STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	LE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPL	ETED
		15K140	B. WING			04/24/	/2019
			CT)	DEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIE	R			MICHIGAN ROAD SUITE D		
COLDEN	I HEART HEALTH	SEDVICES II C			APOLIS, IN 46268		
GOLDEN	ITICANT HEALITI	SERVICES LLC	IIN	DIAIN	AFOLIS, IN 40200		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREF	ΊX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE
G 0000							
Bldg. 00							
			G 0000				
		a recertification survey of a					
	Medicaid home health agency. Three (3)						
		evestigated in conjunction with					
	the recertification survey. This survey was partial extended on 4-17-19, and at 2:35 the administrator						
	was so notified.						
	Complaint #s:	IN 00291961; substantiated with					
	findings.						
	DI 002/4502 - 1 - 4 - 4 - 1 - 14 - 5 - 1 - 1						
	IN 00264	4593; substantiated with findings					
	DI 00014	(270 1 4 4 4 1 1 1 6 1					
	IN 00216	6370; substantiated with findings					
	C 1 16	5 4 16 4 17 4 19 4 22 4 22 1					
	4-24-2019	5, 4-16, 4-17, 4-18, 4-22, 4-23, and					
	4-24-2019						
	Facility #: 013772	,					
	1 acm ty π. 015/72	•					
	Medicaid #: 15K1	40					
	Wiculcald #. 15K1	40					
	Undunlicated skille	ed admissions prior 12 months:					
	1	ed ddinissions prior 12 months.					
	1						
	Current census:						
	Skilled	8					
	Home Health	Aide only 30					
		-					
	Total	38					
	Home visits w	with record review 3					
	Clinical recor	d review only 7					

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

TITLE (X6) DATE

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

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CE: (TEROTO)	THE CONTENTS	III OLIVICES			312 1.31 0700 007
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15K140	B. WING		04/24/2019
			GER DES	ADDRESS SITE STATE STATES	
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD	
		SEDVICES II C		MICHIGAN ROAD SUITE D	
GULDEN	I HEART HEALTH S	SEKVICES LLC	INDIAN	IAPOLIS, IN 46268	
(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 APPROPRIAT	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Total clinical r	records reviewed 10			
G 0484					
Bldg. 00					
			G 0484	G 484	05/10/2019
	Based on record rev	view and interview, the agency		1.The administrator has	
		the existence of 3 complaints,		in-serviced the nursing staff on	
		2019, out of a total sample of 13		Client/family complaint/grievan	
		2017, 2018, and 2019, reviewed.		policy. A complaint is defined a	
	•			any expression of dissatisfaction	
	The findings includ	ed:		by a client/family regarding car	
				services that can be addressed	
	Review of a policy,	"Client/Family		the time by the staff present	
		ce Policy," administrator stated		grievance is any formal or info	
	-	ed 8-24-15, evidenced the		or verbal expression of	THUI
		omplaint is defined as 'any		dissatisfaction with care or ser	vice
		tisfaction by a client/family		that is expressed by the	VICC
	-	ervices that can be addressed			, l
		raff present A grievance is		client/family that is not solved a	٦١
	-	-		the time by the staff present	
		mal or verbal expression of care or service that is		Any complaint that fits the	
				grievance definition will require	a
		ient/family that is not solved at		written response to the person	
	-	f present Any complaint that		complaining All client	
		efinition will require a written		complaints will be documented	
		son complaining Client		a client complaint form and file	
	*	documented on a client		with the complaint logbook. All	
		filed with the complaint log in		grievances will be addressed	
		le Grievances will be		within 7 calendar days of recei	pt of
		7 calendar days of receipt a		the complaint.	
	-	ered resolved when the the			
		ith the actions taken on their		The administrator has in-service	
	behalf "			the nursing staff on incident re	port
				policy. An incident report is an	
		ent report/adverse event log,		expression of dissatisfaction, a	
	evidenced:			complaint form will be complete	ed
				along with the incident report.	
	An incident report,	dated 4-19-17, a patient made		Both incident and complaint for	rms
	an accusation their	home health aide (HHA),		will be completed and logged.	

05/28/2019 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/24/2019 15K140 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7770 N MICHIGAN ROAD SUITE D GOLDEN HEART HEALTH SERVICES LLC INDIANAPOLIS, IN 46268 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE former employee BB, was not following plan of care for the patient, asked for caregiver to sign 2.100% of all complaint/incident visit note without providing all the time forms and logs will be reviewed documented, and offered to pay one of the quarterly for evidence that a

caregivers to give the patient a shower. The accusation was not found credible as HHA was having a surgical procedure on the alleged date of having offered caregiver money to shower patient, HHA visit notes evidenced the HHA did not always work the assigned hours, and modified work hours to meet school obligations. The daughters of the patient, one of whom filed the complaint, contradicted each others' statements. A credible HHA adamantly denied the accusation and presented supporting documentation of surgery date. This incident report represented an expression of dissatisfaction, and per agency policy, required documentation as a complaint in the complaint log, to include a resolution which satisfied the patient.

An incident report, dated 3-15-18, a patient complained 2 pain medications (Norco) were missing from the bottle, and accused the HHA, former employee DD, of taking them. Document evidenced the patient requested the HHA not be assigned anymore. This incident report represented an expression of dissatisfaction, and per agency policy, required documentation as a complaint in the complaint log, to include a resolution which satisfied the patient.

An incident report, dated 3-19-18, patient complained pain medication (Tramadol) was missing, and accused former employee DD, an HHA, of taking them. The patient later admitted having dropped the bottle of Tramadol, spilling pills out of the bottle, and instructed the HHA to put the 6-7 spilled on floor pills in the trash. This incident report represented an expression of

written complaint form has been resolved within 7 days of receipt of the complaint.

3. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.

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	F CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 CO.  15K140 B. WING 04		COMPL	3) DATE SURVEY COMPLETED 04/24/2019			
	PROVIDER OR SUPPLIER			7770 N	ADDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D APOLIS, IN 46268		
(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
	dissatisfaction, and	per agency policy, required complaint in the complaint					
	reports were review the clinical manager incident reports had complaints, as well have been. When conformation, or door	AM, the above incident ed with the administrator and r. The administrator stated the not been documented as as incident reports, and should queried for further explanation, umentation, the administrator ag further to present for					
G 0572							
Bldg. 00	failed to sure the set according to the writer as required by agent and 10) of 10 patient reviewed.  The findings included.  1. Review of a polital administrator stated 8-24-15, evidenced services are furnished direction of the client develop a plan of caspecific identified in ability to make choit establishing and fol attain personal health shall be completed in the state of the services are furnished as a service of the client develop a plan of caspecific identified in ability to make choit establishing and fol attain personal health shall be completed in the service of the service	cy, "Plan of Care," last reviewed/revised on the policy stated, "Home care ed under the supervision and nt's physician Purpose to are individualized to meet eeds To reflect client's ces and actively participate in lowing the plan designated to th goals The Plan of Care in full to include: all	G 05	72	1. The director of nursing has in-serviced the nursing staff or Plan of Care policy. Home car services are furnished under the supervision and direction of the client's physician. The purpose develop a plan of care individualized to meet specific identified needs To reflect client's ability to make choices and actively participate in establishing and following the designated to attain personal health goals. The Plan of care shall be competed in full to incall pertinent diagnosis(es), typ frequency, and duration of all visits/services, medication treatments, and procedures.	n the e e e e to plan clude e, will	05/10/2019
		es) type, frequency, and s/services Medications,			be reviewed for evidence that plan of care is being followed		

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Event ID: 048M11 Facility ID: 013772

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l` í		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLE	
		15K140	B. W	ING		04/24/2	2019
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP COD	-	
					MICHIGAN ROAD SUITE D		
GOLDEN	I HEART HEALTH S	SERVICES LLC		INDIAN	APOLIS, IN 46268		
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		cedures all of the above be addressed on the Plan of			the patient is receiving the hou	ırs	
	Care "	be addressed on the Flan of			of care ordered.		
	Care				3.The Director of Nursing wi	ll he	
	2. Review of the cl	inical record of patient #3,			responsible for monitoring the		
		care date of 3-13-17, and			corrective actions to ensure th		
		care for the certification period			this deficiency is corrected and		
	-	with orders for home health aide			will not recur.		
	(HHA) services up	to 8 hours, 7 days a week.					
		sit notes evidenced the aide					
	made 2 visits the week of 3-24 to 3-30-19 (5 missed						
	visits); 6 visits the week of 3-31 to 4-6-19 (1 missed visit), and 5 visits the week of 4-7 to						
	4-13-19 (2 missed v						
	4-13-19 (2 IIIISSEU V	/ISItS.)					
	Review of a missed	visit note dated 4-11-19,					
		on for missed visit on 4-10-19,					
	was "staffing issues						
		inical record of patient #10,					
		care date of 8-4-16, and					
		care for the certification period					
		with orders for home health aide					
		ours a day, 5 days a week, to					
	-	care, ADLs (Activities of housekeeping as needed.					
	Dany Living), ngili	nousekeeping as needed.					
	Review of visit note	e 10-3-16, evidenced the HHA					
		care; 10-4-16, the HHA					
	provided 3 hours of	care; 10-5-16, the HHA					
	provided 4 hours of	care; 10-6, 4 hours of care;					
	10-7, hours of care	; 10-10, 5 hours of care; 10-11, 5					
	·	2, 5 hours of care; 10-13, 5					
	·	7, 5 hours of care; 10-18, 5					
	· · · · · · · · · · · · · · · · · · ·	9; 5 hours of care; 10-20, 4					
		4, 4 hours of care; 10-25, 4					
	· · · · · · · · · · · · · · · · · · ·	6, 4 hours of care; 10-27, 2					
	· ·	3, no care provided; 10-31, 5					
	hours of care; 11-1,	5 hours of care;11-2, 5 hours					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K140		(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG <u>00</u>	(X3) DATE SURVEY COMPLETED 04/24/2019	
	PROVIDER OR SUPPLIER		77	REET ADDRESS, CITY, STATE, ZIP COD 70 N MICHIGAN ROAD SUITE I DIANAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO THE APPR	D BE COMPLETION
	of care; 11-3, 5 hours of care; 11-9, 5 hours of care; 11-18 hours of care; 11-18 hours of care; 11-22 hours of care; 11-26 hours of care; 11-30 hours of care are; 11-30 hours of care ordered of the visits during of the visits during the verified staffing issufailure to provide care for further explanat	rs of care; 11-4, 4.75 hours of of care; 11-8, 2.5 hours of care; e; 11-10, 5 hours of care; 11-11, 14, 2 hours of care; 11-17, 3.5 g, 4 hours of care; 11-21, 0 g, 4.5 hours of care; 11-23, 3 g, 2 hours of care; 11-29, 4 g, 5 hours of care; 12-1-16, 0 g, 4 hours of care; 12-1-16, 0 g, 4 hours of care; 12-1-16, 0 g, 5 hours of care; 12-1-16, 0 g, 5 hours of care; 12-1-16, 0 g, 6 hours of care for any the certification period.  PM, the administrator verified g, had not received services as of care. The administrator uses was the cause of the are as ordered. When queried ion, information, or administrator stated having			
G 0574 Bldg. 00					
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	failed to ensure the frequency order of 27, and 9) of 10 paties duration of visits was required by agen and 10) of 10 patier plan of care identificated visits and hospitalizagency would imple (Patient #1) of 10 p.		G 0574	1.The Director of Nursin in-serviced all nursing state plan of care policy that it reduced all the pertinent diagnoses, the patient's many psychosocial, and cognitive status, type of services, so and equipment required, the frequency and duration of be made, prognosis, rehate potential, functional limitatical activities permitted, nutritical requirements, all medications treatments, safety measure protect against injury; a	ff on the must  nental, /e upplies, he visits to bilitation tions, onal ons and

