PRINTED:	08/25/2017
FORM AP	PROVED
OMB NO.	0938-0391

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

	STATEMENT OF DEFICIENCIESX1) PROVIDER/SUPPLIER/CLIAAND PLAN OF CORRECTIONIDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NONIDER.	B. WING	00	05/18/2017		
NAME OF I	PROVIDER OR SUPPLIE	P	STREET A	ADDRESS, CITY, STATE, ZIP COE	DE		
		ι κ					
	L HOME HEALTH			RSON, IN 46013			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL)	LD BE COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	DATE		
G 0000							
Bldg. 00							
			G 0000				
		or an Initial Medicaid					
	agency.	vey of a home health					
	Survey dates: 5 and 5-18-17	5-15-17, 5-16-17, 5-17-17,					
	Facility # 01409	92					
	Unduplicated sk	cilled admissions: 6					
	Unduplicated no	on-skilled admissions: 4					
		7 patients, 1 skilled care ome health aide only					
	Discharged Pati	ents: 3					
	Home Visits wi	th record review : 4					
	Discharged reco	ords reviewed : 3					
	Total charts rev	iewed: 10					
	providing its ow training and cor program for a p 5-18-2017, for l	Health, is precluded from yn home health aide npetency evaluation eriod of 2 years beginning naving been found out of h the Conditions of					
	compliance with	in the Conditions of					

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

TITLE

(X6) DATE

Any defiencystatement 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.

STATEMEN	R MEDICARE & MEDI- VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R	•	5730 D	ADDRESS, CITY, STATE, ZIP CO NR MLK BLVD RSON, IN 46013	DDE		
(X4) ID	-	STATEMENT OF DEFICIENCIES		ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH	OULD BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PPROPRIATE	DATE	
	Participation at	42 CFR 484.14,						
	Organization, S							
		; 42 CFR 484.16 Group of						
		rsonnel; 42 CFR 484.18,						
	· ·	Patients, Plan of Care, and						
	-	vision; and 42 CFR						
	484.30, Skilled	Nursing Services.						
G 0108	484.10(c)(1)							
	RIGHT TO BE IN	IFORMED AND						
Bldg. 00	PARTICIPATE							
·		he right to be informed, in						
		ne care to be furnished, and						
	of any changes in	n the care to be furnished.						
		duing the notiont in advance						
		dvise the patient in advance that will furnish care, and						
		visits proposed to be						
	furnished.							
		dvise the patient in advance						
		the plan of care before the						
	change is made.			100			00/11/12/01	
			G 0	108	no response		08/11/201	
		d review and interview,						
	the agency faile	ed to advise the patient in						
	advance of the	frequency of proposed						
	visits for the dis	sciplines to be provided						
		patients (Patients #3 and						

STERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA							OMB NO. 0938-03	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	JILDING	istruction 00	CON	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIEF	ł	•		DDRESS, CITY, STATE, ZI	P CODE		
ADMIRA	L HOME HEALTH				MLK BLVD SON, IN 46013			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETI DATE	
IAG	7).	LSC IDENTIFTING INFORMATION)		IAU		,	DATE	
	The findings inc	luded:						
	1. Review of the	e clinical record of						
	· ·	enced a start of care date						
		contained a plan of care						
		ion period 3-15- to						
		ler for home health aide						
		2 times a week for 8						
	weeks. Review	niral Home Health"						
		Plan of Care involves the						
		bline(s):" and the box for						
		e was checked. The						
		nent, signed and dated						
	3-23-17, by the							
	-	and by patient #3, failed						
		frequency of proposed						
	HHA visits.	requerey of proposed						
	2. Review of the	e clinical record of						
		enced a start of care date						
	of 2-17-17, and	contained a plan of are						
	for the certificat	ion period of 2-17 to						
	4-17-17, with or	der for skilled nursing						
	visits 1 time a w	eek for 1 week, then 2						
		8 weeks. Review of an						
		nent "Admiral Home						
		ed "The Plan of Care						
		owing Discipline(s)."						
		led nurse was checked.						
		ocument, signed and						
	dated 2-17-17, b	y the registered nurse						

	T OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED 1B NO. 0938-0391
STATEME	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	UILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
ADMIRA	L HOME HEALTH			ANDEF	RSON, IN 46013		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
G 0122 Bldg. 00	to evidence the visits. 3. On 5-18-17 a supervisor state provide the pati frequency of pro- there was no fur provide for revi 484.14 ORGANIZATION ADMINISTRATIC Based on record the agency faile with this condit governing body responsibility for agency to inclue professional per agency's policie governing body bylaws prior to 131); (See G 133);	, SERVICES & N I review and interview, d to maintain compliance ion of participation. The failed to assume or the operation of the de appointing a group of rsonnel to establish the ss (See G 128); the failed to adopt agency survey entrance (See G	GO	0122	no response		08/11/201
		d to ensure adequate staff of 1 alternate					

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

Event ID:

ABKF11

Facility ID: 014092

If continuation sheet

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TERSTO	R MEDICARE & MEDIC	HD SERVICES					OMB NO. 0938-0
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ISTRUCTION	. ,	TE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	ING	00		IPLETED
			B. WING			05/1	18/2017
JAME OF	PROVIDER OR SUPPLIER	-	STREET ADDRESS, CITY, STATE, ZIP CODE				
					MLK BLVD		
ADMIRA	L HOME HEALTH		A	NDERS	SON, IN 46013		
X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		COMPLET
TAG		LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
		ernate nursing supervisor					
		agency failed to ensure					
		ninistrator, employee B,					
		he position and was					
		to an emergencies,					
	provide guidance						
	questions, and re	solve issues within a					
	reasonable amou	nt of time for 1 of 1					
	alternate adminis	strator, and failed to					
	ensure the altern	ate nursing supervisor,					
	employee B, was	s oriented to the position					
	and prepared to a	assume the duties of					
	nursing supervis	or if required, for 1 of 1					
	alternate nursing	supervisor (G 141);					
	-	all personnel coordinated					
		patients (See G 143); and					
	-	ent its advance directive					
	-	ate care for 1 of 1					
		advance directive					
	-	failed to document					
		care activities for 2 of 10					
	patients (See G 1						
	partenes (See S a						
	The cumulative	effect of these systemic					
		d in the home health					
	_	y to ensure provision of					
		re in a safe environment					
		n of Participation, 42					
		ganization, Services, and					
	Administration.						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF	R		5730 D	ADDRESS, CITY, STATE, ZIP CODE DR MLK BLVD RSON, IN 46013		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRC DEFICIENCY)	BE	(X5) COMPLETION DATE
G 0128 Bldg. 00	functioning) assur responsibility for t agency. Based on record the governing bor responsibility for agency to includ professional per- agency's policies agency. The findings inco 1. Review of the during the surve adoption of 9-6- 2. On 5-17-17 a minutes of the g 4-19-17, 4-5-17, 11-20-16, 9-6-10 8-24-16, 8-21-10 7-29-16, and 6-10	 (or designated persons so mes full legal authority and he operation of the review and interview, ody failed to assume r the operation of the le appointing a group of sonnel to establish the s for 1 of 1 home health duded: e policies presented y evidenced a date of 17. t 1:17 PM, the meeting overning body dated , 12-14-16, 12-6-16, , 8-30-16, 8-25-16, , 8-18-16, 8-1-16, , 6-16, were reviewed and be the governing body had 	G 01	.28	no response		08/11/201

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	CON	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R	5730	T ADDRESS, CITY, STATE, ZIP CC DR MLK BLVD ERSON, IN 46013	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	personnel to esta policies.	ablish the agency's					
	administrator sta used the policies binder to direct administrator sta	at 10:47 AM, the ated agency personnel s in the the agency policy care and processes. The ated a group of sonnel had not been					
6 0131 Bldg. 00		DY dy adopts and periodically /laws or an acceptable					
	the governing be	l review and interview, ody failed to adopt prior to survey entrance health agency.	G 0131	no response		08/11/201	
	The findings inc	cluded:					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN B. WING	IE CONSTRUCTION	C0	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF	κ.	573	EET ADDRESS, CITY 30 DR MLK BLVI DERSON, IN 460	D		
(X4) ID PREFIX TAG	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO		ER'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE		
	 provided a list o members of the include a non-eremployee G, the 2. On 5-17-17, a document titled Medical Home Freviewed. 3. On 5-18-17 a the same docum included the sign the governing be dated 9-6-16. The governing be dated 9-6-16. The governing be dated of 5-17-17, and signature as 9-6-10 st signature as 9-6-10 st	t :15 PM, the agency f the names of the 2 governing body to nployee owner, and agency office manager. an unsigned and undated "Bylaws of Admiral Health Inc.," was t 9:30 AM, a 2nd copy of ent was presented, which nature of one member of ody, the agency's owner, he office manager ated the owner had I the bylaws the evening documented the date of e16. Employee G stated, ult I didn't get signature t 4:11 PM, the rified the above findings was no additional o provide to be reviewed.					

