dressing aid slacks, socks or nyloof "03" placed in both Patient depends entidress lower body." Bathing: Current all safely. Excludes gray washing hands, and a code of "05" placed - Unable to use the in bathing self in be with assistance or start of CARE' "(M1870) Feeding of the control	and blouses, managing ps." that had a code of "02" e "02" stated "2 - Someone at put on upper body subtitled "(M1820) Current wer Body safely (with or ds) including undergarments, ons, shoes." that had a code ox. Code "03" stated "3 - irely upon another person to An area subtitled "(M1830) bility to wash entire body coming (washing face, shampooing hair)." that had ed in box. Code "05" stated "5 shower/tub, able to participate ed/sink/bedside chair/commode					
	refers only to the pr swallowing, not pre that had a code of "to stated "1 - Able to f	ocess of eating, chewing, and paring the food to be eaten." 01" placed in box. Code "01" eed self but requires meal ont assistance/supervision, or a					
	START OF CARE"	document titled "OASIS-C2 ' had an area subtitled Ability to Plan and Prepare					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/C		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	ETED	
		157538	B. W	ING	_	01/19/	/2018	
NAME OF B	DOLUBED OD GUDDU IER			STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIEF	C		8300 B	ROADWAY STREET STE F2A			
PROCAR	RE HOME HEALTH	SERVICES		MERRI	LLVILLE, IN 46410			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE	
		ereal, sandwich) or reheat ely:" that had a code of "02"						
		-						
	placed in box. Code "02" stated "2 - Unable to prepare any light meals or reheat any delivered meals." f. The agency document titled "OASIS-C2"							
		' had an area subtitled						
		Use Telephone: Current						
		e phone safely, including						
	-	nd effectively using the						
	telephone to communicate." that had a code of							
	"04" placed in box. Code "04" stated "4 - Unable to answer the telephone at all but can listen if							
	assisted with equip	ment."						
	Clinical record r	eview on 1/19/18 evidenced the						
	skilled nurse initial/	/comprehensive assessment						
	titled "OASIS-C2 S	START OF CARE" dated						
	12/19/17 and electro	onically signed by employee C.						
	This document asse	essment provided by employee						
		ed for the patient to have						
		y and speech therapy as						
		sician. The home health						
		ovide these services to patient						
		et patient #1's needs in their						
	place of residence.							
N 0545	410 IAC 17-14-1(a	a)(1)(F)						
	Scope of Services							
Bldg. 00		(1)(F) Except where						
		ed to therapy only, for						
		ice in the home health						
		ered nurse shall do the						
	following:							
	(F) Coordinate se							
		view, observation and	N 0	545	N545. The Administrator	and	02/08/2018	
		ered nurse failed to coordinate			Director of Nursing (DON	l)		
		alth care providers serving			reviewed the policy titled			
	their patients in 5 of	f 7 clinical records reviewed.	1]			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157538	B. W			01/19/	/2018
				·			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
550045		055) #050			ROADWAY STREET STE F2A		
PROCAF	RE HOME HEALTH	SERVICES		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	(#1, #2, #4, #5, #6)				"3.16 Case Conferences"	' for	
					clarification and reeducat		
	The findings includ	e:				.1011	
					on coordinating services		
	_	ency policy titled "3.16 Case			provided by all Healthcar	е	
		l "The purpose of case			Providers in the patient's		
		Determine the adequacy of the			home. All field staff were		
		nd appropriateness of			in-serviced by the DON o	n	
		e Assure coordination of			2/8/18 on the importance		
	services in patient-goal directed activity on the				identifying all Healthcare		
	part of each home care staff member Evaluate				providers; types, disciplin	.00	
	patient progress and plans for future care Provide				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	16 5	
	assistance to team members having difficulty				with frequencies and		
	planning care for specific problem cases Refer				documenting and		
	_	orther study to the clinical			coordinating services with	า	
		mittee Case conferences shall			them.		
		review problem cases and to			The DON or clinical		
	_	reatment for appropriateness ontinued services. Such			designee will review all		
	_	e documented separately or in					
		and should be held on each			progress notes weekly to		
		of admission; prior to the date			ensure compliance with		
		nt is due for the review at least			Care Coordination. Also,		
	•	prior to discharge. However, if			during the monthly case		
		case-specific conference would			conference meetings,		
	_	rofessional disciplines			Coordination of Care will	he	
	_	patient's care should have			emphasized.	~0	
		nference. For personnel			· •	داما:	
	_	patient's care but unable to			The DON will be respons		
		ce, a telephone conference			to ensure that this deficie	ncy	
		d. Documentation of the			does not recur.		
	conference shall be	the responsibility of the					
	primary nurse or su	pervisor, or other professional					
	as instructed by the						
		l include a summary of					
	progress, assessmen	nt of the need for continued					
		harge goals All staff					
	delivering patient c	are services is encouraged to					
	have at least weekly	y contact with their Case					
	manager and as nee	ded. Any conference related					