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Event ID:

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED
		15K140	B. WI	NG		04/24/2019
NAME OF E	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	-
				-	MICHIGAN ROAD SUITE D	
GOLDEN	I HEART HEALTH S	SERVICES LLC		INDIAN	IAPOLIS, IN 46268	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	ì ·	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
		l last reviewed/revised on			description of the patient's risk	
		the policy stated, "Home care			emergency department visits a	and
		ed under the supervision and			hospital re-admission, and all	
		nt's physician Purpose to			necessary interventions to	
		are individualized to meet			address the underlying risk fac	ctors
	1 ^	needs The Plan of Care shall I to include: all pertinent			etc.	
		e, frequency, and duration of			The Director for Nursing has	
		Medications, treatments, and			in-serviced all nursing staff on	
		the above items must always			documentation of the plan of c	l l
	be addressed on the	<del>_</del>			frequency, duration of visits, to	l l
	be addressed on the	Train of Care			identify risk for emergency roc	
	2 Review of the cl	inical record of patient #1,			visits and hospitalization and	,,,,,
	evidenced a start of care date of 6-12-18, and				interventions the agency would	d
		care for the certification period			implement to reduce the risk of	
		th order for home health aide			emergency room visits or	,,,
		lay, 5 days a week, and 6 hours			hospitalization. The nursing st	aff
		The order failed to evidence			will discontinue documenting "	l l
		home health aide visits.			to" the number of hours and	
		multiple sclerosis, dementia,			ensure the duration of visits w	as
		ic kidney disease stage 3,			ordered on the plan of care "0"	
	_	an of care failed to evidence			hours cannot be documented.	
		and interventions the agency				
		o reduce the risk of emergency			2.Going forward, all charts w	vill
	room visits or hospi				be audited until 100% of chart	
					are compliant and then 10% w	<i>r</i> ill
	3. Review of the cl	inical record of patient #3,			be audited quarterly for evider	l l
	evidenced a start of	care date of 3-13-17, and			that the plan of care includes	
	contained a plan of	care for the certification period			duration for the ordered visits,	
	of 2-26 to 4-26-19,	with orders for home health aide			frequency not to include zero	(0)
	(HHA) services up	to 8 hours, 7 days a week. The			visits and the risk for emergen	icy
	order frequency inc	luded an order for zero (0)			room visits and hospitalization	IS.
	_	to" 8 hours included zero (0)				
	visits. The order al	so failed to evidence a			3.The Director of Nursing wi	ll be
	duration for the ord	ered visits.			responsible for monitoring the	se
					corrective actions to ensure th	at
	4. Review of the cl	inical record of patient #4,			this deficiency is corrected and	d
	evidenced a start of	care date of 10-18-17, and			will not recur.	
	contained a plan of	care for the certification period				
	of 2-10 to 4-10-19.	with orders for skilled nursing				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K140		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/24/2019		
	PROVIDER OR SUPPLIEN HEART HEALTH		7770 N	ADDRESS, CITY, STATE, ZIP COE I MICHIGAN ROAD SUITE NAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE COMPLETION
IAU	and home health at services were order and up to 5 hours; proder frequency in visits, because "up hours, included zer failed to evidence at the evidence at th	de (HHA) services. HHA red up to 4 hours, 1 day a week, per day, 1 day a week. The cluded an order for zero (0) to" 4 hours, or "up to" 5 ro (0) visits. The order also a duration for the ordered visits.  dinical record for patient #5, f care date of 7-9-16, and f care for the certification period with order for HHA up to 5 hours seek. The order frequency for zero (0) visits, because "up ed the frequency of zero (0)  dinical record for patient #6, f care date of 6-26-17, and f care for the certification period with order for HHA up to 3 es a week, and up to 4 hours a k. The order frequency for zero (0) visits, because "up to" 4 hours, included zero (0)			

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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 B. WING 04/24/2019 15K140 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7770 N MICHIGAN ROAD SUITE D GOLDEN HEART HEALTH SERVICES LLC INDIANAPOLIS, IN 46268 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE of 3-10-19 to 5-8-19, with order for home health aide services "up to 4 hours a day, 6 times a week, for 9 weeks." The order included a frequency of zero (0), because up the order of up to 4 hours, included 0, 1, 2, 3, and 4 hours. 9. Review of the clinical record of patient #10, evidenced a start of care date of 8-4-16, and contained a plan of care for the certification period of 10-3 to 12-1-16, with orders for home health aide (HHA) services 9 hours a day, 5 days a week. The plan of care order failed to evidence the duration of the home health aide visits. 10. On 4-23-19 at 3 PM, the administrator verified the above findings. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review. G 0580 Bldg. 00 G 0580 G580 05/13/2019 Based on record review and interview, the agency 1. The Director for Nursing has failed to ensure a verbal order for disciplines, in-serviced all nursing staff on the frequency of visits, duration of visits, and care Plan of Care policy that the home orders was obtained prior to furnishing services care services are furnished under for 7 ( Patients #1, 2, 4, 5, 6, 8, and 10) of 10 the supervision and direction of the patients who were retained on service more than client's physician. The plan of care 60 days. will be individualized to meet the specific identified needs and shall The findings included: be completed in full to include all pertinent diagnosis(es), type, Review of a policy, "Plan of Care," administrator frequency, and duration for all stated last reviewed/revised on 8-24-15, evidenced visits/services, medication, the policy stated, "Home care services are treatment and procedures. furnished under the supervision and direction of the client's physician ... Purpose ... to develop a The Director of Nursing has plan of care individualized to meet specific in-serviced all nursing staff on

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Event ID:

048M11

Facility ID: 013772

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15K140	B. W	ING		04/24	/2019
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			MICHIGAN ROAD SUITE D		
GOLDEN	I HEART HEALTH	SERVICES LLC	_		APOLIS, IN 46268		
(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	<u> </u>	TAG	DEFICIENCY)		DATE
		The Plan of Care shall be			Physician Orders policy that a	II	
		o include: all pertinent			medication, treatment, and		
		be, frequency, and duration of			services provided to clients m		
		Medications, treatments, and			be ordered by a physician. Wh		
	1 ~	the above items must always			the nurse receives a verbal or		
	be addressed on the	e Plan of Care "			from the physician, he/she sha		
	D. 1. C. 1.	HDI COLOR OF LOW H			write the order as given and th	nen	
		, "Physician Orders,"			read the order back to the		
		l last reviewed/revised on			physician verifying that the pe	rson	
		the policy stated, "All			receiving the order heard it		
		nents, and services provided to			correctly and interpreted the o		
	clients must be ordered by a physician When				correctly. The verbal order will		
	the nurse receives a verbal order from the				verify that the order was taken		
		hall write the order as given			verified by documenting this o		
		rder back to the physician			form and signing the form. The	9	
		erson receiving the order heard			order must include the date,		
	1	erpreted the order correctly.			specific order, be signed with		
		all verify that the order was			full name and title of the perso		
		by documenting this on the			receiving the order and be ser		
		ne form. The order must			the physician for signature. Or		
	_	ecific order, be signed with the			Recertification verbal orders for		
		of the person receiving the o the physician for signature			disciplines, frequency, duratio		
	order, and be sent to	o the physician for signature			visits, and care orders must be	9	
					completed.		
	Review of the phys	icians orders in the clinical			2.10% of all clinical records	will	
	record of patient #1	, failed to evidence a verbal			be audited quarterly for evider	nce	
		s, frequency, duration of visits,			that the plan of care includes a	all	
	and care orders at the	he time of recertification, on or			the pertinent diagnosis(es), ty	pe,	
	about 4-7-19. Revi	ew of home health aide (HHA)			frequency, and duration for all		
	visit notes, evidence	ed care visits were made on			visits/services and includes a		
	4-8, 4-9, 4-10, 4-11	, 4-12, and 4-13-19. The plan of			verbal order at the time of		
	care orders were sig	gned by the physician on			recertification.		
	4-15-19.						
					3.The Director of Nursing wi	ll be	
	Review of the phys	icians orders in the clinical			responsible for monitoring the	se	
	record of patient #2	, failed to evidence a verbal			corrective actions to ensure th	at	
	order for discipline	s, frequency, duration of visits,			this deficiency is corrected and	d	
	and care orders at the	he time of recertification, on or			will not recur.		
	about 12-29-18 Re	eview of home health aide	1				İ

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K140		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/24/2019	
	ROVIDER OR SUPPLIER		7770 N	ADDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D IAPOLIS, IN 46268	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION  evidenced care visits were	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	made on 1-4, 1-5, 1	evidenced care visits were -6, 1-11, 1-12-19. The plan of gned by the physician on			
	record of patient #4 order for disciplines and care orders at the about 2-6-19. Revivisit notes, evidence 2-10, 2-11, and 2-13	icians orders in the clinical, failed to evidence a verbal s, frequency, duration of visits, ne time of recertification, on or ew of home health aide (HHA) ed care visits were made on -19. The plan of care orders physician on 2-14-19.			
	record of patient #5 order for disciplines and care orders at tl about 3-4-19. Revi visit notes, evidence	icians orders in the clinical, failed to evidence a verbal s, frequency, duration of visits, ne time of recertification, on or ew of home health aide (HHA) ed care visits were made on 0. The plan of care orders were cian on 3-11-19.			
	record of patient #6 order for disciplines and care orders at the about 2-15-19. Rev visit notes, evidence 4-8, 4-9, 4-10, 4-11	icians orders in the clinical, failed to evidence a verbal s, frequency, duration of visits, ne time of recertification, on or view of home health aide (HHA) ed care visits were made on , 4-12, and 4-13-19. The plan of gned by the physician on			
	record of patient #8 order for disciplines and care orders at tl about 12-1-16, and aide (HHA) visit no	icians orders in the clinical, failed to evidence a verbal s, frequency, duration of visits, ne time of recertification, on or 2-1-17. Review of home health otes, evidenced a care visits 7. The plan of care orders were			

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	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION  PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00  B. WING				(X3) DATE SURVEY COMPLETED 04/24/2019		
	ROVIDER OR SUPPLIER		7	7770 N I	DDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D APOLIS, IN 46268		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	PR	ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	(X5) COMPLETION
TAG	signed by the physic	LISC IDENTIFYING INFORMATION cian on 2-10-19.		ΓAG	DEFICIENCY)		DATE
	record of patient #1 order for disciplines and care orders at the about 9-29-16. Revisit notes, evidence 10-3, 10-4, 10-5, 10. The plan of care order physician on 10-12-0. On 4-23-19, at 3 PM registered nurses have and a verbal order verbal verb	icians orders in the clinical 0, failed to evidence a verbal s, frequency, duration of visits, ne time of recertification, on or view of home health aide (HHA) ed care visits were made on 0-6, 10-7, 10-10, and 10-11-16. ders were signed by the 16.  M, the administrator verified the d not received authorization with disciplines, frequency and and care orders, at the the time or the above patients. The 1-the HHAs had provided ties of daily living and 1-ties of daily living for patients 10. When queried for further ation, or documentation, the 1-having nothing further to					
G 0706	<b>P</b> 333 7 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3						
Bldg. 00	registered nurse fail were continually as nurse visit in relatio #3) of 2 patients wi	view and interview, the led to ensure patient's needs sessed and documented in the on to reported fall for 1 (Patient th reported fall during the reviewed, of a total sample of led:	G 070	6	G706  1. The Director for Nursing had in-serviced all nursing staff on ongoing interdisciplinary assessment of the patient and follow-up documentation of fall Making sure that the patient's needs are continually assessed and documented on visit notes communications notes, physic orders. Any injury must be	the ls. d	05/14/2019
	Review of the clinic	cal record of patient #3,			assessed, and follow-up must	be	