STATEMEN	R MEDICARE & MEDIC VT OF DEFICIENCIES OF CORRECTION					(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R		5730 D	address, city, state, zip code R MLK BLVD RSON, IN 46013	3	
		STATEMENT OF DEFICIENCIES			1 10 10 13		(115)
(X4) ID PREFIX		NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OPRIATE	DATE
G 0133 Bldg. 00	supervising phys required under pa organizes and din functions; mainta the governing bo	r, who may also be the ician or registered nurse aragraph (d) of this section, rects the agency's ongoing ins ongoing liaison among					
			G 01	33	n/a		08/11/2017
		I review and interview,					
		or failed to organize and					
	-	y's ongoing functions and iaison between the staff					
		ng body, to include failure					
		ientation for the alternate					
		nd alternate nursing					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<u> </u>	LTIPLE CON LDING IG	struction 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF	2		5730 DR	dress, city, state, zip c MLK BLVD ON, IN 46013	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION)	PRFFIX (EACH COR		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
	bylaws, and faile had appointed a	re to ensure the had reviewed the agency ure to ensure the agency group of professional ablish the agency's					
	The findings inc	luded:					
		rator failed to ensure the had reviewed the agency 31)					
	agency's policies	rator failed to ensure the s were adopted by the ional personnel (See G					
	and direct the ag to include failure for the alternate	rator failed to organize gency's ongoing functions e to ensure the orientation administrator and g supervisor (See G 134).					
	4. On 5-18-17 a verified the above	t 3 PM, the administrator ve findings.					
6 0134 Bldg. 00	484.14(c) ADMINISTRATOF	२ , who may also be the					
Diag. 00	supervising physic required under pa employs qualified	ragraph (d) of this section, personnel and ensures ucation and evaluations.					

	T OF HEALTH AND HU! R MEDICARE & MEDIC						FORM APPROVE DMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	AULTIPLE C BUILDING VING	onstruction 00	COM	te survey 19leted 18/2017	
NAME OF	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, Z	IP CODE		
ADMIRA	L HOME HEALTH				DR MLK BLVD RSON, IN 46013			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO T DEFICIENCY	HE APPROPRIATE	COMPLETIO	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	G	TAG 0134	n/a	.,	DATE 08/11/201	
	Decod on moord	marries and interview	0.0	J134	1		06/11/201	
		review and interview,						
	the administrato							
	-	lucation for 1 of 1						
		strator/alternate nursing						
	supervisor (emp	loyee B).						
	The findings inc	luded:						
	1. Review of a l	ist of agency employees						
	prepared by the	office manager,						
	employee G, evi	denced the name of						
	employee B as the	ne alternate administrator						
		mate nursing supervisor.						
	2. Review on 5-	17-17, of the personnel						
	file for employed	e B, alternate						
	administrator an	d alternate nursing						
	supervisor, evide	enced a date of hire of						
	1-18-17.							
	A. The pers	onnel file evidenced a						
	self-assessment	of nursing clinical skills						
	for employee B.	Employee B's personnel						
	file failed to evid	lence documentation of						
	orientation to sk	illed nurse visits, failed						
	to evidence docu							
	establishment of	registered nurse						
		clinical skills; orientation						
	to the agency's s							
		orientation to supervision						
		ion to agency procedures						
		l responsibilities to						
		es of the alternate nursing						
		is of the alternate hurbing						

	R MEDICARE & MEDI						OMB NO. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	r í	LTIPLE CO LDING IG	(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIE	R		5730 DF	ADDRESS, CITY, STATE, ZIP COE R MLK BLVD SON, IN 46013	DE	
	1			ID			(1)5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	F	REFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	JLD BE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
	supervisor.						
	D. The new	connel file failed to					
	-	sonnel file failed to					
		nentation employee B had in orientation to the skills					
	-						
	alternate admin	form the duties of the					
		istrator.					
	3. Review of a	job description "Alternate					
		evidenced employee B's					
	signature dated	1-18-17. The job					
	description state	ed, "Alternate					
	Administrator v	vill act as Administrator					
	in the absence of	of the Administrator."					
	4. Review of a	job description "Assistant					
	Director of Nur	sing" evidenced it was					
	signed and date	d by employee B on					
	9-6-16, and stat	ed, "Assistant Director of					
	Nursing will ac	t as director of nursing in					
	the absence the	director of nursing."					
	5. Employee B	was interviewed by					
	phone on 5-17-	17 at 1:10 PM, regarding					
	her orientation	to the role of alternate					
	administrator an	nd alternate nursing					
	supervisor, state	ed "I would be back up to					
	(employee A).	I am learning process,					
	home health sys	stem is new to me I have					
	reviewed proce	ss paperwork as we					
	grow I would g	o out to do home visits I					
		et up and blood pressure					
		e orders I would follow					
	through I would	ld be on call if needed I					

	R MEDICARE & MEDI		-	a 11 m	1000011000		OMB NO. 0938-03	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		NSTRUCTION		TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00		IPLETED	
			B. W			05/1	18/2017	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, 2	ZIP CODE		
					R MLK BLVD			
ADMIRA	L HOME HEALTH			ANDER	SON, IN 46013	SON, IN 46013		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN O		(X5)	
PREFIX	ί.	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE	COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC	CY)	DATE	
		omplaints, issues with						
		y or home health aide, on						
		g and training I guess I						
	would be on ca	ll for (employee A)						
	Right now I am	trying to understand						
	process for refe	rral" When asked						
	about the 7 curr	ent cases in agency,						
	Employee B rep	ported I know there is a						
	person that nee	ded physical therapy, a						
	-	ded additional testing						
		a for rectal abscess						
		seizures 2 people need						
		eds (sic medications) and						
	-	sure)"Asked if						
	· •	d nursing experience in						
		plied "I have not been a						
		lurse." Denied having						
		me visits during						
		•						
		a self- assessment check						
		ving been present for any						
		tings. Denied having						
	current physica	•						
	-	sume the role of nursing						
	supervisor.							
	6 The adminis	trator/nursing supervisor,						
		as interviewed on 5-18-17						
		ted, "We need to set up						
		· ·						
		lth exam for (employee						
		. (employee B) needs to						
		go with me on visits						
		ny home visitswe had						
		(employee B) said " it's						
	I not my favorite	thing to do (home visits)"	1				1	

STATEME	R MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	construction 00	COM 05/1	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF L HOME HEALTH		5730	T ADDRESS, CITY, STATE, ZIP (DR MLK BLVD ERSON, IN 46013	CODE		
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	come in and do probably talk the current patient c communication employee A stat load hasn't chan B) he knows wh Employee A der	t to have (employee B) t if needed we could rough things." Regarding ase conference with employee B, ed "we talk my patient ged a bunch, (employee at I do in a visit." tied there was any f case conference with					
6 0141 Bldg. 00		LICIES es and patient care are ropriate, written personnel					
	licensure that are Based on record the agency failed administrator, er	s include qualifications and kept current. review and interview, I to ensure the alternate nployee B, was oriented nd was ready to respond	G 0141	n/a		08/15/20	

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CC JILDING ING	DNSTRUCTION 00	CO	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEI	2		5730 DI	ADDRESS, CITY, STATE, ZIP R MLK BLVD SON, IN 46013	CODE		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	staff, answer que issues within a r time for 1 of 1 a and failed to ensi- supervisor, emp the position and duties of nursing for 1 of 1 alterna The findings ince 1. Review of a ju Administrator " of signature dated description state Administrator w in the absence of 2. Review of a ju Director of Nursi- signed and dated 9-6-16, and state Nursing will act the absence the of 3. The personne alternate admini- nursing supervis- and no first patio on 5-17-17. A si- was in the file.	ob description "Alternate evidenced employee B's 1-18-17. The job						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIE	ER	5730	DR MLK		DDE		
					111 40013	N 46013		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA CROS	PROVIDER'S PLAN OF CORRE CH CORRECTIVE ACTION SHO SS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
	 skilled nursing competency, an orientation for the position. 4. Employee B on 5-17-17 at 1 orientation to the administrator and supervisor, state (employee A). home health systemeter grow I would ge could do med se control and take throughI would would handle ce physical therape boarding, hiring would be on ca Right now I amprocess for refer about the 7 cure Employee B repperson that need young lady need under anesthesi (patient 8) has a RN to set up motion boarding boarding boarding boarding be an easthesi (patient 8) has a RN to set up motion boarding boarding boarding boarding be an easthesi (patient 8) has a RN to set up motion boarding boarding boarding boarding be be been boarding boarding boarding be be	cumentation of home visit establishment of ad failed to evidence the alternate administrator was interviewed by phone :10 PM, regarding her ne role of alternate and alternate nursing ed "I would be back up to I am learning process, stem is new to me I have ss paperwork as we o out to do home visits I et up and blood pressure e orders I would follow Id be on call if needed I omplaints, issues with y or home health aide, on g and training I guess I II for (employee A) a trying to understand arral" When asked rent cases in agency, ported I know there is a ded physical therapy, a ded additional testing a for rectal abscess seizures 2 people need eds (sic medications) and sure)"Asked if d nursing experience in plied " I have not been a						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 05/18/2017		
			STREET	ADDRESS, CITY, STATE, ZIP CO			
NAME OF	PROVIDER OR SUPPLIE	R		R MLK BLVD			
	L HOME HEALTH			RSON, IN 46013			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE	DF	ATE	
		urse." Denied having					
		me visits during					
		a self- assessment check					
		ving been present for any					
		tings. Denied having					
	current physical	-					
	immediately as	sume the role of nursing					
	supervisor.						
	5 The adminis	trator/nursing supervisor,					
		as interviewed on 5-18-17					
		ted, "We need to set up					
		· ·					
		Ith exam for (employee					
		. (employee B) needs to					
		go with me on visits					
		hy home visitswe had					
		(employee B) said " it's					
	-	thing to do (home visits)"					
	-	rsing We haven't been					
	assertive enoug	h to have (employee B)					
	come in and do	it if needed we could					
	probably talk th	rough things." Regarding					
	current patient	case conference					
	communication	with employee B,					
	employee A sta	ted "we talk my patient					
		nged a bunch, (employee					
		nat I do in a visit."					
	Employee A denied there was any documentation of case conference with						
	Employee B.						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. 1	MULTIPLE CO BUILDING WING	ONSTRUCTION 00	COM	te survey ipleted 18/2017	
	PROVIDER OR SUPPLIEI	2	-	5730 D	ADDRESS, CITY, STATE, ZIP CODI DR MLK BLVD RSON, IN 46013	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
G 0143 Bldg. 00	All personnel furn liaison to ensure to coordinated effect objectives outlined Based on record the agency failed coordinated care (Patient #3 and 3) The findings inco 1. A policy title Directives", whi date of 9-6-16, at 9:30 AM, and Advanced Direct statement abo medical decision provided in acco directives pendir physician Age [sic education] of Advance Direct patient has adva	luded:	G	0143	n/a		08/07/201	