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	OF CORRECTION	IDENTIFICATION NUMBER 157538	A. BUILDING B. WING	00	COMPLETED 01/19/2018
	ROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2/ LLVILLE, IN 46410	4
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) COMPLETION DATE
		ent may be documented as a			
	evidenced an agency START OF CARE" electronically signed document had an arr Care" that stated " Regarding: Homen The registered nurse documentation that care with agency #2 1/19/18 at 1:35 p.m. that they are not doc care. The administreverything is going down. 3. Clinical record revidenced an agency START OF CARE" electronically signed document had an arr Care" that stated " health aide] services failed to indicate whome health aide seany coordination of registered nurse fail agency that provide health aide. 4. Clinical record refailed to evidence and the patient's primary document titled "Hoplan Of Care" dated signed by employee	eview on 1/19/18 for patient #1 y document titled "OASIS-C2 that was dated 12/19/17 and d by employee C. This ea subtitled "Coordination of Name: [agency #26] naker Services 9 Hours/Week". e failed to provide any evidenced coordination of the administrator indicated cumenting coordination of rator also indicated that if ok they don't write anything eview on 1/18/18 for patient #2 y document titled "OASIS-C2 dated 11/25/17 and d by employee C. This ea subtitled "Coordination of Regarding: HHA [home s 5 days/week. This document nat agency was providing rvices and failed to evidence care with other agency. The ed to coordinate care with the d their patient with a home eview on 1/19/18 for patient #4 ny coordination of care with y care physician. The agency ome Health Certification And 11/30/17 and electronically e L indicated the patient's an #BB, which was a			
	·		I	Î	l

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538 A. BUILDING B. WING			COMPL 01/19/	ETED			
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD COADWAY STREET STE F2A		
PROCAR	RE HOME HEALTH	SERVICES			LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	III PRE TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION DATE
TAG	hospitalist affiliated physician only pracadmitted patients. Identify the patient's identify the patient's 5. Clinical record start of care 7/23/17 1/18/18, evidenced Health Care Certific electronically signe with no physician stantare a subtitled "2 Treatment (Specify Amount/Frequency Coordination of Care [Home Health Aide [Skilled Nursing] for failed to provide an show coordination of care agencies that p During an interview employee C indicated agency #26 because that agency that the with both agencies a problems but I'm not documented." During employee G stated assign different continue in reference to the result of the coordination of the coordination of the coordination of the coordination of the care agencies that pour interview employee C indicated agency #26 because that agency that the with both agencies agency #26 because that agency that the with agencies of the coordination of the coordination of the care agency agency agency agency agency agency agency in the coordination of the care agency agen	with agency #29. This tices inside the facility with The registered nurse failed to sprimary physician. review on 1/17/18 for patient #5, 7, certification period 11/20/17 - a document titled "Home cation And Plan Of Care", d by employee C and undated, ignature. This document had 1. Orders for Discipline and 2. Orders with agency #26 (HHA agency #27 (SN or wound care)". The agency y clinical documentation to 1. Orders for their patient. The view of the patient likes are there is a home health aide at patient really likes. We speak and there have been no of sure if that has been not sure if the patient if t	TA	.G	DEFICIENCY)		DATE
	dialysis type is "Ho	t was on dialysis, that the me dialysis Permacath and a "Patient receives home					

State Form Event ID: NT6X12 Facility ID: 003042 If continuation sheet Page 111 of 129

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018	
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP C ROADWAY STREET ST ILLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION	
N 0546	dialysis daily with I visit on 1/19/18 obs dialysis machine in an interview with pa a.m. the patient indi Monday - Friday fro Patient #6 was unay provided the in-hon interview with the f he/she indicated he/company name. Ob on patient #6 dining on the label; upon a services they provide indicated they offer aide hours and that employing agency # the clinical supervisional 1/19/18 at 1:42 p.m. indicated that their scoordination because every day. During the supervisor indicated name of the compan home hemodialysis.	Dialysis nurse". During a home ervation was made of a home the patient's bedroom. During atient #6 on 1/19/18 at 10:50 cated he/she received dialysis om a home dialysis nurse. Ware of the company that he dialysis. During an family member on 1/19/18, she was not aware of the eservation was made of a folder groom table with agency #30 sking the family member what led for patient #6 he/she ed the patient free home health they were considering #30. During an interview with cor and administrator on the clinical supervisor should probably be the he/she gets home dialysis the interview the clinical I he/she did not remember the my that provided the patient. The registered nurse failed to a the home hemodialysis at #6.				
Bldg. 00	Scope of Services Rule 14 Sec. 1(a) services are limite purposes of practi setting, the registe following: (G) Inform the phi appropriate medic the patient's condi the patient and far	(1)(G) Except where d to therapy only, for ce in the home health ered nurse shall do the				

