STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	15K003		LDING	00	10/19/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			82ND ST STE 101		
ALERE V	VOMEN'S AND CH	IILDREN'S HEALTH LLC		INDIAN	APOLIS, IN 46250		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
G0000	ABGGEATTON 1			1110			5.112
	recertification si extended survey Survey dates: 10 Facility # 00595	0/1612 - 10/19/12 51	G00	000	Opening comments accepted. deficiency noted on N0000.Deficiencies addressed below on following tags.		
	Medicaid# 1000	)25130A					
	Survey Team:						
	•	N, PHNS-Team Leader I, PHNS-Team member,					
	Census Service	Type:					
		: 671 ide Only Patients: 0 e Only Patients: 0					
	Sample:						
	RR w HV: 4 RR w/o HV: 8						
	Total RR: 12						
	Quality Review	: Joyce Elder, MSN, BSN,					

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

TITLE

IN005951

(X6) DATE

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

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

PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K003			00	(X3) DATE SURVEY COMPLETED 10/19/2012
NAME OF F	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP CODE	-
ALERE V	VOMEN'S AND CH	ILDREN'S HEALTH LLC		82ND ST STE 101 IAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
PREFIX	(EACH DEFICIEN REGULATORY OR RN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE

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Event ID: 0JOX11

Facility ID: IN005951

If continuation sheet Page 2 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15K003				10/19/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ALEDE V	VOMENIO AND OLI	I DDENIO LIE AL TILLI O			82ND ST STE 101		
ALERE V	VOMEN'S AND CHI	LDREN'S HEALTH LLC		INDIAN	IAPOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
G0121	accepted profession principles that applications that applications are recommended as a partial to a dressing of a Prinserted central control where a patient we creating the potential to affect agency. (#9)  Findings include  1. The procedure titled "P1-Sterile Midline Catheter site with chlorhe and forth scrubbin seconds. Allow the before proceeding with alcohol and the principle of the procedure of the procedure of the procedure of the proceeding with alcohol and the procedure of the p	estaff must comply with staff must comply with standards and ply to professionals as in an HHA. The agency employees provided dance with the policy for evenous) Dressing Change eters" in 1 of 1 changing ICC (peripherally eatheter) line observed was receiving IV therapy intial for transfer of gethe patient and the et all patients of the	G01	21	G121 The Agency Administrate Alternate Administrator will revolute policy on sterile PICC dsg chawith nursing staff and require tall staff caring for patient's with PICC lines complete the requirement cell course on Alere learning systems by 11/15/2012Agency Administrator/Alternate Administrator will co-travel with nursing staff, when patient population permits, caring for PICC line patients Quarterly xivisits. Any nurse found out of compliance with policy will be required to complete a skills disession on PICC dsg changes the Indianapolis office. Administrator/Alternate Administrator are responsible monitoring and ensuring compliance and that all staff and properly trained to provide sterile PICC dsg change as well as taking appropriate actions to correct deficiency to ensure it not reoccur.	riew nge hat n red  2 ay in	11/15/2012

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Event ID: 0JOX11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15K003	B. WING			10/19/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ALERE V	VOMEN'S AND CH	LDREN'S HEALTH LLC			82ND ST STE 101 APOLIS, IN 46250		
					711 OE10, 114 40200	1	avs)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	followed for AL	L patients 3. Patients					
		dministering infusion					
	therapy or parenteral medications						
		nstructed in proper hand					
		ptic techniques as					
	needed G. As	eptic and sterile					
	procedures. 1. St	terile technique					
	appropriate to th	e service being provided					
	is practiced by n	urses. 2. Patients and					
	caregivers will b	e instructed on proper					
	storage and hand						
	medical devices,	and equipment, and the					
	safe care of an ir	nfusion site (e.g., site					
	change, IV tubin	g change, medication					
	administration, e	etc.)"					
		me visit on 10/18/12 at					
		yee E was observed to					
	_	dure for a PICC line					
		on patient #9. After					
		ICC line dressing, upon					
		le technique, Employee E					
		cumference of the					
	1 ^	he insertion site with a					
	_	ntained in the sterile					
		e cleansed the insertion					
		ding skin area with the					
	_	ep, cleansed the IV					
	_	ections and again					
		rounding area of the					
	insertion site usi						
		ep (creating the potential					
		n). She measured the area					
	of tubing from th	ne insertion site to the hub					