NTERS FOR MEDICARE & MEDIC STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	JLTIPLE CON IILDING NG	(X3) DA CON	OMB NO. 0938-03 TE SURVEY MPLETED 18/2017	
NAME OF PROVIDER OR SUPPLIE ADMIRAL HOME HEALTH	R	•	5730 DR	DDRESS, CITY, STATE, ZIP MLK BLVD SON, IN 46013	CODE	
PREFIX (EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
not resuscitate), AND, (allow na obtained from th the patient's clir honored by the to the admission The original aut DNR/DNI/ANI visible location per patient/care, of the physician patient's in-hom placed in the pa a copy sent to th book will reflec Appropriate sta the request by n conferences, car medical records DNR/DNI/ANI book, or by vert communication 2. During home aide (HHA), en on 5-16-17 at 1 prior to entering patient was a D Observation of	order in the on-call bal and written " e visit of a home health poloyee F, for patient #3, I AM, the HHA stated g patient #3's home, the NR (do not resuscitate). patient #3's home failed DNR order was posted as					
A. Review	of the clinical record of					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	È É	JILDING	NSTRUCTION 00	COM	te survey Mpleted 18/2017
	PROVIDER OR SUPPLIEF			5730 DR	DDRESS, CITY, STATE, ZIP MLK BLVD SON, IN 46013	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL JLATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	 of care date of 3 plan of care for the 23-17 to 5-21-17, with DNR (do not resson B. Review of evidence docume DNR status. 3. Review of the patient #5 on 5-1 referral document include document fibromyalgia, art weakness, fallent weeks," and was supervisor (empleying evidenced patient the week of 2-19 doctor visit on 2 changed patient Buspirone 10 mag times a day (anti Cholecalciferol of 1 capsule by mont Hyzaar was incre- to 100/25mg, 1 the lower blood press 	f the on call log failed to entation of patient #3's e clinical record of 15-17, evidenced a at dated 3-13-17, to ntation "Diagnosis: thritis, hypertension, 11 X [times] in 3 signed by the nursing loyee A). The document at #5's falls had started 0-17, one week after a -14-17, when the doctor #5's medications; g, 1 tablet by mouth, 3 -depressant), was added; (Vitamin D) 1,000 units, uth daily, was added; and eased from 110/12.5 mg, ablet by mouth daily (to ssure). Known side one and Hyzaar are					
	A. Review	of a document dated 2-14					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			STRUCTION		TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI B. WING		00	_	mpleted /18/2017
NAME OF	PROVIDER OR SUPPLIE	R	s	TREET AL	DDRESS, CITY, STATE, ZIP	CODE	
	L HOME HEALTH			730 DR			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)	Т	TAG	DEFICIENCY)		DATE
		ce visit" evidenced					
		by patient # 5's physician					
		daughter with breast					
		ping well plan:					
		n-HCTZ (a blood pressure					
		y buspar for anxiety (an					
		, discontinue furosemide					
	(a diuretic), dis						
	medication)."						
	B. Review	of a comprehensive adult					
	nursing assessn	nent dated 3-15-17,					
	completed by th	ne nursing supervisor,					
		evidenced the care coordination boxes					
	were checked for	or physician and aide.					
	C. Review	of patient #5's plan of					
		a start of care date of 3-15					
		fication period of 3-15-17					
		n order for "Home health					
		ours per day, 2 times a					
	· /	s (activities of daily					
	living) and ligh	· ·					
	e / e	e (RN) to do supervisory					
	-	onth." The established					
		"patient will be free from					
	falls or falls will						
	D. During	an interview with the					
	-	sor, who admitted patient					
		ne health aide (employee					
		at 3:55 PM, the nursing					
		d not having considered					
	-	ed nursing services for					

AND PLAN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIEF	ι.	Ę	STREET ADDRESS, CITY, STATE, ZIP CO 5730 DR MLK BLVD ANDERSON, IN 46013				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE	
	frequent falls 1 v medication cham having considered referral to addre improvement an Employee G, the a home health ca outside provider patient #5 receiv physical therapy outside agency. recall the name of stated not having information to th The nursing sup agency admitted health aide servit had been no coo outside agency. coordinate care of related to knowl provider of skill therapy services E. On 5-18- telephone interv name of the outs verified the servit agency were skit therapy.	d safe transfers. e HHA stated having met are provider from an , who told employee G, red skilled nursing and services from the Employee G could not of the other agency, and g reported this ne nursing supervisor. ervisor reported the the patient for home ces only, and there there rdination of care with the The HHA failed to with the supervising RN edge of an outside ed nursing and physical for patient #5. e17 at 9:30 AM, during iew, patient #5 stated the tide provider and ices provided by the lled nursing and physical						

			N			
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	. ,	E SURVEY PLETED
			B. WING		05/18/2017	
NAME OF	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP COD	E	
ADMIRA	L HOME HEALTH			DR MLK BLVD RSON, IN 46013		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)		COMPLETIC DATE
		gs and stated not having mentation to present for				
90144 Bldg. 00	The clinical record conferences estal interchange, repo patient care does Based on home review, and inter	rting, and coordination of occur. visit observation, record rview, the agency failed	G 0144	n/a		08/02/20
	to coordinate can an advance direct failed to docume	advance directive policy re for 1 of 1 patients with etive (Patient #3), and ent coordination of care f 10 patients (Patient #3				
	The findings inc	luded:				
	date of 9-6-16, at 9:30 AM, and Advanced Direc	d, "Advanced ch evidenced an effective was reviewed on 5-18-17 stated, "Purpose tives. Refer to a written ut how individual wants				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP	CODE	
ADMIRA	L HOME HEALTH			DR MLK BLVD ERSON, IN 46013		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		ons made care will be				
	·	ordance with the advance				
	-	ing orders from patients				
		gency will provide staff				
		on issues concerning				
		tives Procedure: If a				
	*	ance directives which				
	include - not to	be resuscitated, then a				
	written and sign	ned order for DNR (do				
	not resuscitate)	, DNI (do not intubate),				
	AND, (allow na	atural death) must be				
	obtained from t	he physician and placed in				
	the patient's clin	nical record prior to being				
	honored by the	agency Order is added				
	to the admission	n 485 [plan of care]				
	The original au	thorization/consent				
	DNR/DNI/ANI	D will be posted in a				
	visible location	in the patient's home as				
	per patient/care	giver request, and a copy				
	of the physician	n's order maintained in the				
	patient's in-hon	ne chart/folder. Copies are				
	placed in the pa	atient's clinical record and				
	a copy sent to t	he physician. On call				
	book will reflect	et patient status.				
	Appropriate sta	iff will be made aware of				
	the request by r	neans of patient care				
	conferences, ca	re plans, flagging of				
	medical records	s, a copy of				
	DNR/DNI/ANI	D order in the on-call				
	book, or by ver communication					
	-	e visit of a home health nployee F, for patient #3,				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	JLTIPLE CON ILDING NG	struction 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF		-	5730 DR	DRESS, CITY, STATE, ZIP MLK BLVD ON, IN 46013	CODE	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC
TAG	on 5-16-17 at 11 prior to entering patient was a DN Observation of p to evidence the D required by ager A. Review patient #3 on 5-1 of care date of 3 plan of care for t 23-17 to 5-21-17 on 4-12-17, with DNR (do not res B. Review of evidence docum DNR status. 3. Review of the	of the clinical record of 16-17, evidenced a start -23-17, and contained the certification period 3- 7, signed by the physician a order "Pt [patient] is a suscitate)." of the on call log failed to entation of patient #3's		TAG	DEFICIENCY)		DATE
	referral document include document fibromyalgia, art weakness, fallen weeks," and was supervisor (emp evidenced patient the week of 2-19 doctor visit on 2 changed patient	15-17, evidenced a nt dated 3-13-17, to ntation "Diagnosis: thritis, hypertension, 11 X [times] in 3 a signed by the nursing loyee A). The document nt #5's falls had started 0-17, one week after a -14-17, when the doctor #5's medications;					
	times a day (anti	g, 1 tablet by mouth, 3 -depressant), was added; (Vitamin D) 1,000 units,					