State Form Event ID: NT6X12 Facility ID: 003042 If continuation sheet Page 112 of 129

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			LETED	
		157538	B. W	NG		01/19	/2018
		l .		CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ROADWAY STREET STE F2A		
PROCAF	RE HOME HEALTH	SERVICES			LLVILLE, IN 46410		
	1	22.11.020			T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
	nursing personne	pervise and teach other					
		view and interview the skilled	N 0	516	N546. The Administrator	and	02/08/2018
	nurse failed to ensure the physician was notified		IN U	340			02/08/2018
	for vital signs outside of parameters in 1 of 7				Director of Nursing (DON	1)	
	clinical charts reviewed. (#2)				reviewed the Policy "3.9		
	(*2)				Medical Supervision/Pati	ent	
	The findings include:				Plan of Care" for reeduca	ation	
					and clarification of		
	1. The agency policy dated 10/15/05 titled "3.9				procedures. The DON		
	Medical Supervision/Patient Plan Of Care" stated				in-serviced the skilled sta	ıff	
	"Policy ProCare Home Health services are				on following the Physicia		
	furnished under the general supervision of a				orders (including discipling		
	physician, based on a plan of care that is						
	_	iodically reviewed by the			requested with frequencie	es),	
		appropriate application of the ent's condition. Purpose To			performing only ordered		
		n of quality and legally			tasks, providing instruction	ns	
	_	Home Health services.			i.e. caregiver/patient		
		Home Health services are			instructions on employing)	
	furnished to patient	s: Under the general			non-pharmacological pair	n	
	supervision of a ph	ysician Based on a patient			relief modalities, filling the	е	
	_	shed and periodically reviewed			medication box, patient		
		ensure appropriate application			positioning and		
		e patient's condition			repositioning, etc. in		
		gns, or other significant out of			accordance with the plan	of	
		nd events must be reported the hierarchy to supervision			care. Staff to notify the	Oi	
	RN [registered nurs				_	a a d	
		OF PATIENT SERVICES FOR			patient's physician of mis		
		STANDARD PARAMETERS			visits when they cannot b	e	
		S ON CARE PLAN SPECIFIC			made up.		
	TO PATIENT: BL	OOD PRESSURE - SYSTOLIC			The DON or clinical		
	READING ->160	DIASTOLIC READING - <60			designee will review all		
	HEART RATE ->	100 OR <60 TEMPERATURE -			progress notes weekly as	3	
	>100 OR <96 RESPIRATIONS->22 OR <12 PAIN				part of the weekly quality		
	LEVELS GREATER THAN PAIN THRESHOLD				assurance process to en		
	ON CARE PLAN CLINICAL STAFF TO				compliance.	- 3. 0	
		RMAL VITALS BEFORE			· ·	iblo	
	LEAVING PATIE	NT'S HOME SN to report the	1		The DON will be respons	ible	

State Form Event ID: NT6X12 Facility ID: 003042 If continuation sheet Page 113 of 129

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIP A. BUILDIN B. WING		onstruction 00	(X3) DATE COMPI 01/19/	LETED
	PROVIDER OR SUPPLIER		83	00 BF	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Range reported by the checked at visit to M MUST DOCUMEN ALL SIGNIFICAN' PATIENT'S PHYSI DISEASE PROCES OTHER SIGNS AN 2. Clinical record restart of care 11/25/1 - 1/23/18, principle hypertension, evidentitled "LVN [licensed practical reflectronically signed document had an arrindicated the patient a sitting position of its outside of paramed documentation or in was notified of the extra the skilled nursipressure. During an p.m. the clinical supwould write down the nurse at the visit. As supervisor indicated indicated to her that he/she couldn't under the co	eview on 1/18/18 for patient #2, 7, certification period 11/25/17 diagnosis essential need an agency document ed vocational nurse/LPN nurse] Visit" dated 1/10/18 and d by employee J. This ea subtitled "Vital Signs" that is had a blood pressure while in 182/85. This blood pressure			to ensure that this deficie does not recur.	ency	
N 0547		established parameters.					
	410 IAC 17-14-1(a Scope of Services						
Bldg. 00	services are limite purposes of practi	(1)(H) Except where d to therapy only, for ce in the home health red nurse shall do the					

State Form Event ID: NT6X12 Facility ID: 003042 If continuation sheet Page 114 of 129