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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 15K140 B. WING 04/24/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7770 N MICHIGAN ROAD SUITE D **GOLDEN HEART HEALTH SERVICES LLC** INDIANAPOLIS, IN 46268 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE evidenced a start of care date of 3-13-17, and completed and documented. contained a plan of care for the certification period of 4-27 to 6-25-18, with orders for with order for 2.10% of all clinical records will skilled nursing 1 time a week for medication be audited quarterly for evidence set-up, and home health aide (HHA) 7 times a that the nursing notes, week to assist with activities of daily living. communication notes, physician orders were properly documented, Review of a HHA visit note dated 5-20-18, including assessments and evidenced patient #3 "fell, I called the nurse." follow-up visits. Review of visit notes, communication notes, and 3. The Director of Nursing will be physician orders, failed to evidence the registered responsible for monitoring these nurse had assessed patient #3 for injury after the corrective actions to ensure that reported fall. this deficiency is corrected and will not recur. On 4-23-19 at 3 PM, the administrator verified the above findings. When queried for further explanation, information, or documentation, the administrator stated having nothing further to present for review. G 0768 Bldg. 00 G 0768 G768 05/17/2019 Based on record review and interview, the agency 1. The Director of Nursing will failed to ensure the home health aide in-service all nursing staff on establishment of skills competency included the competency evaluation to ensure taking of temperature, pulse, and respiration, for 1 the Home Health Aide skills (employee R) of 1 home health aide whose competency includes the taking of establishment of skills competency was reviewed, Temperature, Pulse, and of a total sample of 29 home health aides Respirations. Each skill must be employed. documented. The findings included: The Director of Nursing will ensure that all active Home Health Aides Review of the establishment of skills competency be competency evaluated/Skills for employee R, a home health aide with date of competency on Temperature, hire of 8-9-16, date of first patient contact of Pulse, and respirations. 8-22-16, failed to evidence the establishment of

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		15K140	B. W	NG		04/24/	2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				MICHIGAN ROAD SUITE D		
GOLDEN	HEART HEALTH S	SERVICES LLC			APOLIS, IN 46268		
(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'	ΤF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	competency to perfo	orm temperature, pulse, and			2.10% of all personnel record	ds	
	respiration.				will be audited quarterly for		
					evidence of proper documenta	ition	
	_	orther explanation, information,			of the competency evaluation		
		he administrator stated having			form. Each skill must be		
	nothing further to pr	resent for review.			documented.		
					3.The Director of Nursing wil	l be	
					responsible for monitoring thes	se	
					corrective actions to ensure th	at	
					this deficiency is corrected and	t	
					will not recur.		
G 0798							
0 0.00							
Bldg. 00							
			G 0	798	G798		05/15/2019
		view and interview, the			1.The Director of Nursing ha		
	_	ed to ensure the home health			in-service all nursing staff on the	ne	
	_	tained adequate code status			Home Health Aide Care Plan,		
		or the patient's rights			Home Health aide assignment	-	
		resuscitate) for 1 (Patient #3)			duties and proper documentati		
	-	e clinical record was reviewed			of patient code status to honor	the	
	for 1 (Patient #3) of	10 patients.			patient's rights regarding		
	Th. C. 1	. 1			resuscitate/do not resuscitate.		
	The findings include	ed.			The home health aide is assign	nea	
	Paviany of a policy	"Home Health Aide Care			to a specific patient by a		
		stated last reviewed/revised			registered nurse or other	, I	
	· ·	ed the policy stated, "A			appropriate skilled professiona with written patient care	11,	
		priate Care Plan, identifying			instructions including code sta	tuc	
		ned by the Home Health Aide,			on the Home Health Aide Care		
	•	by a Registered Nurse all			plan which is prepared by that		
	-	aff will follow the identified			registered nurse. Prior to initia		
		o provide documentation that			care the Home Health Aide sh	-	
		ndividualized to his/her			be oriented by a Registered N		
		for to initiating care, the Home			via phone or in person, to the		
	•	e oriented by a Registered			clients care needs. The Home		
		or in person, to the client's care			Health Aide will report in		
		updated on the modifications			modifications or changes in the	e	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15K140	B. W	NG		04/24	/2019
	PROVIDER OR SUPPLIER			7770 N	ADDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D APOLIS, IN 46268		
(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	or changes in the cl	R LSC IDENTIFYING INFORMATION ient's care "		TAG	client's care.		DATE
	evidenced a start of orders for skilled not times a week for 9 whealth aide care (HI 2-25-19; also review 8-27-18, failed to exprovided the patient the HHA care plan.  Review of the clinic evidenced patient where with the affindings. The admit trained to use the Hof services, and to extend the status. The administratus when queries information, or doc	cal record of patient #3			2.10% of all clinical records be audited quarterly for evider proper documentation of code status.  3.The Director of Nursing wiresponsible for monitoring the corrective actions to ensure the this deficiency is corrected and will not recur.	ll be se at	
G 0804							
Bldg. 00	failed to implement policy, and the inter home health aide (e health aide docume condition, and faile responsible for man	view and interview, the agency its clinical documentation rdisciplinary participation of a employee to ensure the home nted a change in the patient's d to ensure the the nurse taging the client's care to health aide visit notes to	G 0	804	G804 1.The Director of Nursing had in-serviced all nursing staff and Home Health Aides on clinical documentation. Home Health aides are members of interdisciplinary team and must report changes in the patient's condition to a registered nurse	d st	05/17/2019

STATEMENT OF AND PLAN OF CO		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K140	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION  G 00	(X3) DATE COMPI <b>04/24</b> .	LETED
	IDER OR SUPPLIER	SERVICES LLC	7770	ET ADDRESS, CITY, STATE, ZIP COD O N MICHIGAN ROAD SUITE [ IANAPOLIS, IN 46268	)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ION D BE OPRIATE	(X5) COMPLETION DATE
PREFIX TAG  en: pal Th  Re add: 8-2 do do cai pro cai rec on coi to  Re Pla on coi du sha ho pla the spo	REGULATORY OR sure accurate and tient's falls for 1 (and tient's falls fal	complete documentation of a Patient #3) of 10 patients.  "Clinical Documentation," last reviewed/revised on the policy stated, "Agency will be contact with the client. This be completed by the direct tored by the skilled ible for managing the client's insure there is an accurate ovided, client response and	PREFIX	other appropriate skilled professional and must con appropriate clinical documentation. Each direct contact with the client will documented. The docume will be completed by the docaregivers and monitored skilled professional resport managing the clients care will ensure there is an accord of services provide response and ongoing near care.  2.10% of all clinical record be audited quarterly for every proper clinical documentation.  3.The Director of Nursin responsible for monitoring corrective actions to ensure this deficiency is corrected will not recur.	nplete  ct be entation irect by the nsible for . This urate d, client ed for  rds will ridence of tion of  g will be these re that	COMPLETION
Re evi	odifications or cha eview of HHA visi idenced "she fell a	and shall be updated on the enges in the client's care "  It note dated 5-20-18, and I called the nurse" and shall be updated the				
nu em	rse," both entries aployee, HHA, em	were signed by former				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15K140	B. WI	NG		04/24/	2019
	ROVIDER OR SUPPLIER			7770 N	ADDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D APOLIS, IN 46268		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE	DATE
	5-29-18, failed to ev	ridence the nurse had assessed rafter 2 reported falls.					
	reviewed with the adfindings. The admin members of the inte by the registered nu employee UU, failed details of the 5-20 a administrator stated nurse had not follow queried for further expenses.	PM, the above findings were dministrator, who verified the nistrator stated HHAs were rdisciplinary team, supervised rse, and the HHA, former d to completely document the nd 5-22-18 patient falls. The the HHA and the registered wed agency policy. When explanation, information, or administrator stated having resent for review.					
G 0818							
Bldg. 00			G 08	010	G818		05/17/2019
	registered nurse fail aide had complete in patient's rights in reference (resuscitate/do not rof 10 patients whose and failed to identificiate to provide care care, due to missed visits for 1 (Patient The findings include Review of a policy, Plan," administrator on 8-24-15, evidence complete and approduties to be perform shall be developed by	esuscitate) for 1 (Patient #3) e clinical record was reviewed, by the failure of the home health as ordered on the plan of visits, during supervisory #3) of 10 patients.		510	1.The Director of Nursing ha in-service all nursing staff on the Home Health Aide Supervision must ensure that aides furnish care in a safe and effective manner, including, but not limit to the following elements: follo the Patient's plan of care for completion of tasks assigned, maintaining an open communication process with a parties, demonstrating competency with assigned tas complying with infection prevention, report changes in patients condition and honoring patient rights. Nursing staff will ensure the HHA has complete information to care for the patiencluding code status	ne n ted wing II k,	03/17/2019

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ENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
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
		15K140	B. W	ING		04/24	/2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			MICHIGAN ROAD SUITE D		
GOLDEN	I HEART HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46268		
(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
		To provide documentation that			(resuscitate/do not resuscitate	•	
		ndividualized to his/her			Nursing staff will make sure co	ode	
	_	ior to initiating care, the Home			status is addressed on the HH	IA	
		e oriented by a Registered			care plan. Supervisory visit no	tes	
		or in person, to the client's care			will reflect proper documentati	on of	
		updated on the modifications			questions, including HHA was		
	or changes in the cl	ient's care "			following the care plan.		
	Review of the clinic	cal record of patient #3,			2.10% of all clinical records	will	
		Care date of 3-13-17, with			be audited quarterly for evider		
		ursing visits and HHA visits 7			proper documentation of code		
		weeks. Review of the home			status on HHA care plan and		
		HA) plan, last reviewed			supervisory visits notes		
	,	wed 12-26-18, 10-24-18, and			Supervisory visits rioles		
		vidence the HHA had been			3.The Director of Nursing wi	ll ha	
		t's code status in writing on			responsible for monitoring the		
	the HHA care plan.	_			corrective actions to ensure th		
	the 1111/1 care plan.				this deficiency is corrected and		
	Review of supervise	ory visit note dated 4-8-19,			will not recur.	u	
	-	e had marked the HHA was			Will flot recal.		
		plan, when during the					
		of 2-26 to 4-26-19, the HHA					
	_	n 2-26-19, 3-24, 3-25, 3-26, 3-27,					
	3-28, 4-6, and 4-7-1						
	3 20, 1 0, and 1 7 1						
	Review of the clinic	cal record of patient #3					
	evidenced patient w	•					
	•						
	On 4-17-19 at 2:15	PM, the above findings were					
		dministrator, who verified the					
		nistrator stated HHAs were					
	_	HA care plan for the delivery					
		confirm the patients' code					
		strator stated the registered					
		completed the portion of the					
		ch identified patient #3's code					
	_	ave reviewed the HHA care					
	· ·	supervisory visits to ensure					
	1 r	r			I		1

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code status was documented, and correctly identified the HHA had not followed the plan of

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gastrostomy tube ... " The policy failed to ensure

admission.