NTERS FO	R MEDICARE & MEDI	CAID SERVICES				O	MB NO. 0938-03	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD ANDERSON, IN 46013					
(X4) ID		STATEMENT OF DEFICIENCIES		D			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE	COMPLETIC	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE	
	1 capsule by m	outh daily, was added; and						
	Hyzaar was inc	reased from 110/12.5 mg,						
	to 100/25mg, 1	tablet by mouth daily (to						
	lower blood pro	essure). Known side						
	effects of Busp	irone and Hyzaar are						
	dizziness or lig	htheadedness.						
	A. Review	of a document dated 2-14						
	-17, titled "offi	ce visit" evidenced						
	-	by patient # 5's physician						
		, daughter with breast						
		ping well plan:						
		in-HCTZ (a blood pressure						
		ry buspar for anxiety (an						
	, · ·	, discontinue furosemide						
		continue tramadol (a pain						
	medication)."	ecumine namaon (a pam						
	B. Review	of a comprehensive adult						
	nursing assessm	nent dated 3-15-17,						
	completed by the	he nursing supervisor,						
		care coordination boxes						
	were checked f	or physician and aide.						
	C. Review	of patient #5's plan of						
		a start of care date of 3-15						
		fication period of 3-15-17						
		h order for "Home health						
		nours per day, 2 times a						
		s (activities of daily						
		t housekeeping.						
		se (RN) to do supervisory						
	-	ionth." The established						
		"patient will be free from						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		TE SURVEY MPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	B. WING	G <u>00</u>		05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	UR .		EET ADDRESS, CITY, STAT	TE, ZIP CODE		
	L HOME HEALTH			0 DR MLK BLVD DERSON, IN 46013			
						(775)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX		AN OF CORRECTION ACTION SHOULD BE	(X5) COMPLETIO	
TAG	,	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED	TO THE APPROPRIATE IENCY)	DATE	
	falls or falls wi						
	D. During	an interview with the					
	-						
	• •	sor, who admitted patient					
		he health aide (employee					
		at 3:55 PM, the nursing					
	-	d not having considered					
		ed nursing services for					
	-	sess the development of					
	-	week after prescribed					
		nges (2-14-17), and not					
	-	red a physical therapy					
		ess possible gait					
	-	nd safe transfers.					
		e HHA stated having met					
		care provider from an					
	-	r, who told employee F,					
	-	ved skilled nursing and					
		y services from the					
		Employee F could not					
		of the other agency, and					
	stated not havin	•					
		he nursing supervisor.					
		pervisor reported the					
		d the patient for home					
		rices only, and there there					
		ordination of care with the					
		The HHA failed to					
		with the supervising RN					
		ledge of an outside					
	-	led nursing and physical					
	therapy service	s for patient #5.					
	E. On 5-18	8-17 at 9:30 AM, during					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD B. WING			сомі 05/1	e survey pleted 8/2017
	PROVIDER OR SUPPLIE	R	5	TREET ADDRESS, C 730 DR MLK B NDERSON, IN		E	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PRE	FFIX (EACH C	OVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOUL EFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	name of the out verified the serv agency were sk therapy. 4. On 5-18-17 administrator/m the above findin	view, patient #5 stated the side provider and vices provided by the illed nursing and physical at 3:00 PM, the ursing supervisor verified ngs and stated not having umentation to present for					
G 0151 Bldg. 00	the agency faile with this Condi agency failed to professional per 152); failed to e professional per	DFESSIONAL d review and interview, ed to maintain compliance tion of Participation. The o ensure a group of rsonnel was appointed (G ensure a group of rsonnel was appointed to ency's policies (G 153);	G 0151	į n/a			08/04/2017

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R		5730 D	ADDRESS, CITY, STATE, ZIP DR MLK BLVD RSON, IN 46013	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 0152 Bldg. 00	advise the agen (See G 154). The cumulative problems result agency's inabili quality health c for the Condition CFR 484.16, Gr Personnel. 484.16 GROUP OF PRO PERSONNEL A group of profes at least one phys nurse (preferably appropriate repre- professional disc Based on record the agency faile professional per 1 of 1 home hea The findings ind 1. On 5-17-17 a minutes of the g 4-19-17, 4-5-17	effect of these systemic ed in the home health ty to ensure provision of are in a safe environment on of Participation, 42 roup of Professional DFESSIONAL esional personnel includes ician and one registered a public health nurse), and esentation from other iplines. I review and interview, ed to ensure a group of rsonnel was appointed for alth agency.	G 0	152	n/a		08/16/201

ENTERS FO	R MEDICARE & MEDIC	AID SERVICES			L L	OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEI	λ	5730 E	ADDRESS, CITY, STATE, ZIP DR MLK BLVD RSON, IN 46013	CODE	
(X4) ID	•	TATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	COMPLETIO DATE
	 7-29-16, and 6-1 failed to evidence appointed a groupersonnel to esta policies. 2. On 5-17-17 a administrator sta 	6, 8-18-16, 8-1-16, 16-16, were reviewed and the the governing body had up of professional ablish the agency's at 10:47 AM, the ated the agency did not professional personnel.				
G 0153 Bldg. 00	establishes and a agency's policies services offered, a policies, medical s care, emergency personnel qualific evaluation. At lea group is neither a of the agency. Based on record the agency failed professional per	essional personnel nnually reviews the governing scope of admission and discharge supervision and plans of care, clinical records, ations, and program ast one member of the n owner nor an employee review and interview, d to ensure a group of sonnel was appointed to ency's policies for 1 of 1	G 0153	n/a		08/15/201

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	AID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	IULTIPLE CO UILDING ⁄ING	nstruction 00	(X3) DA COM	DMB NO. 0938-039 TE SURVEY 1PLETED 18/2017
	PROVIDER OR SUPPLIEF			5730 DI	ADDRESS, CITY, STATE, ZIP R MLK BLVD SON, IN 46013	_	
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO		(X5) COMPLETIO
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
	 1. On 5-17-17 a minutes of the g 4-19-17, 4-5-17, 11-20-16, 9-6-16 8-24-16, 8-21-16 7-29-16, and 6-1 failed to evidence appointed a groupersonnel to esta policies. 2. On 5-17-17 a administrator state 	t 1:17 PM, the meeting overning body dated 12-14-16, 12-6-16, 5, 8-30-16, 8-25-16, 5, 8-18-16, 8-1-16, 6-16, were reviewed and the the governing body had up of professional ablish the agency's					
6 0154 Bldg. 00	The group of profe frequently to advis	EVALUATION FUNCTION essional personnel meets se the agency on s, to participate in the					

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

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

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU B. WI		00	- 05/18	eleted 3/2017
	PROVIDER OR SUPPLIE	R		5730 D	ADDRESS, CITY, STATE, ZIP CO R MLK BLVD RSON, IN 46013	DDE	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE	(X5) COMPLETION
TAG	evaluation of the assist the agency other health care	R LSC IDENTIFYING INFORMATION) agency's program, and to y in maintaining liaison with providers in the community y's community information	G 0	TAG 154	n/a		DATE 08/09/201
	the agency faile professional per	d review and interview, ed to ensure a group of rsonnel was appointed to cy on professional issues health agency.					
	minutes of the g 4-19-17, 4-5-17 11-20-16, 9-6-1 8-24-16, 8-21-1 7-29-16, and 6- failed to eviden appointed a gro	cluded: at 1:17 PM, the meeting governing body dated 7, 12-14-16, 12-6-16, 6, 8-30-16, 8-25-16, 6, 8-18-16, 8-1-16, 16-16, were reviewed and ce the governing body had up of professional cablish the agency's					
	administrator st	at 10:47 AM, the ated the agency did not professional personnel.					
G 0156	484.18 ACCEPTANCE (OF PATIENTS, POC, MED					

	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	B. WING		00	05/	
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP C	CODE	
ADMIRA	L HOME HEALTH				OR MLK BLVD RSON, IN 46013		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX	Ϋ́,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 00	SUPER			15(n/a		09/02/201
	D 1	1 to	G 0	130	100		08/03/201
		d review and interview,					
	6 3	ed to maintain compliance					
		ion of participation. The					
		ensure visits were made					
		with plan of care orders for					
	-	(Patient #1)(See G 158);					
		the plan of care included					
	all durable med	ical equipment,					
	nutritional requ	irement, complete					
	medication orde	er, safety measures, and a					
	discharge plan	for of 10 patients					
	(Patients #1-10)), and failed to ensure the					
	plan of care sta	rt of care date and					
	certification per	riods were correct for 4 of					
	10 patient's who	ose clinical record was					
	reviewed (Patie	nts # 1, 3, 5 and 9)(See G					
		lert the physician the					
		ined the established goals,					
	-	d a need to alter the					
		care to include discharge,					
	-	ents whose clinical record					
	_	Patient #10)(See G 164);					
		sure the registered nurse					
		bal order for disciplines,					
	-	d care orders at the start of					
	· ·						
		patients (Patient #1, 2, 3,					
		1 10) and failed to ensure					
	-	urse requested a verbal					
		e agency services to					
	-	nes, frequencies, and care					
		2 patients on service more					
	than 60 days (P	atients #1 and 10)(See G					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	JILDING ING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIEF	2	5730 DF	ADDRESS, CITY, STATE, ZIP C R MLK BLVD SON, IN 46013	CODE	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
	problems resulte agency's inability quality health ca for the Condition CFR 484.18, Ac	effect of these systemic d in the home health y to ensure provision of re in a safe environment n of Participation, 42 ceptance of Patients, d Medical Supervision.					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 05/18/2017		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD ADMIRAL HOME HEALTH ANDERSON, IN 46013								
PREFIX (EACH DEFICIEN		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			

CENTERS FOR MEDICARE & MEDIC STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			СОМ	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD 5730 DR MLK BLVD ADMIRAL HOME HEALTH ANDERSON, IN 46013								
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
9 0158 Bldg. 00	SUPER Care follows a wri- established and p doctor of medicine medicine. Based on record the agency failed made in accorda orders for 1 of 1 The findings inc 1. Review of th patient #1, evide 3-15-17, and con the certification 5-13-17, with or services 2 times Review of physi evidenced 1 visi 3-26 to 4-1-17, o notes failed to e	eriodically reviewed by a e, osteopathy, or podiatric review and interview, d to ensure visits were nce with plan of care 0 patients (Patient #1).	G 0	158	n/a		08/11/201	
	confirmed the al	at 3 PM, the administrator pove finding and stated ther documentation to viewed.						