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  15K003	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 10/19/2012			
	ROVIDER OR SUPPLIER  VOMEN'S AND CHILDREN'S HEALTH LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 6525 E 82ND ST STE 101 INDIANAPOLIS, IN 46250					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	of the connection tubing with the same tape measure used to measure the arm circumference (creating the potential for contamination).						
	4. On 10/19/12 at 12:30 PM the administrator indicated Employee E was a very experienced registered nurse regarding PICC line care, but indicated employee E's care did result in the potential for contamination.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE  A DIFFERENCE OO COMPL					
11112 121111	or confidence.	15K003	A. BUII			10/19/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			6525 E	82ND ST STE 101		
ALERE V	VOMEN'S AND CH	LDREN'S HEALTH LLC		INDIAN	APOLIS, IN 46250		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
G0159	484.18(a)	ESC IDENTIF TING INFORMATION)	+	IAG	,		DATE
	PLAN OF CARE						
		developed in consultation					
	with the agency staff covers all pertinent diagnoses, including mental status, types of						
	_	ipment required, frequency					
	• •	is, rehabilitation potential,					
		ons, activities permitted, ements, medications and					
	•	afety measures to protect					
	-	structions for timely					
	_	rral, and any other					
	appropriate items	s. I record review and	G01	50	0450 A		11/15/2012
		ne agency failed to ensure	Gui	.39	G159 Agency Administrator/Alternate		11/15/2012
	1 2	of care was signed by the			Administrator will review with		
	•	30 days of the start of			agency staff the required inter		
		by agency policy on 1 of			for MD signature on Physician Plan of Treatment(PPOT).The		
	•	ds reviewed (#10) with			PPOT will be faxed weekly x 2		
		affect all the patients of			wks then the office will be called	ed	
	the agency.	arrect arrane patients or			daily after day 14 until orders a	are	
	the agency.				returned with signature within appropriate time frame. The		
	Findings include	:			Agency Administrator/ALterna Administrator will monitor all	te	
	1 Clinical recor	d #10, start of care			charts a minimun of bi-weekly		
		d #10, start of care d a plan of care for the			ensure timely return of physici orders. Agency	an	
		od 7/21/12 to 9/18/12.			Administrator/Alternate		
	•	failed to evidence a			Administrator are responsible	for	
	•	ature. The plan of care			monitoring compliance with		
		cond request 10/16/12"			regulations and ensuring gorrective action takes place to	0	
	•	e and sign" along with a			ensure that deficiency does no		
	fax cover page to	0			recur.		
	2. The policy da	te 11/20/09 titled					
		rs" states, "D. Orders					
	_	by the physician and					

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PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number:  15K003	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPLETED  10/19/2012
	PROVIDER OR SUPPLIER  VOMEN'S AND CHILDREN'S HEALTH LLC	6525 E	ADDRESS, CITY, STATE, ZIP CODE 82ND ST STE 101 IAPOLIS, IN 46250	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE COMPLETION
	returned to the center in accordance with state regulations, but not exceed 30 days from the date the order was written. (Fax signatures are, as permitted by state regulations, considered to be the same as original signatures.) J. Signed physician orders returned to Alere, must be reviewed by the nurse, signed and dated, and placed in the patient's medical record within 30 days of the date the order was written or in accordance with state regulations."			