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K140		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/24/2019	
	E OF PROVIDER OR SUPI	PLIER TH SERVICES LLC	7770 N	ADDRESS, CITY, STATE, ZIP COD I MICHIGAN ROAD SUITE D NAPOLIS, IN 46268	
(X4) II PREFI	X (EACH DEFI	ARY STATEMENT OF DEFICIENCIE CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAC	only nurses could HHA could assigned to per such as adminiment administer eye HHA could assigned to per such as adminiment administer eye HHA could assigned to per such as adminiment administer eye HHA could assigned to per such as adminiment administer eye HHA could assigned to per such as adminiment administer eye HHA could assigned to per such as administrator sevidenced the pertinent diagnincluding dates frequency, and Specific processervice e. Diagand x-rays f. S. Rehabilitation and precautions restrictions k. requirements of treatments, and and equipment protect against client/caregiver q. Instructions plans s. Name Other approprimust always be The policy failed conditions of p	Ilicy, "Home Health Aide Care inistrator stated last ed 8-24-15, evidenced the policy pose To provide documentation care is individualized to his/her If the Home Health Aide is form delegated nursing functions, stering medications, i.e. eye drops y failed to ensure only nurses could drops and other medications, and ist patient to take medications.  Ilicy, "Plan of Care," the tated last reviewed/revised 8-24-15, policy stated, "The Plan of Care eted in full to include: a. all osis(es), principle and secondary, of onset b. Mental Status c. Type duration of all visits services d. Itures and modalities for therapy gnostic tests, including laboratory urgical Procedures g. Prognosis h. Potential i. Functional limitations is j. Activities permitted or Specific dietary or nutritional restrictions l. Medications, procedures m. Medical supplies needed n. Any safety measures to injury o. Instructions to r., as applicable p. Treatment goals for timely discharge r. Discharge and address of client's physician t. ate items u. All of the above items addressed on the Plan of Care "ed to include required items in the articipation for home health tive 1-13-18, that required the plan	TAG		new, need ector

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15K140	B. WING		04/24/2019
	PROVIDER OR SUPPLIER		7770	I ADDRESS, CITY, STATE, ZIP COD N MICHIGAN ROAD SUITE D NAPOLIS, IN 46268	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDENCE NAME CONNECTION	(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)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	contact information risk of emergency r hospital admission.  During interview or administrator stated therapy services, stated of practice did not i administration, and document the name contact information risk of emergency r hospital admission. these policies had b should have been refurther explanation,	at 4-22-19 at 2:33 PM, the the agency did not provide ated home health aides' scope include medication the plan of care must s of all patient physicians and advance directive status, and soom trips, and risk acute care The administrator stated een in effect since 2015, and evised. When queried for information, or administrator stated having			
G 0966					
Bldg. 00	manager failed to et continually assessed 1 (Patient #3) of 2 p during the certificat sample of 10 patien  The findings includ  Review of the clinic evidenced a start of contained a plan of of 4-27 to 6-25-18, skilled nursing 1 tin set-up, and home he		G 0966	G966  1.The Director of Nursing had in-serviced all nursing staff on ensuring that patient needs are continually assessed related to any follow-up falls or injuries. Inursing staff will document all assessment information for follow-up on nursing notes, communication notes, HHA not and physician orders.  1.10% of all clinical records to be audited quarterly for evidenthat all documentation is completed, all follow-up documentation is completed of	e D The otes will oce

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K140		(X2) MULT A. BUILD B. WING		nstruction 00	(X3) DATE COMPL <b>04/24</b> /	ETED	
	ROVIDER OR SUPPLIER		7	770 N	DDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
		risit note dated 5-20-18, 3 "fell, I called the nurse."			nursing notes, communication notes, HHA notes and physici orders.		
	physician orders, fa	es, communication notes, and iled to evidence the registered patient #3 for injury after the			1. The Director of Nursing wiresponsible for monitoring the corrective actions to ensure the this deficiency is corrected an will not recur.	se nat	
	above findings. Wh explanation, inform	I, the administrator verified the en queried for further ation, or documentation, the having nothing further to					
G 0968							
Bldg. 00	manager failed to en implemented, as rec (Patients #3 and 10) record was reviewed.  The findings included the	ed:	G 0968	3	G968  1.The Director for Nursing hin-serviced all nursing staff on Plan of Care policy that the hocare services are furnished urthe supervision and direction of client's physician. The plan of will be individualized to meet a specific identified needs and seed to be completed in full to include pertinent diagnosis(es), type, frequency, and duration for all visits/services, medication, treatment and procedures. The nursing staff will ensure that the plan of care is being implementated to the HHA orders.  2.10% of all clinical records	the ome nder of the care shall all	05/15/2019
	shall be completed in pertinent diagnosis(	in full to include: all es) type, frequency, and s/services Medications,			be audited quarterly for evider Plan of Care being followed a the patient receiving the HHA	nce of	

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

Event ID:

048M11

Facility ID: 013772

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	JILDING	00	COMPL	ETED
		15K140	B. W	ING		04/24/	/2019
		<u> </u>		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			MICHIGAN ROAD SUITE D		
COLDEN	N HEART HEALTH	SEBVICES II C			APOLIS, IN 46268		
GOLDEN	NITEARTITEALIT	SERVICES LLC		INDIAN	APOLIS, IN 40200		
(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
	treatments, and pro	ocedures all of the above			hours are ordered by the		
	items must always be addressed on the Plan of				physician.		
	Care "						
					The Director of Nursing will be	٤	
	2. Review of the clinical record of patient #3, evidenced a start of care date of 3-13-17, and contained a plan of care for the certification period of 2-26 to 4-26-19, with orders for home health aide				responsible for monitoring the	se	
					corrective actions to ensure th	ıat	
					this deficiency is corrected an	d	
					will not recur.		
	(HHA) services up	to 8 hours, 7 days a week.					
	Review of HHA vi	sit notes evidenced the aide					
	made 2 visits the w	veek of 3-24 to 3-30-19 (5 missed					
	visits); 6 visits the	week of 3-31 to 4-6-19 (1					
	missed visit), and 5	visits the week of 4-7 to					
	4-13-19 (2 missed	visits.)					
		d visit note dated 4-11-19,					
		on for missed visit on 4-10-19,					
	was "staffing issue	s."					
		linical record of patient #10,					
		f care date of 8-4-16, and					
	_	care for the certification period					
		with orders for home health aide					
	1 1	nours a day, 5 days a week, to					
	_	l care, ADLs (Activities of					
	Daily Living), ligh	t housekeeping as needed.					
		te 10-3-16, evidenced the HHA					
	*	f care; 10-4-16, the HHA					
	*	f care; 10-5-16, the HHA					
		f care; 10-6, 4 hours of care;					
		e; 10-10, 5 hours of care; 10-11, 5					
	· ·	2, 5 hours of care; 10-13, 5					
	· ·	7, 5 hours of care; 10-18, 5					
		9; 5 hours of care; 10-20, 4					
		4, 4 hours of care; 10-25, 4					
		6, 4 hours of care; 10-27, 2					
		8, no care provided; 10-31, 5					
	hours of care; 11-1	, 5 hours of care; 11-2, 5 hours					

	AN OF CORRECTION IDENTIFICATION NUMBER A. BUI		(X2) MULTIPL A. BUILDING B. WING			(X3) DATE SURVEY  COMPLETED  04/24/2019	
	ROVIDER OR SUPPLIER		777	0 N M	DRESS, CITY, STATE, ZIP COD ICHIGAN ROAD SUITE D POLIS, IN 46268		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	ζ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	(X5) COMPLETION
N 0000 Bldg. 00	of care; 11-3, 5 hours of care; 11-9, 5 hours of care; 11-18 hours of care; 11-18 hours of care; 11-22 hours of care; 11-28 hours of care; 11-30 hours of care in the care of the visits during the care of the visits during the care of the care of the care of care of care of the visits during the care of care of care of care of the visits during the care of the care of the care of care of care of the visits during the care of the care of the care of ca	rs of care; 11-4, 4.75 hours of care; 11-10, 5 hours of care; 11-11, 14, 2 hours of care; 11-17, 3.5 a, 4 hours of care; 11-21, 0 a, 4.5 hours of care; 11-23, 3 a, 2 hours of care; 12-1-16, 0 and #10 did not receive the 9 d on the plan of care for any the certification period.  PM, the administrator verified had not received services as of care. The administrator are were the cause of the the plan of care as ordered. The plan of care as ordered arther explanation, information, the administrator stated having of the for review.	TAG		DEFICIENCY)		DATE
	Medicaid home hea complaints were inv the state re-licensure Complaint #s:	state re-licensure survey of a lth agency. Three (3) restigated in conjunction with e survey.  IN 00291961; substantiated with	N 0000				
	findings.  IN 00264	593; substantiated with findings					
	IN 00216	370; substantiated with findings					
	Survey dates: 4-15, 4-24-2019	4-16, 4-17, 4-18, 4-22, 4-23, and					

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PRINTED: 05/28/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K140		A. BU	A. BUILDING <u>00</u> COMPLET		(X3) DATE SURVEY COMPLETED 04/24/2019	
	ROVIDER OR SUPPLIER			7770 N	ADDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D APOLIS, IN 46268	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	Facility #: 013772	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENC!)	DATE
	1 definey #1. 013 / / 2					
	Medicaid #: 15K14	40				
	Unduplicated skilled	d admissions prior 12 months:				
	Current census:					
	Skilled	8				
	Home Health A	Aide only 30				
	Total	38				
	Home visits w	ith record review 3				
	Clinical record	l review only 7				
	Total clinical r	records reviewed 10				
N 0444	410 IAC 17-12-1(d	c)(1)				
Distr. 00	Home health ager	-				
Bldg. 00	administration/ma	nagement  An individual need not be				
		ency employee or be				
	_	t the home health agency				
	in order to qualify	as its administrator. The				
	administrator, who	-				
		cian or registered nurse ction (d), shall do the				
	following:	ction (d), snaii do the				
		I direct the home health				
	agency's ongoing					
	D 1		N 04	144	N444	04/26/2019
		view and interview, the			1.The Governing body	
		to ensure 3 (Home Health dministration, Home Health			in-serviced the Administrator of the Administrator job description	
		diffinistration, Frome Fleating Plan of Care,) of 19 policies			that plans, organizes, and dire	l l

State Form Event ID: 048M11 Facility ID: 013772 If continuation sheet Page 25 of 51