STATEMEN	R MEDICARE & MEDIC VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIE	R	Ę	STREET ADDR 5730 DR M ANDERSON		DE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PR	ID REFIX CF FAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 0159 Bldg. 00	with the agency s diagnoses, includ services and equi of visits, prognos functional limitation nutritional requires treatments, any s against injury, insidischarge or refe appropriate items Based on observ- interview, the applan of care ince equipment, nutricomplete medice measures, and apatients (Patien ensure the plan and certification 4 of 10 patient's was reviewed (I The findings incomplete medice 1. Review of the patient #1, evidi of 3-15-17, and	vation, record review, and gency failed to ensure the luded all durable medical itional requirement, ration order, safety discharge plan for of 10 ts $\#1-10$, and failed to of care start of care date n periods were correct for whose clinical record Patients $\#1$, 3, 5 and 9).	G 015	9 nor	le		08/29/2017

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED
			B. WING	05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO	DE
ADMIRA	L HOME HEALTH			R MLK BLVD RSON, IN 46013	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION (X5)
PREFIX	ί.	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	PROPRIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	5-13-17.				
		of nutritional requirement			
	evidenced "non	e", durable medical			
	equipment and "walker", Medi	supplies evidenced			
		y/Route, evidenced			
		in antibiotic) 300 mg/4 ml			
every 12 hours P.O. (by mouth		, C			
	Measure evider				
		oals/rehabilitation			
	-	narge Plans evidenced			
		in transfers and is steady			
	-	use of furniture.			
	-	vith all ADL's (activity of			
		ersonal care, transfers and			
		ing. Independence with			
	-	alker if that is what she			
		free from falls, injuries			
	and hospitalizat	tion."			
	-	home visit observation of			
		ide (HHA) on 5-17-17, at			
		1 stated the Tobramyacin			
	was administer	ed by nebulizer, not by			
	mouth. A cane	, a nebulizer, an oxygen			
	concentrator, or	xygen tubing and cannula,			
	were observed	in the home.			
	C. Review	of the plan of care failed			
	to evidence the	cane, nebulizer, oxygen			
		xygen tubing and cannula,			
		ce fall precautions and			
		s safety measures, failed			

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		CON	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIER			STREET A 5730 D ANDEF	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED TO		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION & CROSS-REFRENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	to evidence a die evidence a disch	et order, and failed to arge plan.						
	patient# 2, evide of 3-15-17, and of for the certification 5-13-17. Diagn Thrombocytoper	nia (a disease that alters or of the blood and						
	medications evic "Hydrochlorthia: Lisinipril, Rantic Clonidine and V goals included "I hospitalizations a Patient will be al medications on o reminders/cues e Patient will have	zide, Metroprolol, dine, Citralopram, itamin D3." Established Patient will be free from and falls with injury. ble to set up all own and will have established in the home. e understanding of edications and the need						
	registered nurse AM, patient #2 s following medic the plan of care Aspirin and 65 n (aspirin is an ant	ome visit observation of a (RN) on 5-16-17 at 11 stated taking the ations not evidenced on 'B.C. packets (845 mg of ng of caffeine) for pain, i-platelet medication and otting of the blood,						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF			STREET A 5730 D ANDER	CODE		
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
IAG	caffeine can incr freeze (a topical joint pain, and p fiber medication C. The nurs -18-17 at 3 PM, document all the #2 on the plan o 3. Review of the #3, evidenced a 3-23-17, and con the certification 5-23-17. A. Review of equipment evide motorized wheel B. During h HHA, on 5-16-1 was observed to guardian", a safe button. C. Review of	rease blood pressure), bio pain medication) for polyethylene glycol (a) for constipation." ing supervisor stated on 5 having failed to medications for patient f care. clinical record of patient start of care date of ntained a plan of care for period of 3-23-17 to of durable medical nced "walker, cane, chair." ome visit observation of a 7 at 11 AM, patient #3 have a "medical ety/emergency call		IAG			
	#4, evidenced a 2-15-17, and con	clinical record of patient start of care date of ntained a plan of care for period of 2-15-17 to					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COM	OMB NO. 0938-039 X3) DATE SURVEY COMPLETED 05/18/2017 ODE	
	PROVIDER OR SUPPLIEF	2		CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE TAG DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE	
	requirements even established goals breath resolution client is using the positive airway p correctly. Client effects. Client we and hospitalizative will be able to re- independently." B. Review of to evidence the O medical equipment ordered diet, and discharge plan. 5. The clinical re- reviewed, and even and a plan of care period of 3-15-1 the plan of care of potential/dischar "Patient will be st will decrease. Pathospitalization of IADLs will be n failed to evidence patient #5.	of the nutritional idenced "none," is included "shortness of in is the goal and that the e CPAP (continuous pressure) machine will have no adverse ill remain free from falls ons and injuries. Client eturn to her own home of the plan of care failed CPAP machine as durable ent, failed to evidence an d failed to evidence a ecord of patient # 5 was videnced a start 3-15-17, re for the certification 7 to 5-13-17. Review of Goals/Rehabilitation rge plans evidenced free from falls or falls atient will not have any or injuries. ADLs and het." The plan of care a discharge plan for					

NTERS FO	R MEDICARE & MEDIC.	AID SERVICES				(OMB NO. 0938-03	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	AULTIPLE CO BUILDING VING	nstruction 00	COM	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIER		-		DDRESS, CITY, STATE, ZII	P CODE		
ADMIRA	L HOME HEALTH				R MLK BLVD SON, IN 46013			
(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 C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE	
	medical plan of a evidenced a start and contained a p certification peri 4-17-17. The pa Type 2 diabetes dependent. A. The plan medical equipme The nutritional re evidenced "none B. Review o nursing assessme evidenced patien and Diabetic die Lantus 30 units monitored by and competen glucometer." C. The plan evidence a diet o	care was reviewed, c of care date of 2-17-17, plan of care for the od of 2-17-17 to tient had diagnosis of mellitus and was insulin of care evidenced durable ent (DME) of "none". equirement section ". f a comprehensive adult ent, dated 2-17-17, t #6 required "Diabetes t." The form evidenced " blood sugar selfTID (3 times daily)						
	supplies. D. Review of							
	plans evidenced take medications understanding w	tion potential /discharge "Goal is that patient will as ordered and have an hy she is on each nt will have no adverse vill be free from						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED B. WING 05/18/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5730 DR MLK BLVD ADMIRAL HOME HEALTH ANDERSON, IN 46013 (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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG hospitalization". The plan of care failed to evidence a discharge plan for patient #6 7. The clinical record of patient #7, was reviewed and evidenced a start of care date of 2-17-17, and contained a plan of care for the certification period of 4-18-17 to 6-16-17. A. DME on the plan of care evidenced "none". B. The Goals /Rehabilitation potential /discharge plans evidenced "Patient will remain compliant with medications as ordered by MD and remain free from adverse effects. Patient will remain free from injuries and hospitalizations." C. The plan of care failed to evidence DME of a glucometer, needles, and diabetic testing supplies and failed to evidence a discharge plan. 8. The clinical record of patient #8, was reviewed and evidenced a start of care of 4-11-17, and contained a plan of care for the certification period of 4-11-17 to 6-9-17. The patient had a diagnosis of obstructive sleep apnea. The order section of the plan of care evidenced "Pt just received CPAP machine and requires teaching and care of machine." FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ABKF11 Facility ID: 014092 If continuation sheet Page 43 of 147

PRINTED:

08/25/2017

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES I OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A.	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIER			STREE 5730 ANDE	E, ZIP CODE			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	NCIES ID PROVIDER'S PLAN OF -		N OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE A		COMPLETIC	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICI		DATE	
	A. Review of evidenced "none	of the plan of care DME						
	B. Review o	f the Goals						
		otential /discharge plans						
		is that patient will be						
		of CPAP, BP will						
		ontrolled, pain will be						
		and more comfortable.						
		as needed. Will remain						
	free of injury and							
	hospitalizations.							
	F							
	C. The plan	of care evidenced for						
	nutritional requir							
	-	of care failed to evidence						
	1	DME and supplies of						
	•	lles, diabetic testing						
		led to evidence a						
	discharge plan.							
	9. Review of the	clinical record of patient						
		start of care date of						
		ntained a plan of care for						
		period of 4-12-17 to						
	6-10-17.	r						
	A. Review	of the nutritional						
	requirements evi	denced "none".						
		of the comprehensive						
	nursing assessme	ent dated 4-12-17,						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. E	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF		-	STREET A 5730 DI ANDER	CODE			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	evidenced the N "regular" as pati	utritional requirement ent #9's diet.						
	evidenced "Will oversight and be free from injury hospitalizations.	f the Goals otential /discharge plans be compliant with ADL odor free daily. Will be and no falls and no Will be free of seizures medication reminders."						
	-	of care failed to evidence failed to evidence a						
	patient #10 evide of 3-4-17, and co for the certificat 5-2-17, and a pla	e clinical record of enced a start of care date ontained a plan of care ion period of 3-4-17 to an of care for the od of 5-3-17 to 7-3-17.						
	A. Review o "none."	f DME evidenced						
	nursing assessm evidenced "Diab diet injectable Humalog mor The plan of care patient #10's glu	of a comprehensive adult ent dated 3-4-17, etes type 2, diabetic medication, Lantus hitored by self bid." failed to evidence cometer, diabetic test es as DME and supplies.						