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Event ID: 0JOX11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 . BUILDING 15K003 10/19/2012 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6525 E 82ND ST STE 101 ALERE WOMEN'S AND CHILDREN'S HEALTH LLC INDIANAPOLIS. IN 46250 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  $\mathsf{TAG}$ TAG DATE G0332 484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. G0332 11/15/2012 G332 Agency Based on clinical record review, policy Administrator/Alternate Administrator have created a review, and interview, the agency failed referral timeline checklist to ensure the registered nurse made an identifying Referral status, initial assessment visit within forty-eight insurance approval, date RN hours of a physician referral or on the assigned and date Patient request physician-ordered start of care date (SOC) Start of care (SOC). Verbal orders for 2 of 12 (#1 and 7) clinical records will be written for all referrals identifying that MD has agreed that reviewed and agency policy was in SOC will occur per Alere protocol, compliance with federal requirements after insurance approval, and upon with the potential to affect all the agency's patient's acceptance of service. If for new admissions any reason SOC falls outside of the Alere protocol/guidelines (17P to be Findings include: started wk 16 or as otherwise ordered by MD), MD is to be notified and documentation is to 1. Clinical record #1, start of care occur. RN staff is to be educated on 7/12/12, evidenced a referral intake form the conditions for participation and dated 5/30/12. The physician signed necessity in documenting all order dated 6/11/12 states,"Admit to communication with patient and MD Alere for weekly 17P [17 office regarding SOC variances. Agency Administrator/ Alternate Alpha-hydroxyprogesterone Caproate Administrator will complete chart injections per Alere protocol to begin audits monthly on 10% of all charts after insurance approval and upon patients for appropriate documentation to [sic] acceptance to service." The measure compliance and ensure physician ordered start of care date is that deficiency is corrected. unclear. The consent for treatment, initial Agency Administrator/Alternate Administrator are responsible for assessment visit, and comprehensive monitoring corrective actions and assessment was completed on 7/12/12. ensuring compliance.

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K003	(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE ( COMPL 10/19/	ETED
	PROVIDER OR SUPPLIER	LDREN'S HEALTH LLC	•	6525 E	DDRESS, CITY, STATE, ZIP CODE 82ND ST STE 101 APOLIS, IN 46250	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	intake form date signed order date to Alere for wee Alere protocol to approval and up acceptance to se ordered start of a consent for treat visit, and compressive, and compressive and the patient discharge from a states, "H. When patient assessment assessment on 9/5/12.  3. The policy last 2009 titled "Patistates, "H. When patient assessment assessment on a discharge from a sign of the policy day and the patient assessment of the patient assessment of the patient assessment assessment of the patient assessment of the patient assessment of the patient assessment as a discharge from a sign of the policy day and the policy day are patient assessment of the policy day and the policy day are patient assessment of the p	rvice." The physician care date is unclear. The ment, initial assessment was 1/12.  the physician ordered arged from services.  the physician ordered to ctions. When the oresume was not consent for treatment,					

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

PRINTED: 10/30/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
	33	15K003		LDING		10/19/	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1	82ND ST STE 101		
ALERE V	VOMEN'S AND CHI	LDREN'S HEALTH LLC			APOLIS, IN 46250		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		hours of the: 1. Time of		mo	·		DATE
		atient's return home or					
	·	care, as applicable; or 3.					
	_	ed start of care date." This					
	is not what is rec	quired by this regulation.					
	5. On 10/18/12 a	*					
		licated the start of care					
		t date of the certification					
	_	he physician signs the					
	plan of care which	od dates. (However, this					
	•	e start of care has already					
	_	col orders allow for					
	patient acceptant						
	patront acceptant	to service.					