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED
		15K140	B. WII	NG		04/24/2019
			-	STREET .	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	8			MICHIGAN ROAD SUITE D	
GOLDEN	I HEART HEALTH	SERVICES LLC			IAPOLIS, IN 46268	
(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	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	reviewed were upda	ated in compliance with federal			the agency's ongoing function	S,
	and state requireme	nts for a home health agency,			provides direction in formulating	ng
	an ongoing function of the agency.				the programs and policies,	
					assures compliance with	
	The findings includ	ed:			federal/state regulations gove	rning
					home health care services.	
	Review of the job d	lescription of the administrator,				
	signed by the admir	nistrator on 7-5-16, evidenced,			The Administrator and Govern	ning
	"Reports to Governing Body/Board of Directors				body have reviewed and revis	_
	Plans, organizes, an	nd directs the Agency's			the home health aide medicati	ion
	ongoing functions.	Provides direction in			administration policy, home he	ealth
	formulating the programs and policies Assures				aide care plan policy, and the	plan
	compliance with federal/state regulations				of care policy to be in complia	nce
	governing home he	alth care services."			with federal and state	
					requirements. Home Health ai	de
	Review of a policy,	"Home Health Aide			medication administration and	
	Medication Admini	stration," the administrator			Home health Aide care plan p	olicy
	stated last reviewed	/revised 8-24-15, evidenced			was reviewed and revised to	
	the policy stated, "	Purpose To assure that			ensure only nurses could	
		s are trained and deemed			administer medication eye dro	pps
	competent to assist	in safe, accurate			and other medications, and H	
	administration of re	gularly scheduled medications			could assist patient to take	
	Procedure oral	medications eye			medications.	
	medications drop	the prescribed number of				
		le of the client's lower lid ear			The Director of Nursing has	
	drops rectal supp	positories vaginal			in-serviced all nursing staff on	the
	suppositories top	ical medications via			plan of care to be completed in	
		" The policy failed to ensure			full, documenting all physician	
		dminister medications, and			names and contact information	
	HHA could assist p	atient to take medications.			advance directive status, and	
					of emergency room trips, or a	
	Review of a policy,	"Home Health Aide Care			care hospital.	
	Plan," the administr	rator stated last				
	reviewed/revised 8-	-24-15, evidenced the policy			2.100% of all policy and	
	stated, " Purpose	To provide documentation			procedures will be reviewed	
	_	e is individualized to his/her			annually for evidence of any n	ew,
	specific needs If	the Home Health Aide is			updates, revisions, changes in	
	_	delegated nursing functions,			state/federal regulations that r	
		ng medications, i.e. eye drops			to be made to the policy and	
		led to ensure only nurses could			procedures	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K140	(X2) MULTIPLE A. BUILDING B. WING	00	COMP	ESURVEY LETED 1/2019
	PROVIDER OR SUPPLIER		7770	ET ADDRESS, CITY, STATE, ZIP CO N MICHIGAN ROAD SUITE ANAPOLIS, IN 46268		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
	administer eye drop HHA could assist p Review of a policy, administrator stated evidenced the policy shall be completed pertinent diagnosist including dates of of frequency, and dura Specific procedures service e. Diagnosis and x-rays f. Surgi Rehabilitation Pote and precautions j. a restrictions k. Spec requirements or restreatments, and pro and equipment need protect against injuclient/caregiver, as q. Instructions for plans s. Name and Other appropriate it must always be add. The policy failed to conditions of partice agencies, effective of care document a contact information risk of emergency responsible to the policy failed to conditions of partice agencies, effective of care document a contact information risk of emergency responsible to the process of practice did not it administrator stated therapy services, stated therapy services and some services and services are servic	replan of Care," the last reviewed/revised 8-24-15, y stated, "The Plan of Care in full to include: a. all (es), principle and secondary, onset b. Mental Status c. Type ation of all visits services d. and modalities for therapy the tests, including laboratory cal Procedures g. Prognosis h. Intial i. Functional limitations Activities permitted or effic dietary or nutritional trictions 1. Medications, cedures m. Medical supplies ded n. Any safety measures to ray o. Instructions to applicable p. Treatment goals timely discharge r. Discharge address of client's physician t. tems u. All of the above items are sed on the Plan of Care "Include required items in the ipation for home health 1-13-18, that required the plan all physicians names and an advance directive status, and from trips, or acute care		3. The Administrator a of Nursing will be responding these correct actions to ensure that the deficiency is corrected a recur.	nsible for tive nis	

State Form Event ID: 048M11 Facility ID: 013772 If continuation sheet Page 27 of 51

PRINTED: 05/28/2019 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15K140	B. W	NG		04/24/	/2019
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D		
GOLDEN	HEART HEALTH S	SERVICES LLC		INDIANAPOLIS, IN 46268			_
(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)	ΓΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		oom trips, and risk acute care					
	•	The administrator stated					
	these policies had been in effect since 2015, and should have been revised. When queried for						
	further explanation,	-					
	-	administrator stated having					
	nothing further to pr	_					
	nothing further to pr	resent for review.					
N 0456	410 IAC 17-12-1(e	9)					,
	Home health agen	•					
Bldg. 00	administration/mar	nagement					
	Rule 12 Sec. 1(e)	The administrator shall be					
	-	ongoing quality assurance					
		to do the following:					
		d systematically monitor					
		quality and appropriateness					
	of patient care.						
	(2) Resolve identi	-					
	(3) Improve patier	nt care.	NO	150	N456		04/26/2010
	Based on record rev	riew and interview, the	N 0	436	1.The Governing Body has		04/26/2019
		to maintain a quality			in-serviced the Administrator of	n.	
		ance improvement (QAPI)			maintaining a quality assurance		
		quarter of 2019, and failed to			performance improvement (QA		
		PI data tracked and analyzed			program each quarter to track		
		OASIS data, as required by			analyze adverse events and		
	policy, for 1 of 1 ho	me health agency.			OASIS data as required by po	licy.	
					Administrator shall establish a	-	
					performance improvement pla	n to	
	The findings include	ed:			continuously measure, assess		
					and improve the performance	of	
		, "Performance Improvement,"			clinical and other processes		
		d 8-24-2015, evidenced the			across the spectrum of care.		
	policy stated, "Ager	-			2 OADI will wast sweets the te-		
		vement plan to continuously d improve the performance of			2.QAPI will met quarterly to	orify.	
		rocesses The agency's			review its QAPI program and v QAPI data.	cilly	
		vement program consists of,			i Whi⁻i uala.		
	•	the following: OASIS			3.The Administrator will be		
		ssment and Information Set)			responsible for monitoring the	se	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15K140		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/24/2019	
	PROVIDER OR SUPPLIER		7770 N	ADDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D IAPOLIS, IN 46268	
(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)	DATE
	evidence documentareporting for the 1st On 4-23-19 at 3:05 data from the 1st qu February, and Marc and reviewed by no the agency met quan program, and verification and the second dispersion of the	I binder, on 4-23-19, failed to ation of data review and		corrective actions to ensure the this deficiency is corrected and will not recur.	
N 0472 Bldg. 00	Rule 12 Sec. 2(a) must develop, impevaluate a quality performance improprogram must reflehome health organ (including those secunder arrangement agency must take improvements in the performance across The home health a assessment and performance across the second seco	The home health agency element, maintain, and eassessment and every element program. The ect the complexity of the nization and services ervices provided directly or each to the home health agency's est the spectrum of care.			
	failed to maintain a performance improv 1st quarter of 2019, QAPI data tracked a and OASIS data, as	riew and interview, the agency quality assurance, vement (QAPI) program for the and failed to ensure the 2018 and analyzed adverse events required by policy, to ensure covered the entire spectrum of	N 0472	N472 1.The Governing Body has in-serviced the Administrator of maintaining a quality assurant performance improvement (Querogram each quarter to track analyze adverse events and OASIS data as required by po	ce, API) and

State Form Event ID: 048M11 Facility ID: 013772 If continuation sheet Page 29 of 51

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION (IDENTIFICATION NUMBER)  15K140		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/24/2019	
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	
GOLDEN	I HEART HEALTH	SERVICES LLC		N MICHIGAN ROAD SUITE D NAPOLIS, IN 46268	
(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 APPROPRI DEFICIENCY)	COMPLETION D. TES
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
	care, for 1 of 1 hom	le nearm agency.		Administrator shall establish	
	The findings includ	ed:		performance improvement plicontinuously measure, asses	SS,
	D	UD of control of the		and improve the performance	e of
		, "Performance Improvement," ed 8-24-2015, evidenced the		clinical and other processes	
		ncy shall establish a		across the spectrum of care.	
		vement plan to continuously		2.QAPI will met quarterly to	
		d improve the performance of		review its QAPI program and	
		rocesses The agency's		QAPI data.	voy
	_	vement program consists of,			
	but is not limited to	the following: OASIS		3.The Administrator will be	
	(Outcome and Asse	ssment and Information Set)		responsible for monitoring the	ese
	review Adverse 6	events "		corrective actions to ensure t this deficiency is corrected ar	
	Review of the QAP	I binder, on 4-23-19, failed to		will not recur.	
	evidence document	ation of data review and			
	reporting for the 1st	t quarter of 2019.			
		PM, the administrator stated the			
	_	arter of 2019 (January,			
	1	ch) should have been tabulated			
	I -	w. The administrator stated			
		rterly to review its QAPI			
		ed the QAPI data from 2018			
		9 at 3:05 PM, failed to evidence			
	1 -	is of adverse events and uired by agency policy.			
	OASIS data, as requ	uned by agency poncy.			
N 0514	410 IAC 17-12-3(d	e)			
	Patient Rights `	•			
Bldg. 00	Rule 12 Sec. 3(c)				
	(c) The home he	ealth agency shall do the			
	following:				
	` <i>'</i>	omplaints made by a			
	l ·	ent's family or legal			
	1 '	arding either of the			
	following:				
	` '	care that is (or fails to be)			
	furnished.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			COMPLETED	
	15K140		B. WING 04/24/2019			/2019	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					MICHIGAN ROAD SUITE D		
GOLD	EN HEART HEALTH	SERVICES LLC			IAPOLIS, IN 46268		
					1		1
(X4) ID		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	ΙΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	1 ' '	respect for the patient's					
	1	ne furnishing services on					
	behalf of the hom						
	1 ' '	oth the existence of the					
	complaint and the	e resolution of the complaint.	1,10	-14			0.4/2.0/2.01.0
	D 1 1		N 0	514	N514		04/30/2019
		view and interview, the agency			1.The Director of Nursing ha		
		the existence of 3 complaints,			in-serviced all nursing staff on	l	
	•	2019, out of a total sample of 13			patient rights. Nursing must		
	incident reports in a	2017, 2018, and 2019, reviewed.			investigate all complaints mad	•	
	Tri C 11	1. 1.			a patient or the patient's family	-	
	The findings include	led:			legal representative for treatm		
	D	"C1:/E1			or care that is furnished, lack		
	Review of a policy	-			respect for the patient propert		
		ce Policy," administrator stated			anyone furnishing services an	a	
		ed 8-24-15, evidenced the			must document both the	-1 41	
		omplaint is defined as 'any			existence of the complaint and		
		tisfaction by a client/family			resolution. All complaints have	e to	
		ervices that can be addressed			be completed and logged.		
		taff present A grievance is			The advantage has in a suit		
	1 *	mal or verbal expression of			The administrator has in-servi		
		care or service that is			the nursing staff on Client/fam	illy	
	1 .	ient/family that is not solved at freesent Any complaint that			complaint/grievance policy. A		
		efinition will require a written			complaint is defined as any		
	_	son complaining Client			expression of dissatisfaction be client/family regarding care or	-	
		documented on a client			services that can be addresse		
	_	I filed with the complaint log in			the time by the staff present		
		ile Grievances will be			grievance is any formal or info		
		7 calendar days of receipt a			or verbal expression of	,,,,,,,	
		ered resolved when the the			dissatisfaction with care or se	rvice	
	1 -	ith the actions taken on their			that is expressed by the		
	behalf "	and and an anomalian			client/family that is not solved	at	
					the time by the staff present		
	Review of the incid	lent report/adverse event log,			Any complaint that fits the		
	evidenced:	F 2-2 3-2 5-2 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6			grievance definition will requir	e a	
					written response to the persor		
	An incident report	dated 4-19-17, a patient made			complaining All client	•	
		home health aide (HHA),			complaints will be documented	d on	
		BB, was not following plan of			a client complaint form and file		
	1 Umploy 00 B	,	1		I a short somplaint form and in		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15K140		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/24/2019				
NAME OF PROVIDER OR SUPPLIER GOLDEN HEART HEALTH SERVICES LLC			7770 N	STREET ADDRESS, CITY, STATE, ZIP COD 7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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	care for the patient, visit note without production documented, and of caregivers to give the accusation was not having a surgical production with a surgica	asked for caregiver to sign roviding all the time fered to pay one of the ne patient a shower. The found credible as HHA was rocedure on the alleged date of giver money to shower patient, idenced the HHA did not signed hours, and modified school obligations. The itent, one of whom filed the cted each others' statements. It is amantly denied the accusation porting documentation of incident report represented an instruction, and per agency to be summerated in the control of the contr	TAG	with the complaint logbook. A grievances will be addressed within 7 calendar days of receithe complaint.  The administrator has in-servithe nursing staff on incident repolicy. An incident report is an expression of dissatisfaction, complaint form will be complealong with the incident report. Both incident and complaint for will be completed and logged.  2.100% of all complaint/incit forms and logs will be reviewed quarterly for evidence that a written complaint form has be resolved within 7 days of receithe complaint.  3.The Administrator will be responsible for monitoring the corrective actions to ensure the this deficiency is corrected an will not recur.	ipt of  ced eport a ted  orms  dent ed en ipt of			