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		157538	B. WI	ING		01/19/	/2018
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ROADWAY STREET STE F2A		
PROCAE	RE HOME HEALTH	SERVICES			LLVILLE, IN 46410		
11100/11	T. TOWE TIE/LETT			WILIKIKI	1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		arry out physician,					
	chiropractor, podi						
	1 '	s (oral and written).	1	5 4 7	NEAT TI D. (02/00/2010
		view the skilled nurse failed to	N 0	547	N547. The Director of		02/08/2018
		are establish by the physician arts reviewed. (#1, #2, #3, #6)			Nursing (DON) reviewed	the	
	in 4 or / clinical ch	arts reviewed. (#1, #2, #3, #6)			Policy "3.9 Medical		
	The findings includ	۵.			Supervision/Patient Plan	of	
	The imanigs metad	С.			Care" for reeducation and		
	1. The agency policy dated 10/15/05 titled "3.9				clarification of procedures	S.	
	Medical Supervision/Patient Plan Of Care" stated				The DON in-serviced the		
	" Policy ProCare Home Health services are				skilled staffs on adhering	to	
	furnished under the general supervision of a				the Plan of Care; no		
	physician, based on a plan of care that is				intervention should be		
		iodically reviewed by the					
		appropriate application of the		carried without the			
	_	ent's condition. Purpose To		Physician's orders. Orders			
	_	n of quality and legally		must be obtained for missed			
		Home Health services. Home Health services are			visits and all instructions	to	
		s: Under the general			patients/caregivers must	be	
		ysician Based on a patient			given in accordance to the		
		shed and periodically reviewed			1 ~		
	_	ensure appropriate application			treatment plan.		
		e patient's condition. The			The DON or clinical		
		: 1. Is developed by a			designee will review the		
		tation with ProCare Home			clinical notes weekly to		
		rdisciplinary team members.			ensure the orders and		
		ing: Review of patient plan			treatment plans are being	a c	
	of care Physician in	nitial documenting review of			followed. Also 10% of clir	-	
	patient plan of care	Date of review of patient plan			records will be selected a		
	of care Any other a	appropriate items 2. Is written				ariu	
		d made available to the			reviewed quarterly for		
		lth agency or is prepared as a			evidence that physician's		
		e ProCare Home Health			orders are being followed	1.	
	agency based on the physicians verbal orders				The DON will be respons	ible	
	following Policy and Procedures re: Telephone				to ensure that this deficie	ency	
		porated into the patient clinical			does not recur.	,	
		wed by the attending physician					
	in consultation with	the home health staff and			1		İ

State Form Event ID: NT6X12 Facility ID: 003042 If continuation sheet Page 115 of 129

PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 157538	A. BUILDING B. WING	00	COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 BI	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	as the severity of the at least every 60 day care are documented plans of modification orally, are reduced to the Home Health Regist countersigned by the as possible, followin Telephone orders, Market Mark	e attending physician as soon ng Policy and Procedure re: Medical orders and Patient care n vital signs, other significant ters and events must be y through the hierarchy to histered nurse] or physician If patient under a patient plan of completed until after an physician is consulted to his or modifications in the higher ProCare Home Health staff inform the physician of that a need to alter the patient eview on 1/19/18 of patient #1, 7, certification period 12/19/17 If an agency document titled fication And Plan Of Care" gned by the physician. This has a subtitled "21. Orders for tements (Specify Duration)" that stated "SN hency: 1W9 [once a week for 9 had therapy] Frequency: 2W4 [2 higher veeks]. Homebound Status: he & taxing effort to leave hassistance of another to get has a subtiled to safely leave home			

State Form Event ID: NT6X12 Facility ID: 003042 If continuation sheet Page 116 of 129

PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157538	B. W	ING	_	01/19/	/2018
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ROADWAY STREET STE F2A		
PROCAF	RE HOME HEALTH	SERVICES		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		t/cold packs. SN to report to					
	1 ^ -	experiences pain level greater					
	than 5, pain medications not effective, patient unable to tolerate pain medications, pain affecting						
	*						
	ability to perform patient's normal activities. SN to assess if the Caregiver can verbalize an						
	understanding of the indication for each						
	mediation. Physical therapist to evaluate and						
	submit plan of treatment. SN to instruct the						
	Caregiver to contact agency to report any fall with						
	_	jury and to call 911 for fall					
	resulting in serious injury or causing severe pain						
	or immobility." The physician signed plan of care						
	failed to be followed by the skilled nurse as						
	evidenced by:						
	a						
		cord review on 1/19/18					
	_	y document titled "LVN					
	_	l nurse]/LPN [licensed					
	_	sit" dated 12/27/17 and					
	1	d by employee E. This rea subtitled "Diabetic Care"					
		nt #1's a.m. blood sugar was					
		m/deciliter] that the check was					
		killed nurse on the patient's left					
		an signed plan of care did not					
		I nurse to perform blood sugar					
		The skilled nurse failed to					
	follow the plan of c						
	•						
	b. Record rev	iew on 1/19/18 failed to					
	evidence the skilled	I nurse instructed the patient					
		gic pain relief measures,					
	_	n techniques, massage,					
		ing, and hot/cold packs, failed					
		egiver can verbalize an					
	_	e indication for each					
		led to instruct the caregiver to					
		to report any fall with or					
	without minor injur	y and to call 911 for fall					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTII A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE COMPL 01/19/	ETED
	PROVIDER OR SUPPLIER		83	00 BR	DDRESS, CITY, STATE, ZIP COD COADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAU	resulting is serious	injury or causing severe pain rected on the physician signed	IA	d			DATE
	start of care 11/25/: - 1/23/18, evidence "Home Health Cert dated 12/11/17 and document had an ar Discipline and Trea Amount/Frequency Frequency: 1W10 Homebound Status taxing effort to leave leave home unassis due to medical restr Patient/Caregiver of hours. SN to assess visit. SN to assess/ signs & symptoms seizure activity. SN Patient/Caregiver to fall with or without fall resulting in seri pain or immobility, mediation box to do preparing correctly Caregiver is able to route, and frequence refused Physical Th The physician signe followed by the ski a. Clinical rec patient #2 evidence 12/31/17 - 1/6/18, at 3:23 p.m. employ couldn't see the pat	/Duration)" that stated "SN [once weekly for 10 weeks]. Exhibits considerable & re home; Unable to safely ted; Unable to leave home riction(s); SN to instruct in turning/repositioning every 2 instruct on seizure disorder and appropriate actions during					

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PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED B. WING 01/19/2018			
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD SROADWAY STREET STE F2A	
PROCAF	RE HOME HEALTH	SERVICES		ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	visit time was arran notified for the miss	ged or that the physician was sed visit. The skilled nurse physician signed plan of care.			
	failed to evidence the seizure disorder signappropriate actions assessed the careginate determine if the cand determine if the the correct dose round medication on skilled 12/7/17, 12/14	ew on 1/18/18 for patient #2 ne nurse assess/instructed on ns and symptoms and during seizure activity, ver filling the medication box caregiver is preparing correctly, e caregiver is able to identify te, and frequency of each ed nurse visits dated 11/30/17, 12/22/17, 12/28/17 and 1/10/18. iled to follow the physician			
	failed to evidence the caregiver on turning on the skilled nurse	ew on 1/18/18 for patient #2 ne nurse instructed the g/repositioning every 2 hours visits dated 11/30/17, 12/7/17, and 1/10/18 as ordered on the an of care.			
	start of care 12/28/1 - 2/25/18, evidenced "Home Health Certidated 1/10/18 and s document had an ar Discipline and Trea Amount/Frequency. Frequency: 1W1 [c times a week for 4 weeks]. HHA [hom 1W1, 2W4. Homel considerable & taxi Requires the assista	Duration)" that stated "SN once a week for 1 week], 2W4 [2 weeks], 1W5 [once a week for 5 ne health aide] Frequency: bound Status: Exhibits ong effort to leave home; once of another to get up and le to safely leave home			

State Form Event ID: NT6X12 Facility ID: 003042 If continuation sheet Page 119 of 129

PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 157538	A. BUILDING B. WING	00 00	COMPLETED 01/19/2018
	PROVIDER OR SUPPLIER		8300 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	effectiveness of pair management therapy patient on nonphari measures, including massage, stretching, packs. SN to instrureduce friction and son wound care as for [sodium chloride] at Allevyn. SN to assovisit. May disconting wound(s) have healed diet compliance. Store proper footwear who patient to use prescript ambulating. SN to a positions slowly. However, an edication if the Patrocrect dose, route, medication. SN to a verbalize an understeach medication. SN to a verbalize an understeach medication. Proper footwear who will be patient to a seed the plan of care evidenced by: a. Clinical recepation of care. During the week visit order was evidenced by: a. The skilled nurse to write an order for the skilled nurse to skilled nur	n medications and current pain by every visit. SN to instruct macologic pain relief relaxation techniques, a positioning, and hot/cold cet the Patient on methods to shear. SN to perform/instruct allows: clean with NaCl poply Medihoney cover with east skin for breakdown every mue wound care when ed. SN to assess patient for N to instruct patient to wear en ambulating. SN to instruct patient to change HA to assistive device when instruct patient to change HA care plan. SN to instruct patient to change in the ADL's fiving Per HHA care plan. SN to its preparing correctly. SN to its preparing correctly. SN to its preparing correctly. SN to its preparing correctly the and frequency of each assess if the Patient can anding of the indication for hysical therapist to evaluate reatment." The physician failed to be followed as			