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K003			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  10/19/2012			
NAME OF F	PROVIDER OR SUPPLIEI	R	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
		ILDREN'S HEALTH LLC	6525 E 82ND ST STE 101 INDIANAPOLIS, IN 46250					
(X4) ID		TATEMENT OF DEFICIENCIES	ID ID		(X5)			
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			

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Facility ID: IN005951

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) MULT	IPLE CON		(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	lG	00	COMPLETED 10/19/2012	
		15K003	B. WING			10/19/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ALERE V	VOMEN'S AND CHI	LDREN'S HEALTH LLC			32ND ST STE 101 APOLIS, IN 46250		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II	)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
PREFIX TAG G0339	A84.55(d)(1) UPDATE OF THE ASSESSMENT The comprehensi updated and revis administration of of every 60 days care date, unless elected transfer; condition resulting assessment; or d same HHA during  Based on clinical agency failed to nurse updated the reassessment during the certification completing a new (#5) clinical recovering skilled least 60 days with all the patients of services longer to the Clinical record #	E COMPREHENSIVE  ive assessment must be sed (including the the OASIS) the last 5 days beginning with the start of there is a beneficiary or significant change in g in a new case mix ischarge and return to the g the 60 day episode.  I record review, the ensure the registered e comprehensive ring the last five days of period and before w plan of care in 1 of 12 ords reviewed of patients nursing services for at the potential to affect of the agency receiving than 60 days.		FIX AG		caff ad ::5	11/15/2012
		e a recertification					
	during the last fi	assessment was completed					
	_	od before creating the					
		nning 9/3/12. The					
		evealed a recertification					
		completed on 9/5/12.					
			1				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K003	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 10/19/2012	
NAME OF P	PROVIDER OR SUPPLIER		•		ADDRESS, CITY, STATE, ZIP CODE 82ND ST STE 101		
		ILDREN'S HEALTH LLC			APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE

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Facility ID: IN005951

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15K003			LDING NG	00	(X3) DATE COMPI 10/19	LETED	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 82ND ST STE 101		
ALERE WOMEN'S AND CHILDREN'S HEALTH LLC					APOLIS, IN 46250		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE
N0000	This visit was for relicensure survers. Survey dates: 10. Facility # 00595 Medicaid# 10002 Survey Team: Dawn Snider, RN Eric Moran, RN, orientation Census Service Totals Air Personal Service Total: 671 Sample: RR w HV: 4 RR w/o HV: 8 Total RR: 12	r a home health state by.  /1612 - 10/19/12  1  25130A  N, PHNS-Team Leader PHNS-Team member,  Type:  671 de Only Patients: 0 Only Patients: 0	NOO		Opening comments accept deficiency noted on N0000.Deficiencies address below on following tags.		DATE
	RN	Joyce Elder, MSN, BSN,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
15K003		B. WING		10/19/2012	
NAME OF PROVIDER OR SUPPLIER  ALERE WOMEN'S AND CHILDREN'S HEALTH LLC			STREET . 6525 E	ADDRESS, CITY, STATE, ZIP CODE 82ND ST STE 101 JAPOLIS, IN 46250	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT.	ION (X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL)	DBE COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	DATE
	Octobe	r 25, 2012			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:		DDIC	00	COMPLETED		
		15K003	A. BUI. B. WIN	LDING		10/19/	/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE			
NAME OF P	ROVIDER OR SUPPLIER	L.			ADDRESS, CITY, STATE, ZIP CODE			
ALEDE M	OMENIC AND OU	II DDENI'S HEALTHALO			82ND ST STE 101			
ALERE WOMEN'S AND CHILDREN'S HEALTH LLC				INDIAN	IAPOLIS, IN 46250			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
N0470	410 IAC 17-12-1(	m)						
	Home health age	-						
	administration/ma							
		) Policies and procedures						
		nd implemented for the						
		nicable disease in						
		applicable federal and state						
	laws.		NIO	170	NO 470 The Assessment	-41	11/15/2012	
			N04	+/U	N0470 The Agency Administra Alternate Administrator will rev		11/15/2012	
					policy on sterile PICC dsg cha			
	Based on proced	ure and policy review,			with nursing staff and require			
	observation, and	interview, the agency			all staff caring for patient's with			
	failed to ensure	employees provided			PICC lines complete the requi			
		dance with the policy for			CEU course on Alere learning			
		venous) Dressing Change			systems by 11/15/2012Agency	y		
	`	, ,			Administrator/Alternate			
		eters" in 1 of 1 changing			Administrator will co-travel with	h		
	_	ICC (peripherally			nursing staff ,when patient			
	inserted central c	eatheter) line observed			population permits, caring for	•		
	where a patient v	was receiving IV therapy			PICC line patients Quarterly x	2		
	creating the pote	ential for transfer of			visits. Any nurse found out of compliance with policy will be			
	• •	g the patient and the			required to complete a skills d	av.		
	<del>-</del>	et all patients of the			session on PICC dsg changes			
	•	an patients of the			the Indianapolis			
	agency. (#9)				office.Administrator/Alternate			
					Administrator are responsible			
	Findings include	:			monitoring and ensuring			
					compliance and that all staff a	re		
	1. The procedure dated 2/1/2012 and				properly trained to provide ste	rile		
	*	e IV Dressing Change for			PICC dsg change as well as			
		rs" states, "13. clean the			taking appropriate actions to	•••		
					correct deficiency to ensure it	WIII		
		xidine prep using a back			not reoccur.			
	and forth scrubb	ing motion for 30						
	seconds. Allow t	to air dry thoroughly						
	before proceeding	g. 14. Clean the catheter						
	-	allow to air dry."						
	,, ini aiconoi and	allow to all dry.						
	2 The policy dat	ted 12/24/2009 and titled						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE :	ETED
		15K003	B. WIN			10/19/	2012
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
ALERE WOMEN'S AND CHILDREN'S HEALTH LLC					82ND ST STE 101 APOLIS, IN 46250		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	02.0, 10200		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B		COMPLETION		
TAG				TAG CROSS-REFERENCED TO THE APPROPRIA		DATE	
	"Infection Preve	ntion Practices" states,					
	"A. Standard pre	ecautions are to be					
	followed for AL	L patients 3. Patients					
	and caregivers a	dministering infusion					
	therapy or paren	teral medications					
	(injections) are i	nstructed in proper hand					
	washing and ase	ptic techniques as					
	needed G. As	septic and sterile					
	procedures. 1. S	terile technique					
	appropriate to th	e service being provided					
	is practiced by n	urses. 2. Patients and					
	caregivers will b	be instructed on proper					
	storage and hand	dling of sterile supplies,					
	medical devices	, and equipment, and the					
		nfusion site (e.g., site					
		ng change, medication					
	administration, 6	etc.)"					
	3. During the ho	me visit on 10/18/12 at					
		yee E was observed to					
	follow the proce	dure for a PICC line					
	dressing change	on patient #9. After					
		PICC line dressing, upon					
		ile technique, Employee E					
	measured the cir	cumference of the					
	_	the insertion site with a					
	_	ntained in the sterile					
	1 .	ne cleansed the insertion					
		ding skin area with the					
	_	ep, cleansed the IV					
		ections and again					
		rounding area of the					
	insertion site usi						
	chlorhexidine pr	rep (creating the potential					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15K003	B. WING		10/19/2012
NAME OF P	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE  82ND ST STE 101	
		ILDREN'S HEALTH LLC	INDIAN	JAPOLIS, IN 46250	_
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		n). She measured the area			
	_	ne insertion site to the hub			
		n tubing with the same ed to measure the arm			
		creating the potential for			
	contamination).				
	4. On 10/19/12 a				
		dicated Employee E was a			
		d registered nurse line care, but indicated			
		re did result in the			
	potential for con				
	1				