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PRINTED: 05/28/2019 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K140		A. BUILDING 00  B. WING		COMPLETED 04/24/2019	
	ROVIDER OR SUPPLIER		7770 N	ADDRESS, CITY, STATE, ZIP COD I MICHIGAN ROAD SUITE D NAPOLIS, IN 46268	
(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 0520 Bldg. 00	documentation as a log.  On 4-23-19 at 10:54 reports were review the clinical manager incident reports had complaints, as well have been. When complaints, as well have been. When complaints are well have been. When complaints are well have been. When complaints are well as the complaints are well as the complaints are well as the complaints.  410 IAC 17-13-1(at Patient Care Rule 13 Sec. 1(a) for care on the base expectation that the can be adequately agency in the patient to the written physic by agency policy, for patients whose clinical to the written physic by agency policy, for patients whose clinical three findings included the findings included the findings included the services are furnished direction of the client develop a plan of case specific identified in ability to make choicestablishing and followed.	AM, the above incident ed with the administrator and r. The administrator stated the not been documented as as incident reports, and should queried for further explanation, amentation, the administrator ag further to present for  A)  Patients shall be accepted sis of a reasonable patient's health needs a met by the home health ent's place of residence.  Tiew and interview, the agency its needs were met according cian's plan of care, as required for 2 (Patients #3 and 10) of 10 cal record was reviewed.  The administrator and the policy stated, "Home care and under the supervision and ant's physician Purpose to the individualized to meet eds To reflect client's ces and actively participate in lowing the plan designated to	N 0520	N520  1.The Director of Nursing had in-serviced the nursing staff or Plan of Care policy. Home can services are furnished under the supervision and direction of the client's physician. The purpose develop a plan of care individualized to meet specific identified needs To reflect client's ability to make choices and actively participate in establishing and following the designated to attain personal health goals. The Plan of care shall be competed in full to incline all pertinent diagnosis(es), typing frequency, and duration of all	04/30/2019 as n the re the ne e to c c c c c c c c c c c c c c c c c c
	attain personal healt	lowing the plan designated to th goals The Plan of Care in full to include: all		frequency, and duration of all visits/services, medication treatments, and procedures.	

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	LAN OF CORRECTION IDENTIFICATION NUMBER A			X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/24/2019	
NAME OF PROVIDER OR SUPPLIER GOLDEN HEART HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP COD 7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION	ID PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
PREFIX TAG	pertinent diagnosis(duration of all visits treatments, and provided a start of contained a plan of of 2-26 to 4-26-19, (HHA) services up  Review of HHA vismade 2 visits the wissed visit), and 5 4-13-19 (2 missed videnced the reason was "staffing issues"  3. Review of the clevidenced the reason was "staffing issues"  3. Review of the clevidenced a start of contained a plan of of 10-3 to 12-1-16, (HHA) services 9 hassist with personal Daily Living), light Review of visit not provided 4 hours of provided 3 hours of	R LSC IDENTIFYING INFORMATION  (es) type, frequency, and s/services Medications, cedures all of the above be addressed on the Plan of  inical record of patient #3, care date of 3-13-17, and care for the certification period with orders for home health aide to 8 hours, 7 days a week.  sit notes evidenced the aide eek of 3-24 to 3-30-19 (5 missed week of 3-31 to 4-6-19 (1 visits the week of 4-7 to visits.)  I visit note dated 4-11-19, on for missed visit on 4-10-19, s."  inical record of patient #10, care date of 8-4-16, and care for the certification period with orders for home health aide ours a day, 5 days a week, to care, ADLs (Activities of thousekeeping as needed.  et 10-3-16, evidenced the HHA Care; 10-4-16, the HHA Care; 10-5-16, the HHA	PRE TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	will the and irs I be se at	COMPLETION DATE
	10-7, hours of care hours of care; 10-12 hours of care; 10-19 hours of care; 10-24	Care; 10-6, 4 hours of care; ; 10-10, 5 hours of care; 10-11, 5 2, 5 hours of care; 10-13, 5 7, 5 hours of care; 10-18, 5 9; 5 hours of care; 10-20, 4 4, 4 hours of care; 10-25, 4 6, 4 hours of care; 10-27, 2					

State Form Event ID: 048M11 Facility ID: 013772 If continuation sheet Page 34 of 51

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K140		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 04/24/2019	
	ROVIDER OR SUPPLIER		7770 N	ADDRESS, CITY, STATE, ZIP COD I MICHIGAN ROAD SUITE D NAPOLIS, IN 46268	
(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
N 0522 Bldg. 00	hours of care; 10-28 hours of care; 11-1, of care; 11-3, 5 hour care; 11-7, 5 hours of 11-9, 5 hours of care; 11-18 hours of care; 11-18 hours of care; 11-22 hours of care; 11-28 hours of care; 11-30 hours of care Patie hours of care ordere of the visits during to 4. On 4-23-19 at 3 patients #3 and #10 ordered in the plan overified staffing issufailure to provide cafor further explanate documentation, the nothing further to or 410 IAC 17-13-1(a Patient Care Rule 13 Sec. 1(a) written medical pla	s, no care provided; 10-31, 5 5 hours of care; 11-2, 5 hours rs of care; 11-4, 4.75 hours of of care; 11-8, 2.5 hours of care; e; 11-10, 5 hours of care; 11-11, 14, 2 hours of care; 11-17, 3.5 e, 4 hours of care; 11-21, 0 e, 4.5 hours of care; 11-23, 3 e, 2 hours of care; 11-29, 4 e, 5 hours of care; 12-1-16, 0 nt #10 did not receive the 9 d on the plan of care for any the certification period.  PM, the administrator verified had not received services as of care. The administrator uses was the cause of the are as ordered. When queried on, information, or administrator stated having effer for review.  Medical care shall follow a an of care established and	TAU		DATE
	periodically review dentist, chiropract podiatrist, as follow	-			
	agency failed to ens disciplines, frequen- and care orders was services for 7 ( Patic	review and interview, the ure a verbal order for cy of visits, duration of visits, obtained prior to furnishing ents #1, 2, 4, 5, 6, 8, and 10) of the retained on service more	N 0522	N522  1.The Director of Nursing wi in-service all nursing staff on vorders for disciplines, frequen visits duration of visits and call orders are obtained prior to furnishing services.  The Director for Nursing has in-serviced all nursing staff on	verbal cy of re

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15K140		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/24/2019				
NAME OF PROVIDER OR SUPPLIER GOLDEN HEART HEALTH SERVICES LLC			7770 N	STREET ADDRESS, CITY, STATE, ZIP COD 7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268				
(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)	5.112			
	8-24-15, evidenced services are furnish direction of the clie develop a plan of caspecific identified in be completed in ful diagnosis(es) typ all visits/services procedures all of be addressed on the 2. Review of a poli administrator stated 8-24-15, evidenced medications, treatmedications, treatmedicatio	last reviewed/revised on the policy stated, "Home care ed under the supervision and nt's physician Purpose to are individualized to meet leeds The Plan of Care shall I to include: all pertinent e, frequency, and duration of Medications, treatments, and the above items must always		Plan of Care policy that the hard care services are furnished use the supervision and direction client's physician. The plan of will be individualized to meet specific identified needs and be completed in full to include pertinent diagnosis(es), type, frequency, and duration for a visits/services, medication, treatment and procedures.  The Director of Nursing has in-serviced all nursing staff on Physician Orders policy that medication, treatment, and services provided to clients in the ordered by a physician. We then urse receives a verbal of from the physician, he/she she write the order as given and read the order back to the physician verifying that the preceiving the order heard it correctly and interpreted the correctly. The verbal order we verified by documenting this form and signing the form. The order must include the date, specific order, be signed with full name and title of the perseceiving the order and be set the physician for signature. Or Recertification verbal orders disciplines, frequency, durativisits, and care orders must be completed.  2.10% of all clinical records	inder of the f care the shall e all  III  In all  III  III			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15K140	B. W	ING		04/24/	2019
NAME OF B	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					MICHIGAN ROAD SUITE D		
GOLDEN	I HEART HEALTH S	SERVICES LLC	-	INDIAN	APOLIS, IN 46268		
(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	4-15-19.	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	be audited quarterly for evider		DATE
	4-13-19.				that the plan of care includes a		
	4. Review of the pl	nysicians orders in the clinical			the pertinent diagnosis(es), type		
	_	, failed to evidence a verbal			frequency, and duration for all	, ,	
	_	s, frequency, duration of visits,			visits/services and includes a		
	and care orders at the	ne time of recertification, on or			verbal order at the time of		
		eview of home health aide			recertification.		
		evidenced care visits were					
		-6, 1-11, 1-12-19. The plan of			3.The Director of Nursing wil		
		gned by the physician on			responsible for monitoring thes		
	1-16-19.				corrective actions to ensure th		
	5 Review of the pl	nysicians orders in the clinical			this deficiency is corrected and will not recur.	J	
		, failed to evidence a verbal			wiii flot recui.		
		s, frequency, duration of visits,					
	1	ne time of recertification, on or					
	about 2-6-19. Revi	ew of home health aide (HHA)					
	visit notes, evidence	ed care visits were made on					
		-19. The plan of care orders					
	were signed by the	physician on 2-14-19.					
	6. Review of the pl	nysicians orders in the clinical					
	record of patient #5	, failed to evidence a verbal					
		s, frequency, duration of visits,					
		ne time of recertification, on or					
		ew of home health aide (HHA)					
		ed care visits were made on					
		7. The plan of care orders were					
	signed by the physic	Ciaii (ii) 3-11-17.					
	7. Review of the pl	nysicians orders in the clinical					
	_	, failed to evidence a verbal					
	_	s, frequency, duration of visits,					
		ne time of recertification, on or					
		view of home health aide (HHA)					
	·	ed care visits were made on					
		, 4-12, and 4-13-19. The plan of					
	4-15-19.	gned by the physician on					
	T-10-17.						
			1				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K140	(X2) MULTIF A. BUILDII B. WING		nstruction 00	(X3) DATE COMPI <b>04/24</b>	LETED
	PROVIDER OR SUPPLIER		77	70 N	NDDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
	record of patient #8 order for disciplines and care orders at the about 12-1-16, and aide (HHA) visit nowas made on 2-3-17 signed by the physical signed si	nysicians orders in the clinical 0, failed to evidence a verbal s, frequency, duration of visits, he time of recertification, on or view of home health aide (HHA) ed care visits were made on 1-6, 10-7, 10-10, and 10-11-16. Hers were signed by the 1-16.  3 PM, the administrator verified is had not received verbal order with disciplines, cion of visits, and care orders, certification for the above instrator stated the HHAs had e of activities of daily living tivities of daily living for 6, 8, and 10. When queried for					
N 0524	nothing further to p 410 IAC 17-13-1(a	resent for review.					
	Patient Care						
Bldg. 00	plan of care shall: (A) Be developed home health agen	vices to be provided if a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í			ľ í	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		15K140	B. W	ING		04/24	/2019
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	NHEART HEALTH				MICHIGAN ROAD SUITE D IAPOLIS, IN 46268		
	ī		1		IAI OLIO, IIN <del>1</del> 0200		ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	(B) Cover all pert			1110			DATE
	(C) Include the following:						
	(i) Mental statu	_					
	` '	rvices and equipment					
	required.	• •					
		and duration of visits.					
	(iv) Prognosis.						
	(v) Rehabilitation	on potential.					
	(vi) Functional li						
	(vii) Activities pe						1
	(viii) Nutritional re	· ·					
	` '	s and treatments.					
		measures to protect					
	against injury.						
		for timely discharge or					
	referral.	1.100					
		dalities specifying length of					
	treatment.	annonrioto itama					
	(xiii) Any other ap	opropriate items.	N O	524	N524		05/03/2019
	Rased on record rev	view and interview, the agency	NU	324	1.The Director of Nursing ha		03/03/2019
		plan of care did not include a			in-serviced all nursing staff on		
		zero (0) for 5 (Patients #4, 5, 6,			plan of care policy that it must		
		ents, failed to ensure the			include all the pertinent	•	
		as ordered on the plan of care,			diagnoses, the patient's menta	al.	
		cy policy, for 3 (Patients #1, 3,			psychosocial, and cognitive	,	
		nts; and failed to ensure the			status, type of services, suppl	ies,	
		ied risks for emergency room			and equipment required, the	•	
	_	zations and interventions the			frequency and duration of visit	ts to	
	agency would impl	ement to reduce the risks for 1			be made, prognosis, rehabilita	ation	
	(Patient #1) of 10 p	atients.			potential, functional limitations		
					activities permitted, nutritional		
	The findings included:				requirements, all medications		
	1. Review of a poli	icv "Plan of Care"			treatments, safety measures t protect against injury; a	U	
					description of the patient's risk	c for	
	administrator stated last reviewed/revised on 8-24-15, evidenced the policy stated, "Home care				emergency department visits		
		ed under the supervision and			hospital re-admission, and all	u. 1u	
		ent's physician Purpose to			necessary interventions to		
		are individualized to meet			address the underlying risk fac	ctore	1