AND PLAN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIER			5730 DF	ADDRESS, CITY, STATE, ZIP R MLK BLVD	CODE	
	AL HOME HEALTH				SON, IN 46013		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	 /Rehabilitation p evidenced "Goal take all medicati ordered and have she is on each m will have no adv will be free from D. The plan evidence a disch 11. Review of th patient #1 evider of 3-15-17, and a 3-15 to 5-13-17. comprehensive a 3-15-17. The fir defines the start health aide on 3- comprehensive a performed 7 day establishment of rather than not m start of care. 12. Review of th patient #3 evider of 3-23-17, and a 3-23 to 5-21-17. comprehensive a 3-23-17. The fir 	assessment was s prior to the a start of care date, hore than 5 days after the ne clinical record of need a start of care date a certification period of The start of care assessment was dated ast billable visit, which of care, was by a home					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD ANDERSON, IN 46013			
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
	rather than not n start of care. 13. Review of th patient #5 evider of 3-15-17, and a 3-15 to 5-13-17. comprehensive a 3-15-17. The fin defines the start health aide on 3- comprehensive a performed 2 day establishment of rather than not n start of care. 14. Review of th patient #9 evider of 4-12-17, and a 4-12 to 6-10-17. comprehensive a 4-12-17. The fin defines the start health aide on 4- comprehensive a performed 6 day establishment of	prior to the a start of care date, hore than 5 days after the the clinical record of fineed a start of care date a certification period of The start of care assessment was dated ast billable visit, which of care, was by a home 17-17. The assessment was s prior to the a start of care date, hore than 5 days after the the clinical record of fineed a start of care date a certification period of The start of care assessment was dated ast billable visit, which of care, was by a home 18-17. The assessment was					

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

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

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	00	05/18/2017	
	PROVIDER OR SUPPLIE	R	5730 [ADDRESS, CITY, STATE, ZIP CODE DR MLK BLVD RSON, IN 46013		
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION	
G 0164 Bldg. 00	the above findin no further docur reviewed. 484.18(b) PERIODIC REVI Agency profession physician to any profession physician to any profession physician to any profession physician to any profession physician the particular the med interview, the approximate the pro- established goal to alter the med include discharg whose clinical r (Patient #10). The findings interview	EW OF PLAN OF CARE nal stated there was mentation to present to be EW OF PLAN OF CARE nal staff promptly alert the changes that suggest a plan of care. vation, record review, and gency failed to alert the attent had attained the s, which suggested a need ical plan of care to ge, for 1 of 10 patients ecord was reviewed	G 0164	none	09/04/2017	
	patient # 10, ev date of 3-4-17, a certification per with order for "	idenced a start of care and contained a first iod of 3-4-17 to 5-2-17, Skilled Nurse biweekly ification period for				
	compliance with	n DM (diabetes mellitus)				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	î î	JILDING	NSTRUCTION 00	CON	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF	2		STREET A 5730 DF ANDER	CODE			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	 and notify MD F (medication) set care for the seco of 5-3-17 to 7-1- physician on 5-8 for "Skilled Nur certification peri technique, moni DM (diabetes m (blood pressure) PRN (as needed) 2. Review of ski dated 4-19-17, e up by patient wi oversight. No en pressure is well to use calendar f to be complaint mellitus)." 3. Review of co physician orders documentation t the physician par established goal certification peri service was bein certification peri appropriate prior 	tor for compliance with ellitus) and follow B/P readings and notify MD)." Iled nurse visit note videnced "Medication set th skilled nurse rrors made Blood controlled Continues for reminders continues with DM (diabetes						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ź		ONSTRUCTION		TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> B. WING		00	COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CO 5730 DR MLK BLVD ANDERSON, IN 46013			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O 1:30 PM. The a patient #10 "do could probably The nursing sup no skilled servio the 2nd recertifi patient had dem with insulin adr goals by the end period. The nur need to talk to (STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) administrator stated es well with insulin, I discharge [patient #10]." pervisor stated there was ce being provided during cation period, as the onstrated competency ministration and met other d of the 1st certification rsing supervisor stated, " I employee G), the office de on discharging."		ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE J DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 0166 Bldg. 00	ORDERS Verbal orders are and dated with th registered nurse defined in section responsible for fu ordered services Based on record the agency faile nurse requested disciplines, frec at the start of ca	E WITH PHYSICIAN e put in writing and signed e date of receipt by the or qualified therapist (as a 484.4 of this chapter) rnishing or supervising the d review and interview, d to ensure the registered a verbal order for uencies, and care orders re for 9 of 10 patients , 4, 5, 6, 7, 8, and 10) and	G 0	166	none		09/04/201

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	AID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	r í	ULTIPLE CON JILDING ING	(X3) DA COM	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF			STREET A 5730 DF ANDERS	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECT CROSS-REFERENCE		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	 failed to ensure to requested a verb agency services frequencies, and patients on servi (Patients #1 and The findings incomplete the findings incomplete the services and treat of documented as 9 and staff Wilf [s services and treat by the physician 2. Review of the clinical recomplete the reg requested a verb 	the registered nurse al order to continue to include disciplines, care orders for 2 of 2 ce more than 60 days 10). luded: policy, "Physician board approval P-6-17, stated, " Agency ic Will] administer tments only as ordered					
	care visits were 3 3-9, 3-16, and 3- physician author notes evidenced performed media monitored vital s B. The plan	of visit notes evidenced furnished by the nurse on 22-17, prior to obtaining ization for care. Visit the registered nurse had cation set up and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED B. WING 05/18/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5730 DR MLK BLVD ADMIRAL HOME HEALTH ANDERSON, IN 46013 (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 DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG C. Review of physician's order about the time of recertification on 5-1-17, failed to evidence a physician's order to continue care. As of 5-18-17, the physician had not signed the plan of care. A home health aide furnished care on 5-17-17. 3. Review of the physician's orders in the clinical record of patient #2 failed to evidence the registered nurse had requested a verbal order for disciplines, frequencies, and care orders prior to furnishing services. A. Review of visit notes evidenced care visits were furnished by the nurse on 3-22, 3-29, and 3-22-17, prior to obtaining physician authorization for care. Visit notes evidenced the registered nurse had performed medication set up. Review of visit notes evidenced the home health aide (HHA) had furnished assistance with ADLs (activities of daily living) and IADLs (instrumental activities of daily living) during care visits on 3-17, 3-19, 3-23, 3-27, and 3-30 -17. B. The plan of care evidenced signature of the attending physician dated 4-3-17. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ABKF11 Facility ID: 014092 If continuation sheet Page 52 of 147

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	UILDING ING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIER			5730 DI	ADDRESS, CITY, STATE, ZIP R MLK BLVD SON, IN 46013	CODE		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAY PREFIX (EACH CORRECTIVE A CROSS-REFERENCED		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETIO	
TAG	 4. Review of the the clinical reconversion of the evidence the regrequested a verb frequencies, and furnishing service A. Review of the HHA had fur ADLs and IADL 24, 3-27, 3-29, 3 and 4-11-17. B. The plan 	LSC IDENTIFYING INFORMATION) e physician's orders in d of patient #3 failed to istered nurse had al order for disciplines, care orders prior to res. of visit notes evidenced nished assistance with LS during care visits on 3- -31, 4-3, 4-5, 4-7, 4-9, of care evidenced attending physician dated		TAG			DATE	
	the clinical recorr evidence the reg requested a verb	ne physician's orders in rd of patient #4 failed to istered nurse had al order for disciplines, care orders prior to res.						
	care visits were a 2-20 and 2-27-12 physician author notes evidenced assessed vital signatient on the us	of visit notes evidenced furnished by the nurse on 7, prior to obtaining ization for care. Visit the registered nurse had gns, and instructed the e of CPAP machine tive airway pressure)						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	IULTIPLE CO UILDING /ING	DNSTRUCTION 00	CO!	te survey Mpleted 18/2017
	PROVIDER OR SUPPLIEF	• {		5730 DI	ADDRESS, CITY, STATE, ZI R MLK BLVD SON, IN 46013	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TI TAG DEFICIENCY		N SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
	_	of care evidenced attending physician dated					
	the clinical record evidence the reg requested a verb	the physician's orders in rd of patient #5 failed to istered nurse had al order for disciplines, care orders prior to ces.					
	care visits for as	of visit notes evidenced sistance with ADLs and nished by the HHA on 3-					
	-	of care evidenced attending physician dated					
	the clinical record evidence the reg requested a verb	the physician's orders in rd of patient #6 failed to istered nurse had al order for disciplines, care orders prior to ces.					
	care visits were 2-21, 2-28, and 2 physician author	of visit notes evidenced furnished by the nurse on 3-7-17, prior to obtaining rization for care. Visit the registered nurse had cation set up.					