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PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		A. BUIL B. WINC	DING	00	COMPL 01/19/	ETED	
NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES				300 BR	DDRESS, CITY, STATE, ZIP COD OADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	patient #3 failed to instruct the patient of relief measures on the 1/2/18 and 1/5/18 assigned plan of care. c. Clinical recepatient #3 failed to instructed the patient when ambulating, in prescribed assistive assessed the patient determine if the patient determine if the patient determined in the pati	ord review on 1/19/18 for evidence the skilled nurse to on nonpharmacologic pain he skilled nurse visits dated s ordered on the physician					
	start of care 1/9/18, 3/9/18 evidenced a Certification And P had an area subtitled and Treatments (Sp Amount/Frequency, Frequency: 24visits [occupational theral Status: Exhibits con- leave home; Requir- get up and move san home unassisted; U- medical restriction(eview on 1/19/18 for patient #6, certification period 1/9/18 - document titled "Home Health lan Of Care". This document d "21. Orders for Discipline ecify (Duration)" that stated "SN s. PT Frequency: 6 visits. OT by]: 3 visits. Homebound insiderable & taxing effort to res the assistance of another to fely; Unable to safely leave (Inable to leave home due to ss); Other: Bilateral BKA attion]; SN to assess pain level					

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PRINTED: 03/01/2018 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157538	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/19/2018
NAME OF F	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A	
PROCAF	RE HOME HEALTH	SERVICES		ILLVILLE, IN 46410	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		f pain medications and current			
		herapy every visit. SN to			
	•	ake pain mediation before pain			
		nchieve better pain control. nt on nonpharmacologic pain			
	_	luding relaxation techniques,			
		, positioning, and hot/cold			
		t to physician if patient			
		vel greater than 5, pain			
		ective, patient unable to			
		tions, pain affecting ability to			
	-	ormal activities. SN to instruct			
		n turning/repositioning every 2			
		ct the Patient/Caregiver on			
	methods to reduce f	friction and shear. SN to			
	instruct the Patient/	Caregiver to pad all bony			
	prominences. SN to	o perform/instruct on wound			
	care as follows: SN	to cleanse wound to sacral			
	area with wound cle	eanser and apply Silver			
	Alginate to wound l	bed and packed with gauze			
		mes weekly]. SN to assess skin			
		ry visit. SN to instruct the			
	_	n signs/symptoms of wound			
	-	o physician, to include			
	-	00.5, chills, increase in			
	-	redness, pain and any other			
		. May discontinue wound			
	· .) have healed. SN to assess gns and symptoms] of			
		tatus, wound deterioration, and			
		to prefill syringes with Levemir			
	-	10units to be taken Q [every]			
		atient to have incontinence			
		each diaper change to prevent			
	* *	N to instruct Patient/Caregiver			
		+ [sodium] ADA [American			
		diet. SN to determine if the			
		identify the correct dose,			
	route, and frequency	y of each medication. SN to			
	assess if the Caregi	ver can verbalize an			
			1		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538			UILDING	nstruction 00	(X3) DATE COMPL 01/19/	ETED	
	PROVIDER OR SUPPLIER		•	8300 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET STE F2A LVILLE, IN 46410		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		TE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	understanding of th	e indication for each					
		assess the Caregiver					
		table medications to determine					
		is utilized. SN to instruct the					
	Caregiver on precar	_					
	medications, such a						
		platelets, narcotics. Physical					
	^	e and submit plan of treatment.					
		pist to evaluate and submit					
	_	Physical therapy to evaluate.					
		by to evaluate. SN to instruct					
	_	er to contact agency to report					
		hout minor injury and to call					
		g in serious injury or causing					
	_	obility." The skilled nurse					
		plan of care, this was					
	evidenced by:						
	a Decord ray	iew on 1/19/18 for patient #6					
		ed nurse failed to instruct the					
		pad all bony prominences,					
		caregiver on signs/symptoms					
	_	to report to physician, to					
		emp > 100.5, chills, increase in					
		, redness, pain and any other					
		, instruct the patient/caregiver					
		diet, determine if the caregiver					
		ne correct dose, route, and					
	-	nedication, assess if the					
	caregiver can verba	lize an understanding of the					
	indication for each	medication, assess the					
	caregiver administe	ering injectable medications to					
		technique was utilized, instruct					
	the caregiver on pro	ecautions for high risk					
	medications, such a						
	-	platelets, narcotics and to					
	_	caregiver to contact agency to					
		or without minor injury and to					
		ulting in serious injury or					
	causing severe pain	or immobility as ordered on					