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	OF CORRECTION	IDENTIFICATION NUMBER  15K140	A. BUILDING B. WING	00	COMPLETED 04/24/2019
NAME OF I	PROVIDER OR SUPPLIER	8		T ADDRESS, CITY, STATE, ZIP COD N MICHIGAN ROAD SUITE D	
GOLDEN	I HEART HEALTH	SERVICES LLC		NAPOLIS, IN 46268	
(X4) ID PREFIX		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)	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION leeds The Plan of Care shall	TAG	etc.	DATE
	-	l to include: all pertinent		The Discrete for Novelous has	
		e, frequency, and duration of Medications, treatments, and		The Director for Nursing has in-serviced all nursing staff on	
		the above items must always		documentation of the plan of o	
	be addressed on the	Plan of Care "		frequency, duration of visits, to	
	2. Review of the cl	inical record of patient #1,		identify risk for emergency roo visits and hospitalization and	om
		care date of 6-12-18, and		interventions the agency woul	d
	^	care for the certification period		implement to reduce the risk of	of
		th order for home health aide ay, 5 days a week, and 6 hours		emergency room visits or hospitalization. The nursing st	off
		The order failed to evidence		will discontinue documenting	
		nome health aide visits.		to" the number of hours and	
		multiple sclerosis, dementia,		ensure the duration of visits w	
	-	ic kidney disease stage 3,		ordered on the plan of care "0	l l
	_	an of care failed to evidence and interventions the agency		hours cannot be documented.	
		o reduce the risk of emergency		2.10% of all clinical records	will
	room visits or hospi	italization.		be audited quarterly for evider	nce
	0.5 01.1			that the plan of care includes	
		inical record of patient #3, care date of 3-13-17, and		duration for the ordered visits, frequency not to include zero	
		care for the certification period		visits and the risk for emerger	• •
	-	with orders for home health aide		room visits and hospitalization	- I
		to 8 hours, 7 days a week. The			
		luded an order for zero (0)		3.The Director of Nursing wi	
	_	to" 8 hours included zero (0) so failed to evidence a		responsible for monitoring the corrective actions to ensure the	
	duration for the ord			this deficiency is corrected an	
				will not recur.	
		inical record of patient #4,			
		care date of 10-18-17, and care for the certification period			
	^	with orders for skilled nursing			
		de (HHA) services. HHA			
	services were order	ed up to 4 hours, 1 day a week,			
		er day, 1 day a week. The			
		luded an order for zero (0) to" 4 hours, or "up to" 5			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K140	(X2) MUL' A. BUIL B. WINC	DING	ISTRUCTION  00	(X3) DATE ( COMPL <b>04/24</b> /	ETED
	PROVIDER OR SUPPLIER			7770 N N	DDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D POLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	hours, included zero	o (0) visits. The order also duration for the ordered visits.					
	evidenced a start of contained a plan of of 3-6 to 5-4-19, wi a day, 6 times a we included an order for	inical record for patient #5, Care date of 7-9-16, and care for the certification period th order for HHA up to 5 hours ek. The order frequency or zero (0) visits, because "up d the frequency of zero (0)					
	evidenced a start of contained a plan of of 2-16 to 4-16-19, hours a day, 3 time day, 2 times a week included an order for	inical record for patient #6, Care date of 6-26-17, and care for the certification period with order for HHA up to 3 s a week, and up to 4 hours a a. The order frequency or zero (0) visits, because "up to" 4 hours, included zero (0) y.					
	evidenced a start of contained a plan of of 3-6 to 5-4-19, wi a day, 3 times a we times a week. The order for zero (0) v	inical record for patient #7 Care date of 7-9-16, and care for the certification period th order for HHA up to 3 hours ek, and up to 4 hours a day, 2 order frequency included an isits, because "up to" 3 hours, included zero (0) visits as a					
	evidenced a start of contained a plan of of 3-10-19 to 5-8-1 aide services "up to for 9 weeks." The	inical record for patient #9, Care date of 4-10-18, and care for the certification period 9, with order for home health 4 hours a day, 6 times a week, order included a frequency of 5 the order of up to 4 hours, and 4 hours.					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K140	r í	UILDING	NSTRUCTION 00	(X3) DATE COMPL <b>04/24</b> /	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268					
(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	
N 0533 Bldg. 00	evidenced a start of contained a plan of of 10-3 to 12-1-16, (HHA) services 9 h plan of care order fa of the home health a 10. On 4-23-19 at 3 the above findings. explanation, inform administrator stated present for review.  410 IAC 17-13-2 Nursing Plan of Care	3 PM, the administrator verified When queried for further lation, or documentation, the laving nothing further to						
	must be develope the purpose of del patient care provid agency for patient health aide service skilled service.	d by a registered nurse for legating nursing directed ded through the home health is receiving only home es in the absence of a						
	following: (1) A plan of care identifying information (2) The name of the control (3) Services to be control (4) The frequency (5) Medications, control (6) Signed and data personnel providing (7) Supervisory (8) Sixty (60) day (9) The discharge	e and appropriate patient ation. The patient's physician. The provided. The provided of the pr						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED	
		15K140	B. WI	NG	04/24/2019		/2019	
				CTREET	ADDRESS OF VICTOR OF THE COR			
NAME OF P	ROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP COD MICHIGAN ROAD SUITE D			
COLDEN		SEDVICES II C						
GOLDEN	HEART HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46268			
(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	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
			N 0	533	N533		05/08/2019	
		view and interview, the			1.The Director of Nursing ha	S		
	_	led to ensure the home health			in-serviced the nursing staff th	at		
	-	tained adequate code status			care must be developed by a			
		or the patient's rights			registered nurse for the purpos			
		resuscitate) for 1 (Patient #3)			delegating nursing directed pa			
	_	se clinical record was reviewed			care provided through the hom			
	for 1 (Patient #3) of	f 10 patients.			health agency for patient recei	_		
					only home health aide services			
	The findings include	led:			the absence of a skilled servic			
					The nursing plan of care must			
		, "Home Health Aide Care			contain the following: a plan of	f		
		r stated last reviewed/revised		care and appropriate				
		ced the policy stated, "A			identifying information, the nar			
		opriate Care Plan, identifying			of the patient's physician, serv			
	_	ned by the Home Health Aide,			to be provided, the frequency			
	_	by a Registered Nurse all			duration of visits, medication,			
		aff will follow the identified			and activities, signed and date			
		Γo provide documentation that ndividualized to his/her			clinical notes from all personne			
		rior to initiating care, the Home			providing services, supervisory			
	_	e oriented by a Registered			visits, sixty (60) day summarie the discharge note and signatu			
		or in person, to the client's care			of the registered nurse who	ll e		
		updated on the modifications			developed the plan. Ensuring	tha		
	or changes in the cl	-			HHA completed contained	uic		
	of changes in the ci	ient's care			adequate code status informat	ion		
	Review of the clinic	cal record of patient #3,			to honor the patient's rights			
		f care date of 3-13-17, with			(resuscitate/do not resuscitate			
		ursing visits and HHA visits 7			Ensuring that the HHA is orien			
		weeks. Review of the home			by a registered nurse via phon			
		HA) plan, last reviewed			in person, to the client's needs			
	,	wed 12-26-18, 10-24-18, and			and the HHA will update on ar			
		vidence the HHA had been			modifications or changes in the	-		
	•	t's code status in writing on			client's care. Ensuring that the			
	the HHA care plan.				code status is clearly marked.			
	•							
	Review of the clini	cal record of patient #3			2.10% of all clinical records	will		
	evidenced patient w	-			be audited quarterly for evider			
					proper documentation of code			
	On 4-17-19 at 2:15	PM, the above findings were			status.			
							•	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ	î î			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	00	COMPL	
		15K140	B. W	ING		04/24/	2019
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268				
(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
N 0541	findings. The admir trained to use the H of services, and to c status. The adminis nurse should have c HHA care plan whice status. When queric information, or door stated having nothing review.				3.The Director of Nursing will responsible for monitoring the corrective actions to ensure the this deficiency is corrected and will not recur.	se at	
Bldg. 00	services are limite purposes of practi setting, the register following: (B) Regularly reeveneeds.  Based on record revergistered nurse fail were continually assumes visit in relation #3) of 2 patients with	(1)(B) Except where d to therapy only, for ce in the home health ered nurse shall do the valuate the patient's nursing liew and interview, the ed to ensure patient's needs sessed and documented in the in to reported fall for 1 (Patient the reported fall during the reviewed, of a total sample of	N 0	541	N541 1.The Director for Nursing had in-serviced all nursing staff on ongoing interdisciplinary assessment of the patient and follow-up documentation of fall Making sure that the patient's	the	05/08/2019
	The findings include Review of the clinic evidenced a start of contained a plan of of 4-27 to 6-25-18, skilled nursing 1 tin set-up, and home he				needs are continually assesse and documented on visit notes communications notes, physic orders. Any injury must be assessed, and follow-up must completed and documented.  2.10% of all clinical records be audited quarterly for evider that the nursing notes, communication notes, physicia orders were properly documer	s, ian be will nce	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. I		A. BU	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/24/2019		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268				
(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
		risit note dated 5-20-18, 3 "fell, I called the nurse."			including assessments and follow-up visits.		
	physician orders, fa nurse had assessed preported fall.	es, communication notes, and iled to evidence the registered patient #3 for injury after the			3.The Director of Nursing will responsible for monitoring the corrective actions to ensure the this deficiency is corrected and will not recur.	se at	
	above findings. Wh explanation, inform	en queried for further ation, or documentation, the having nothing further to					
N 0604	410 IAC 17-14-1(r Scope of Services						
Bldg. 00	Rule 14 Sec. 1(m) must report any ch	The home health aide nanges observed in the s and needs to the					
	Based on record reversal failed to implement policy, and the intershome health aide (eshealth aide document condition, and failed responsible for man monitored the home ensure accurate and patient's falls for 1 (to the findings including Review of a policy, administrator stated 8-24-15, evidenced document each direction of the implementation of the state	riew and interview, the agency its clinical documentation redisciplinary participation of a supployee to ensure the home inted a change in the patient's distortion to ensure the the nurse aging the client's care is health aide visit notes to complete documentation of a (Patient #3) of 10 patients.  "Clinical Documentation," last reviewed/revised on the policy stated, "Agency will contact with the client. This be completed by the direct	N 00	504	1.The Director of Nursing had in-serviced all nursing staff and active Home Health Aides on clinical documentation and Ho health aide care plan. Each directoract with the client will be documented. The documentati will be completed by the direct caregivers and monitored by the skilled professional responsible managing the clients care. Thi will ensure there is an accurate record of services provided, cliresponse and ongoing need for care. To ensure document conformance with the plan of of modifications to the plan, and interdisciplinary involvement.	me rect ion ne e for s e ient or care,	05/09/2019