	R MEDICARE & MEDI NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ILTIPLE CO	NSTRUCTION	(X3) DATE SURVE	Y
	OF CORRECTION	IDENTIFICATION NUMBER:	ì í	ILDING	<u>00</u>	COMPLETED 05/18/2017	1
NAME OF				STREET A	ADDRESS, CITY, STATE, ZIP (CODE	
	PROVIDER OR SUPPLIE	ι κ			R MLK BLVD		
ADMIRA	L HOME HEALTH			ANDER	SON, IN 46013		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COL	RRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	1	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	PLETIC ATE
IAU		n of care evidenced		IAU	,		AIL
	-	attending physician dated					
	3-9-17.	autonamig physician dated					
	8. Review of t	he physician's orders in					
		ord of patient #7 failed to					
	evidence the re	gistered nurse had					
	-	bal order for disciplines,					
	-	d care orders prior to					
	furnishing serve	ices.					
	A Daviau	of visit notes evidenced					
		furnished by the nurse on					
		2-27-17, prior to					
		cian authorization for					
		s evidenced the registered					
		rmed medication set up					
	and monitored	-					
	B. The pla	n of care evidenced					
	signature of the 2-28-17.	attending physician dated					
		he physician's orders in					
		ord of patient #8 failed to					
		gistered nurse had					
	-	bal order for disciplines,					
	· ·	d care orders prior to					
	furnishing serv	ices.					
	A. Review	of visit notes evidenced					
		furnished by the nurse on					
		o obtaining physician					
	-	or care. Visit notes					

NTERS FOR MEDICARE & MEDIC STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	r í	JILDING	NSTRUCTION 00	(X3) DA COM	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF PROVIDER OR SUPPLIES	R		5730 DF	ADDRESS, CITY, STATE, ZIP R MLK BLVD SON, IN 46013	P CODE		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECT CROSS-REFEREN		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
	egistered nurse had cation set up and signs.						
-	n of care evidenced attending physician dated						
the clinical reco evidence the reg requested a vert	he physician's orders in rd of patient #10 failed to gistered nurse had bal order for disciplines, I care orders prior to ces.						
care visits were 3-9, 3-16, and 3 physician author notes evidenced	of visit notes evidenced furnished by the nurse on -22-17, prior to obtaining rization for care. Visit the registered nurse had cation set up and signs.						
-	n of care evidenced attending physician dated						
the time of recent failed to evidence	of physician's order about rtification on 5-2-17, ce a physician's order to The physician signed the ers on 5-8-17.						
D. Review	of visit notes evidenced a						

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00	COM 05/	(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIE	ER	5730 D	address, city, state, zif R MLK BLVD RSON, IN 46013	P CODE			
X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	when the RN m compliance with and medication 12. On 5-18-17 supervisor verifi- and stated the a include calling furnishing servi- order for discip care orders. Th stated the first se patients 1, 2, 3, occurred upon care, up to 30 d begun providin services stated include obtainin continue servic of the previous nursing supervi	e visit note dated 5-3-17, nonitored patient #10 h diabetes mellitus diet and took vital signs. A at 3 PM, the nursing fied the above findings gency practice did not the physician prior to ices to obtain a verbal lines, frequencies, and he nursing supervisor signed order for care for 4, 5, 6, 7, 8, and 10 return of a signed plan of ays after the agency had g care. The nursing the agency practice did not ng a verbal order to es prior to the expiration certification period. The sor stated there was no ntation to present to be						
0168 dg. 00	484.30 SKILLED NURSI	NG SERVICES						

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Event ID:

ABKF11 Facility ID: 014092

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	r í	VILDING	DNSTRUCTION 00	CON	ate survey Mpleted 18/2017	
	PROVIDER OR SUPPLIE	R		5730 D	ADDRESS, CITY, STATE, ZIP C R MLK BLVD RSON, IN 46013	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF O PREFIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH TAG DEFICIENCY		IOULD BE	(X5) COMPLETIC DATE	
	the agency failed with this condit agency failed to nurse (RN) case necessary revis 10 of 10 patient failed to ensure implemented or 2 patients with #1), and failed to nurse implement to monitor the v the diagnosis of patient with a d (Patient #2)(See ensure the regis agency policy to clinical record of for 2 of 2 patien (Patients #3 and The cumulative problems result agency's inabili quality health co for the Condition	d review and interview, ed to maintain compliance ion of participation. The o ensure the registered e manager initiated ions to the plan of care for is (See G 173); the agency the registered nurse cygen precautions for 1 of oxygen therapy (Patient to ensure the registered need nursing interventions weight of a patient with f weight loss for 1 of 1 iagnosis of weight loss e G 175); and failed to tered nurse implemented to color code mark the of patient's at risk for a fall its at risk for falls 1 5)(See G 176).	GO	168	none		09/04/20	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R		5730 E	ADDRESS, CITY, STATE, ZIP DR MLK BLVD RSON, IN 46013	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 0173 Bldg. 00	The registered nuclear and necessar Based on record the agency faile nurse (RN) cas necessary revisi 10 of 10 patient The findings ind 1. Review of th patient #1, evid of 3-15-17, and for the certifica 5-13-17. A. Review narrative evider oxygen at night to evidence an or registered nurse to the plan of ca	I review and interview, d to ensure the registered e manager initiated ons to the plan of care for s (Patient #1-10).	G 0	173	none		09/04/2017
	the first billable	of visit notes evidenced visit was by a home (A) on 3-22-17, which					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 05/18/2017
NAME OF	PROVIDER OR SUPPLIE	R	STREE	T ADDRESS, CITY, STATE, ZIP	CODE
	L HOME HEALTH			DR MLK BLVD ERSON, IN 46013	
	-				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	
TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE
-		hment of the start of care.			
		o initiate revision of the			
		correct the start of care			
	-	, and the certification			
	period to 3-22 t				
	period to 5-22 t	0 5-20-17.			
	C Review	of the plan of care			
		tritional Requirement of			
		N failed to initiate			
		plan of care to document a			
	-	irement for patient #1.			
	The plan of car	-			
	-	tion/discharge plans			
	-				
		evidence any discharge			
		#1. The RN failed to			
		of the plan of care to			
	document a dise	charge plan for patient #1.			
	D. Review	of the referral order, dated			
	3-13-17, for pat	ient #1 was to "evaluate			
	and treat." Pati	ent #1 had not had an			
	initial assessme	nt or physician orders for			
	care on 3-13-17	. The RN failed to			
	initiate revision	to the referral order to			
	clarify the order	r was to evaluate only for			
	the appropriate	ness of home health			
	agency services				
	2. Review of	the clinical record of			
	•	enced a start of care date			
		contained a plan of care			
		tion period of 3-15 to			
	5-13-17.				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/18/2017			
	PROVIDER OR SUPPLIER			5730 D	address, city, state, zif R MLK BLVD RSON, IN 46013	CODE	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE AC CROSS-REFERENCED T TAG DEFICIEN		I SHOULD BE	(X5) COMPLETIO DATE		
	narrative evidend diagnosis of wei to initiate revisio include monitori appropriate nurs B. Review o 3-13-17, for pati and treat." Patie initial assessmen care on 3-13-17. initiate revision for clarify the order the appropriatend agency services. 3. Review of the patient #3, evide of 3-23-17, and of for the certification 5-21-17. A. During a of a HHA on 5-1 #3 was observed guardian" devices the medical guar B. Review of narrative evidend durable medical can, and motoriz	f the referral order, dated ent #2 was to "evaluate nt #2 had not had an at or physician orders for The RN failed to to the referral order to was to evaluate only for ess of home health e clinical record of need a start of care date contained a plan of care ton period of 3-23 to home visit observation 7-17 at 11 AM, patient to have a "medical e. Patient #3 stated using							