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l í í		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	- 1	UILDING	00	COMPLETED		
157538			B. WING 01/19/2018					
NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES				STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROWING DEAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	, L	DATE	
	the plan of care for 1/11/18 and 1/12/18	the skilled nurse visits dated 8.						
N 0608	410 IAC 17-15-1(a	a)(1-6)						
Bldg. 00	pertinent past and accordance with a standards shall be patient as follows: (1) The medical appropriate identif (2) Name of the chiropractor, podia (3) Drug, dietary orders. (4) Signed and contributed to by a Clinical notes shall is rendered and in (14) days. (5) Copies of superson responsible	ying information. physician, dentist, atrist, or optometrist. r, treatment, and activity dated clinical notes all assigned personnel. Il be written the day service corporated within fourteen mmary reports sent to the e for the medical						
	component of the patient's care. (6) A discharge summary. Based on record review, observation and interview the skilled nurse failed to ensure all the patient's medications were on the medication reconciliation during the comprehensive assessment in 2 of 6 clinical charts reviewed. (#4, #6) The findings include: 1. The agency policy dated 10/15/05 titled "4.13 Patient Record Contents" stated " The agency shall maintain a clinical record for each patient, which is initiated at the time of the first visit. The record shall contain pertinent past and current medical, nursing, social, and other therapeutic information. The patient's chart shall contain data		N 0	608	N608. The Director of Nursing (DON) reviewed policy titled "4.13 Patient Record Contents" for reeducation and clarificat of procedures. Medication reconciliation, review and profile update was completed for Clinical Record #4, on 01-23-18. Medication reconciliation review and profile update was completed for Patien	ion n I	01/22/2018	

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STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		157538	B. W	ING		01/19/20	018
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					ROADWAY STREET STE F2A		
PROCAF	RE HOME HEALTH	SERVICES		MERRI	LLVILLE, IN 46410		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION mited to: A complete		TAG	#6 on 01-23-18. The DOI	VI.	DATE
	· ·	t including: vital signs,					
	1	tems review, and other relevant			has provided education to		
		ecific written orders as			staff involved in providing	· I	
		ed by the attending physician			skilled care to the patient		
		ile including action, allergies,			referred to in Record #4 a	and	
		fects or prescribed and			patient #6. The DON		
	over-the-counter dr	ugs"			in-serviced the skilled sta	iff	
	2 Record review of	on 1/19/18 of clinical record #4			on performing a		
		acy order for Daptomycin			comprehensive review of	all	
		[milligrams] IV [intravenous]			medications the patient is	}	
		rs]. This medication failed to be			currently using to identify		
		y's plan of care or medication			adverse effects, drug		
	reconciliation.				reactions, ineffective drug	9	
	3 Observation at a	home visit on 1/19/18 at 10:30			therapy and non-complia	nce	
		start of care 1/9/18, certification			with drug therapy. Record	ding	
	_	18 evidenced patient's home			the patient's medications		
	medications on his/	her kitchen table. Comparison			from discharge paperwor	k	
	_	nedications against ProCare's			from another medical fac	ility	
		liation evidenced the following			as an alternative is		
	medication discrepa	ancies:			unacceptable.		
	a. Patient #6 l	nome prescription bottle			The DON or her clinical		
		ne [for blood pressure] 0.1 mg			designee will review all st	tart	
	[milligram] by mou	th three times a day. ProCare			of cares and recertification		
		liation indicated: Clonidine 0.1			documentation weekly to		
		daily by mouth (PO). The			ensure compliance. Also		
	frequency on the ag	gency's medication not congruent with patient's			10% of clinical records w	ill	
	home prescription.	not congruent with patients			be selected and reviewed		
	prooniphon.				quarterly for evidence that		
	b. Vitamin D2 [supplement] 50,000 IU				Medication reconciliation		
		1 capsule by mouth every			review and profile update		
		This prescription was ordered			being done.	. 13	
		not been updated on the			1	iblo	
	agency medication	reconciliation.			The DON will be respons		
	c Potassium (Cl [Chloride] [supplement]			to ensure that this deficie	псу	
	C. 1 Otassiulli (Ci [Cinoride] [supplement]			does not recur.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		ľ	UILDING	NSTRUCTION 00	(X3) DATE COMPL 01/19/	ETED		
NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	DIF CORRECTION (2) THOS SHOULD BE COMPI		
TAG	micro 10 MEQ [mil release] tabs take 1 medication failed to reconciliation. d. Niferex [iro mouth daily. This p 1/17/18 and had not medication reconcil e. Patient #6 of Acetaminophen 500 ProCare medication Acetaminophen 160 by mouth (PO). The patient's home with the patient's medication in th	RESCIDENTIFYING INFORMATION Iliequivalents] ER [extended tablet by mouth daily. This is to be on the agency's medication on supplement] take 1 tablet by prescription was ordered to been updated on the agency liation. Over-the-counter medication: Omg as needed for pain. Oreconciliation indicated: Omg oral tablet 1 tab q 6 hours be dosage of the medication in was not congruent with the cry's medication reconciliation. Sulin] 10 units subcutaneously be indicated he/she administers hight. This medication failed to medication reconciliation. In reconciliation was on the in reconciliation but was not a latient's home medications: Sign medication but was not a latient's home medications: Sign medicated he/she recorded the lating from discharge paperwork		TAG	DEFICIENCY)		DATE	
N 0610	received from anoth 410 IAC 17-15-1(a	·						
Bldg. 00	Clinical Records Rule 15 Sec. 1. (a legible, clear, com authenticated and	n)(7) All entries must be applete, and appropriately dated. Authentication atures or a secured						