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K003	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/19/2012
	ROVIDER OR SUPPLIER	LDREN'S HEALTH LLC	STREET . 6525 E	ADDRESS, CITY, STATE, ZIP CODE 82ND ST STE 101 IAPOLIS, IN 46250	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
N0524	410 IAC 17-13-1( Patient Care Rule 13 Sec. 1(a) plan of care shall: (A) Be developed home health ager (B) Include all ses skilled service is less and shall state (ii) Types of serequired. (iii) Frequency and (iv) Prognosis. (v) Rehabilitation (vi) Functional Include the folian (vii) Activities per (viii) Nutritional Include the folian Medication (x) Any safety against injury. (xi) Instructions referral. (xii) Therapy moderatement. (xiii) Any other and Based on clinical policy review, the medical plan physician within care on 1 of 12 countries (#10) with the popatients of the against include 1. Clinical record	(1) As follows, the medical of in consultation with the next staff.  rvices to be provided if a peing provided. Sinent diagnoses. Sollowing:  Is.  rvices and equipment and duration of visits.  In potential. Simitations.  rmitted. Sequirements.  Is and treatments.  I	N0524	N 0524Agency Administrator/Alternate Administrator will review with agency staff the required inter for MD signature on Physician Plan of Treatment(PPOT). The PPOT will be faxed weekly x 2 wks then the office will be calle daily after day 14 until orders a returned with signature within appropriate time frame. The Agency Administrator/ALterna Administrator will monitor all charts a minimun of bi-weekly ensure timely return of physici	11/15/2012 val ed are te to

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		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15K003	B. WING		10/19/2012
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	
ALERE V	VOMEN'S AND CH	ILDREN'S HEALTH LLC		82ND ST STE 101 IAPOLIS, IN 46250	
				T	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	certification peri	od 7/21/12 to 9/18/12.		orders. Agency	
		failed to evidence a		Administrator/Alternate	
		ature. The plan of care		Administrator are responsible monitoring compliance with	for
	1	cond request 10/16/12"		regulations and ensuring	
	with "please date	e and sign" along with a		gorrective action takes place t	
	fax cover page to	o the physician.		ensure that deficiency does no recur.	ot
	2. The policy da	te 11/20/09 titled			
		rs" states, "D. Orders			
	*	by the physician and			
		enter in accordance with			
	state regulations	, but not exceed 30 days			
	from the date the	e order was written. (Fax			
	signatures are, a	s permitted by state			
		sidered to be the same as			
	original signatur	es.) J. Signed			
	physician orders	returned to Alere, must			
	1	he nurse, signed and			
	_	d in the patient's medical			
		days of the date the order			
		accordance with state			
	regulations."				

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15K003	B. WING		10/19/2012
				ADDRESS, CITY, STATE, ZIP CODE	I
NAME OF PROVIDER OR SUPPLIER			6525 E	82ND ST STE 101	
ALERE V	VOMEN'S AND CHI	LDREN'S HEALTH LLC	INDIAN	IAPOLIS, IN 46250	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
N0541	410 IAC 17-14-1( Scope of Services Rule 14 Sec. 1(a) services are limite purposes of pract setting, the regist following: (B) Regularly ree nursing needs.  Based on clinica agency failed to nurse reevaluated before completin of 12 (#5) clinica patients receiving for at least 60 da affect all the pati receiving services  Findings include  Clinical record # failed to evidenc revaluated the pati reating the new plan of care was	a)(1)(B) s (1)(B) Except where ed to therapy only, for ice in the home health ered nurse shall do the evaluate the patient's  I record review, the ensure the registered d the patient's needs ag a new plan of care in 1 all records reviewed of g skilled nursing services ys with the potential to ents of the agency es longer than 60 days.	N0541	N0541Agency Administrator/Alternate Administrator will re-educate son the 60 day recertification at the requirement that the reassessment visit must be updated and revised in the last days of the 60 day certification period. Agency administrator/Alternate Administrator will audit 10% of charts quarterly for evidence to a comprehensive assessment was completed within the proprime frame. Agency Administrator/Alternate Administrator will be reponsible for monitoring compliance with regulations and ensuring that deficiency is corrected and will not reoccur.	ataff and at 5 and

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