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K140	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/24/2019			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268					
(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			
	care Purpose To or record of services prongoing need for car conformance with to the plan, and interest administrator on 8-24-15, evident complete and approduties to be perform shall be developed by the developed by the plan Purpose The client's care is in specific needs Proposed the plan and the pla	the Plan of Care, modifications redisciplinary involvement."  "Home Health Aide Care stated last reviewed/revised ted the policy stated, "A priate Care Plan, identifying need by the Home Health Aide, by a Registered Nurse all aff will follow the identified to provide documentation that adividualized to his/her for to initiating care, the Home shall be oriented by a by phone or in person, to the nd shall be updated on the langes in the client's care "		identify duties to be performed the home health aide, shall be developed by a Registered Nu all HHA's will follow the identif plan Prior to initiating care the Home Health Aide shall be oriented by a Registered Nurs phone or in person, to the clie care needs. The Home Health Aide will report in modification changes in the client's care. A interdisciplinary team member document appropriately and completely, and all follow-up assessments will be document.  2.10% of all clinical records be audited quarterly for evider proper clinical documentation the interdisciplinary team and follow-up documentation is completed.	e via nts			
	5-22-18, evidenced	and I called the nurse" and "she fell and I called the were signed by former nployee UU.		3. The Director of Nursing wi responsible for monitoring the corrective actions to ensure the this deficiency is corrected and will not recur.	se nat			
	5-29-18, failed to ev	it notes dated 5-24 and vidence the nurse had assessed vafter 2 reported falls.						
	reviewed with the a findings. The admi members of the inte by the registered nu employee UU, faile details of the 5-20 a	PM, the above findings were dministrator, who verified the nistrator stated HHAs are ordisciplinary team, supervised rse, and the HHA, former d to completely document the nd 5-22-18 patient falls. The the HHA and the registered						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		15K140	B. W	NG		04/24	/2019
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 7770 N MICHIGAN ROAD SUITE D				
GOLDEN	I HEART HEALTH S	SERVICES LLC		INDIAN	IAPOLIS, IN 46268		
(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
		wed agency policy. When					
		explanation, information, or					
	documentation, the administrator stated having nothing further to present for review.						
	nothing further to p	resent for review.					
N 0606	410 IAC 17-14-1(r	1)					
	Scope of Services						
Bldg. 00	! · ·	A registered nurse, or					
	therapist in therap	y only cases, shall make					
	the initial visit to th	ne patient's residence and					
	make a superviso	ry visit at least every thirty					
		when the home health aide					
is present or absent, to observe the care, to							
		ps, and to determine					
	whether goals are	being met.	1	(0)	Noos		05/10/2010
	Dagad on wasand way	view and interview the	N 0	606	N606	_	05/10/2019
		view and interview, the led to identify the failure of the			1. The Director of Nursing ha		
	_	provide care as ordered on			in-serviced all nursing staff on scope of services. The Regist		
		e to missed visits, during			nurse shall make the initial vis		
	_	or 1 (Patient #3) of 10 patients;			the patients residence and ma		
		supervisory visits of the			supervisory visit at least every		
		ere not at least each 30 days			thirty (30) days, either when the		
	for 1 (Patient #7) of	f 10 patients.			home health aide is present of	r	
					absent, to observe the care, to	)	
	The findings includ	ed:			assess relationships, and to		
					determine whether goals are t	•	
		cy, "Home Health Aide Care			met and hours are being work		
		r stated last reviewed/revised			according to the plan of care.	1	
		ced the policy stated, "A			Supervisory visit notes will ref	lect	
		priate Care Plan, identifying ned by the Home Health Aide,			proper documentation of questions, including HHA was		
		by a Registered Nurse all			following the care plan. Nursir		
		aff will follow the identified			staff will ensure the HHA has	iy	
		To provide documentation that			complete information to care f	or	
		ndividualized to his/her			the patient, including code sta		
		ior to initiating care, the Home			(resuscitate/do not resuscitate		
		e oriented by a Registered				,	
		or in person, to the client's care			2.10% of all clinical records	will	
		ipdated on the modifications			be audited quarterly for evider		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K140		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/24/2019	
	F PROVIDER OR SUPPLIE EN HEART HEALTH		7770 N	ADDRESS, CITY, STATE, ZIP COD I MICHIGAN ROAD SUITE D JAPOLIS, IN 46268	
	SUMMARY (EACH DEFICIENT REGULATORY OF Changes in the contained a start of orders for skilled in times a week for 9.  Review of supervise evidenced the nurse following the care certification period had missed visits of 3-28, 4-6, and 4-7-3. Review of the previdenced a start of contained a plan of of 3-8 to 5-6-19, we service to assist we living) and IADLs living.) Review of supervisory visit we supervisory visit in 4-5-19, greater than the status. The administration of the status. The administration of the status.	SERVICES LLC  STATEMENT OF DEFICIENCIE RCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION lient's care "  linical record of patient #3, f care date of 3-13-17, with ursing visits and HHA visits 7 weeks.  sory visit note dated 4-8-19, e had marked the HHA was plan, when during the of 2-26 to 4-26-19, the HHA n 2-26-19, 3-24, 3-25, 3-26, 3-27, 19.  lan of care for patient #7, f care date of 3-13-18, and care for the certification period ith order for home health aide ith ADLs (activities of daily (instrumental activities of daily (instrumental activities of daily f supervisory visits evidenced a as made on 3-1-19; the next the clinical record was dated in 30 days.  15 PM, the above findings were administrator, who verified the inistrator stated HHAs are IHA care plan for the delivery confirm the patients' code strator stated the registered	7770 N	MICHIGAN ROAD SUITE D	DATE  DATE  e  vill be esse that
	HHA care plan wh status, and should l plan at the time of code status was do identified the HHA care due to missed further explanation	completed the portion of the ich identified patient #3's code have reviewed the HHA care supervisory visits to ensure cumented, and correctly had not followed the plan of care visits. When queried for , information, or			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15K140		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 04/24/2019	
NAME OF PROVIDER OR SUPPLIES GOLDEN HEART HEALTH		7770	FADDRESS, CITY, STATE, ZIP COD N MICHIGAN ROAD SUITE D NAPOLIS, IN 46268		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION DESCRIPTION OF THE PROPERTY OF THE PROPERT	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
N 9999	resent for review.				
administrator failed with the requireme in relation to evide 5 drug screen, upon contact, for 3 (emp active home health who had provided sample of 29 home failed to ensure druwith an unexpired health aides hired a screening was revie home health aides of the findings included.  1. Review of agent F, evidenced a date patient contact of 3 drug screen result of signed by the collection of the contact documentation of the screen upon hire are suffered to the contact documentation of the contact documentation documentation of the contact documentation docum	Based on personnel file review and interview, the administrator failed to ensure the agency complied with the requirements of Indiana Code 16-27-2.5, in relation to evidence of completion of a negative 5 drug screen, upon hire and prior to first patient contact, for 3 (employees F, M, and TTT) of 3 active home health aides employed after 7-1-2017, who had provided direct patient care, of a total sample of 29 home health aide employed, and failed to ensure drug screening was completed with an unexpired drug test kit for 4 of 4 home health aides hired after 12-31-18, whose drug screening was reviewed, of a total sample of 29 home health aides employed.  The findings included:  1. Review of agency records for home health aide F, evidenced a date of hire of 3-1-19, date of first patient contact of 3-4-19, and evidenced an urine drug screen result of negative, dated 3-1-19, not signed by the collector/tester.  2. Review of agency records for home health aide M, evidenced a date of hire of 10-30-17, date of first patient contact of 11-1-17, failed to evidence documentation of the completion of a urine drug screen upon hire and prior to patient contact.  3. Review of agency records for home health aide TTT, evidenced a date of hire of 3-28-19, date of first patient contact of 3-29-19, failed to evidence documentation of the completion of a urine drug screen upon hire and prior to patient contact.		N9999  1. The Administrator has in-serviced the Director of nurson Drug Testing Screening requirements of Indiana Code 16-27-2.5. Drug Testing using 5-drug screen panel must be completed upon hire and prior first patient contract. Check al expirations dates on the drug prior to testing. Complete the testing form and sign, date, ar file in the employees file.  2. All current CNA/HHA's employee files will be reviewe and those without a drug screened and proof of passing drug screened and proof of passing drug screen will be placed in temployee medical file. Going forward, all CNA/HHA's will be drug tested upon hire and the 10% of all personnel records where the drug tests have been given and the drug testing form has been completed, signed, dated and filed.  3. The Administrator and Directors of Nursing will be responsible monitoring these corrective actions to ensure that this deficiency is corrected and will recur.	the  to I test drug nd  d en g the heir e n will nce m ector for	

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K140		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 04/24/2019		
NAME OF PROVIDER OR SUPPLIER GOLDEN HEART HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP COD 7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		PR	ID EFIX `AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	K, evidenced a date patient contact of 3 documentation of the screen upon hire we expiration date 12-3. Alere Toxicology.  5. Review of agence.	cy records for home health aide to of hire of 3-28-19, date of first -29-19, evidenced the completion of a urine drug than expired test kit, i Cup, 31-18, Lot # DOA 7010465, by cy records for home health aide to fhire of 3-22-19, date of first					
	screen upon hire w	-31-19, evidenced ne completion of a urine drug ith an expired test kit, i Cup, 31-18, Lot # DOA 7010465, by					
	NNN, evidenced a first patient contact documentation of the screen upon hire was	ey records for home health aide date of hire of 4-8-19, date of of 4-12-19, evidenced ne completion of a urine drug ith an expired test kit, i Cup, 31-18, Lot # DOA 7010465, by					
	RRR, evidenced a c first patient contact documentation of the screen upon hire was	ey records for home health aide date of hire of 2-15-19, date of of 2-23-19, evidenced ne completion of a urine drug ith an expired test kit, i Cup, 31-18, Lot # DOA 7010465, by					
	on 4-23-19 at 3:00 agency had not dru and TTT, prior to p provided direct pati stated for HHA, em	w of the alternate administrator PM, the administrator stated the g tested home health aides M atient assignment, and had lent care. The administrator aployee F, the documentation t was incomplete and therefore					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K140	Î ´	JILDING	onstruction 00	(X3) DATE COMPL <b>04/24</b> /	ETED
NAME OF PROVIDER OR SUPPLIER GOLDEN HEART HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP COD 7770 N MICHIGAN ROAD SUITE D INDIANAPOLIS, IN 46268					
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)		DATE
	and RRR, the admir was performed with reliable negative rea provided direct patie further information,	administrator stated having					

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