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STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		157538	B. W	ING		01/19/20	18
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ROADWAY STREET STE F2A		
PROCAR	RE HOME HEALTH	SERVICES			LLVILLE, IN 46410		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE
		view and interview the home	N 0	610	N610. The Director of	0	01/22/2018
		d to ensure the clinical record			Nursing (DON) reviewed	the	
		elete, and appropriately			policy titled "4.13 Patient		
		ated with a physician			Record Contents" for		
		elinical records reviewed. (#4,				ion	
	#5)				reeducation and clarificat	ı	
	TEL (* 1; · · ·				of procedures. All clinical		
	The findings include	e:			records are now being		
	1 The agency police	cy dated 10/15/05 titled "4.13			reviewed weekly to make		
		tents" stated " The agency			sure that all entries are		
		nical record for each patient,			legible, clear, complete a	nd	
		the time of the first visit. The			authenticated and dated.		
		pertinent past and current			The DON or clinical		
		ocial, and other therapeutic					
	_	atient's chart shall contain data			designee will review all		
	_	mited to: Identifying date:			clinical records weekly as	;	
	-	of birth, sex, patient number			part of the weekly quality		
		nber), health insurance claim			assurance process to en	sure	
		ng physicians name, address,			compliance.		
		the status of the patient upon			The DON will be respons	ihla	
	discharge for the ho	ospital or institution (discharge			-		
	report), and the pati	ent's payment source such as			to ensure that this deficie	ncy	
	Medicare, Medicaid	d, Private Insurance, or Private			does not recur.		
	Pay A complete ph	ysical assessment including:					
		weight, systems review, and					
		mation. Primary diagnosis and					
	secondary diagnosis	s Homebound status, activity					
	-	tional limitations Specific					
		escribed and signed by the					
		Prognosis and length of time					
		jected to be needed An					
		ome environment including					
		pility of the patient to perform					
		ving Persons available in the					
	-	ist with care Medication					
		tion, allergies, effects, and side					
	_	and over-the-counter drugs					
		plan of care for all disciplines					
	providing services	Clinical and progress notes					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157538		A. BUILDING B. WING	G 00	COMPLETED 01/19/2018	
NAME OF F	PROVIDER OR SUPPLIER	1		EET ADDRESS, CITY, STATE, ZIP COD 0 BROADWAY STREET STE F2	A
PROCAF	RE HOME HEALTH	SERVICES	MEF	RRILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROP	E COMPLETION
	delivery, and incorp weekly [sic] A dis to the physician wit shall contain the par- emotional status on date of discharge, e met, and plans for f the discharge summals or retained in the				
	start of care 11/30/1 - 1/28/18, principal evidenced an agenc Health Certification 11/20/17 and electro This document faile physician. The hom obtain a physician s During an interview	eview on 1/19/18 for patient #4, 7, certification period 11/30/17 diagnosis bacterial infection, y document titled "Home And Plan Of Care" dated onically signed by employee L. ed to be signed by the e health agency failed to ignature for the plan of care. You 1/19/18 at 2:10 p.m. the indicated that they never got			
	start of care 7/23/17 1/18/18, evidenced Health Care Certific electronically signe electronic signature a date. On this same to ensure a physicia	eview on 1/17/18 for patient #5, 7, certification period 11/20/17 - a document titled "Home cation and Plan of Care", d by employee C. The of employee C did not include e document, the agency failed in signature and date. During 9/18 at 2:17 p.m., employee C			
	evidenced a docume Certification and Pl evidenced a start of	eview on 1/17/18 for patient #5, ent titled "Home Health Care an of Care". This document care date of 07/23/2017 and ated by a physician. On a			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/19/2018				
NAME OF PROVIDER OR SUPPLIER PROCARE HOME HEALTH SERVICES			STREET ADDRESS, CITY, STATE, ZIP COD 8300 BROADWAY STREET STE F2A MERRILLVILLE, IN 46410				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	DATE
	to Face Encounter" evidenced a Start of agency document ti "Cert. [certification SOC [Start of Ca 11/21/2016". Dur 2:20 p.m., employed	sument titled "Physician Face signed and dated on 3/30/17, 5 Care of 11/23/2016. A third tled "Patient Profile" stated 1 Period: 11/23/2016 - 1/21/2017 re]: 11/23/2016 Referral Date ring an interview on 1/19/18 at the C stated "there must be a r because the start of care for 3/17".					

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