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:			UILDING	DNSTRUCTION 00	CON	te survey Mpleted 18/2017
NAME OF PROVIDER OR SUPPLIER ADMIRAL HOME HEALTH				STREET A 5730 D ANDER	CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX (EACH CORREC CROSS-REFEREN		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	ENCED TO THE APPROPRIATE	
	care to documen	t the durable medical nedical guardian.					DATE
	the first billable health aide (HHZ defines establish The RN failed to plan of care to co	of visit notes evidenced visit was by a home A) on 3-24-17, which ment of the start of care. o initiate revision of the prrect the start of care and the certification 0 5-22-17.					
	patient #4, evide of 2-15-17, and	e clinical record of nced a start of care date contained a plan of care ion period of 2-15 to					
	to evidence a dis #4. The register	of the plan of care failed scharge plan for patient ed nurse failed to initiate lan of care to document a					
	2-13-17, for pati and treat." Patie initial assessmer care on 2-13-17. initiate revision clarify the order	of the referral order, dated ent #4 was to "evaluate nt #4 had not had an at or physician orders for The RN failed to to the referral order to was to evaluate only for ess of home health					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED B. WING 05/18/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5730 DR MLK BLVD ADMIRAL HOME HEALTH ANDERSON, IN 46013 (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 DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG 5. Review of the clinical record of patient #5, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17. A. Review of the plan of care failed to evidence a discharge plan for patient #5. The RN failed to initiate revision to the plan of care to document a discharge plan. B. Review of visit notes evidenced the first billable visit was by a home health aide (HHA) on 3-17-17, which defines establishment of the start of care. The RN failed to initiate revision of the plan of care to correct the start of care date to 3-17-17, and the certification period to 3-17 to 5-15-17. C. Review of the referral order, dated 2-14-17, for patient #5 was to "evaluate and treat." Patient #6 had not had an initial assessment or physician orders for care on 2-14-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 6. Review of the clinical record of patient #6, evidenced a start of care date of 2-17-17, and contained a plan of care FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: ABKF11 Facility ID: 014092 If continuation sheet Page 63 of 147

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE L HOME HEALTH	R	5730 D	ADDRESS, CITY, STATE, ZIP CO R MLK BLVD RSON, IN 46013	DE
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE COMPLETIC
	for the certifica 4-17-17.	tion period of 2-17 to			
	to evidence a di #6. The RN fail	y of the plan of care failed scharge plan for patient ed to initiate revision to to document a discharge			
	evidenced an or spray as needed allergies). The evidence the str and how often t	of the plan of care der for Flonase nasal (a medication to treat medication order failed to ength of the spray ordered he interval for the as ion was ordered.			
	3-13-17, for pat and treat." Pati initial assessme care on 3-13-17 initiate revision clarify the order	of the referral order, dated ient #1 was to "evaluate ent #6 had not had an nt or physician orders for . The RN failed to to the referral order to twas to evaluate only for hess of home health			
	patient #7, evid of 2-17-17, and	te clinical record of enced a start of care date contained a plan of care tion period of 2-17 to			
	A. Review	of the plan of care failed			

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	ISTRUCTION	(X3) DA	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> B. WING		00		COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	D		STREET AI	DDRESS, CITY, STATE, ZIP	CODE		
	AL HOME HEALTH	κ.			MLK BLVD SON, IN 46013			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI	SHOULD BE	(X5) COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		ГAG	DEFICIENCY)		DATE	
	#7. The RN fai	scharge plan for patient led to initiate revision to to document a discharge						
	2-15-17, for pata and treat." Patie	of the referral order, dated ient #7 was to "evaluate ent #7 had not had an nt or physician orders for						
	care on 2-15-17 initiate revision clarify the order	. The RN failed to to the referral order to was to evaluate only for ness of home health						
	patient #8, evid of 4-11-17, and	ne clinical record of enced a start of care date contained a plan of care tion period of 4-11 to						
	narrative evider CPAP (continue pressure) machi failed to eviden durable medical registered nurse	of the plan of care aced patient #8 used a bus positive airway ne. The plan of care ce the CPAP machine as equipment and the failed to initiate revision						
	the CPAP as du B. Review to evidence a di	re to update to include rable medical equipment. of the plan of care failed scharge plan for patient led to initiate revision to						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 05/18/2017
					—
NAME OF	PROVIDER OR SUPPLIE	R		TADDRESS, CITY, STATE, ZIP (DR MLK BLVD	CODE
	L HOME HEALTH			RSON, IN 46013	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	
PREFIX TAG	Ϋ́,	NCY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	
IAG		R LSC IDENTIFYING INFORMATION)	IAG	DEFICIENCET	DATE
	_	to document a discharge			
	plan.				
		of the referral order, dated			
	-	tient #8 was to "evaluate			
		ent #8 had not had an			
		nt or physician orders for			
		. The RN failed to			
	initiate revision	to the referral order to			
	-	r was to evaluate only for			
	the appropriate	ness of home health			
	agency services	L			
	9. Review of t	he clinical record of			
	patient #9, evid	enced a start of care date			
	of 4-12-17, and	contained a plan of care			
	for the certifica	tion period of 4-12 to			
	6-10-17.				
	A Review	of the plan of care failed			
		utritional requirement for			
		the registered nurse failed			
	-	on to the plan of care to			
		le an nutrition order.			
	B. Review	of the plan of care failed			
		scharge plan for patient			
		led to initiate revision to			
		to document a discharge			
	plan.	to advantant a discharge			
	Piun.				
	C Review	of the referral order, dated			
		tient #9 was to "evaluate			
	-	ent #9 had not had an			
	and ucat. rall	$\sin \pi 2$ hau not nau all			

	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF			STREET A 5730 D ANDEF	CODE			
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	care on 4-11-17. initiate revision clarify the order the appropriaten agency services. 10. Review of t patient #10, evic of 3-4-17, and co for the certificat 5-2-17. A. Review narrative eviden diabetic and test The RN failed to to include patien testing strips as equipment and s B. Review 0 3-2-17, for patie and treat." Patie initial assessmen care on 3-2-17. revision to the re- order was to eva appropriateness services. 11. On 5-18-17 administrator/nu	the clinical record of lenced a start of care date ontained a plan of care ion period of 3-4 to of the plan of care ced patient #10 was ed blood sugar at home. o revise the plan of care t #10's glucometer and durable medical upplies. of the referral order, dated nt #10 was to "evaluate nt #10 had not had an at or physician orders for The RN failed to initiate efferral order to clarify the luate only for the of home health agency						

STATEMEN				JILDING ING	ONSTRUCTION 00	(X3) DATE COMP 05/18	
	PROVIDER OR SUPPLIEF	ι.		5730 D	Address, city, state, zip cod DR MLK BLVD RSON, IN 46013	θE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
9 0175 Bldg. 00	 reviewed. 484.30(a) DUTIES OF THE The registered nu preventative and procedures. Based on observent interview, the age registered nurse oxygen precaution with oxygen the failed to ensure the failed to ens	luded: visit observation of a	G 0	175	None		09/04/201
	5-17-17 at 2 PM was observed in stated using it at	e for patient #1 on , an oxygen concentrator the home. Patient #1 night. Review of the ed to evidence the RN					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	JILDING	onstruction 00	(X3) DATE SURVEY COMPLETED	
			B. WING			05/18/2017	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP C	CODE	
ADMIRA	L HOME HEALTH				RSON, IN 46013		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE
	had implemente safety measure.	ed oxygen precautions as a					
		e plan of care for patient					
		diagnosis of weight loss. killed nursing orders					
		led Nursing 1 time a					
		ation set up, B/P (blood					
		oring at each visit." The plement monitoring of					
		propriate nursing					
		d rehabilitative measure.					
	3. On 5-18-17						
		ursing supervisor verified ng and stated there was no					
		ntation to present to be					
	reviewed.						
G 0176	484.30(a)						
Dida 00	DUTIES OF THE	REGISTERED NURSE					
Bldg. 00	progress notes, of informs the physic	cional and control and control and control and control and control of control and control					
	needs.		GO	176	No responsse		08/21/201
		l review and interview,					
		d to ensure the registered					
	-	nted agency policy to color linical record of patient's					
		for 2 of 2 patients at risk					

	NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIEF	R		STREET A 5730 DF ANDER	CODE				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH COL		PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	for falls (Patient sample of 10.	s #3 and 5), of a total							
	The findings inc	luded:							
	of 9-6-17, stated of of the patient' routinely assess for appropriate i fall prevention on the patient's c assignment boar	h date of board approval , "It is the responsibility s nurse or therapist to the patient for the need nterventions related to . A color code is placed chart and on the patient d, if applicable. This personnel that the							
	patient #3 failed	e clinical record of to evidence any color laced on the chart.							
	patient #5 failed	e clinical record of to evidence any color laced on the chart.							
	the above findin	t 3 PM, the rsing supervisor verified gs and stated agency een implemented.							

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. I	BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF	ł		5730 E	ADDRESS, CITY, STATE, ZIP C DR MLK BLVD RSON, IN 46013	ODE	
(X4) ID	•	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX			PROVIDER'S PLAN OF C ST DE DDECEDED DV EULL DDEELV (FACH CORRECTIVE ACTIO)		IOULD BE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
G 0224	484.36(c)(1)						
Bldg. 00	HEALTH AIDE Written patient ca home health aide registered nurse of professional who supervision of the paragraph (d) of the Based on record the registered nur nutritional requi home health aide	review and interview, urse failed to include a rement on the prepared a e care plan for 1 of 6 eived home health aide	G	0224	No response		08/21/201
	patient #1, evide of 3-15-17, and for the certificat 5-13-17, with or services. Review care plan, dated 5-11-17, failed t requirement (die 2. On 5-18-17 at supervisor verifi stated there was	e clinical record for enced a start of care date contained a plan of care ion period of 3-15 to der for home health aide w of the home health aide 3-15-17, and updated on o evidence a nutritional et order).					

	R MEDICARE & MEDI		(V2) MIT		ONSTRUCTION	(V2) DA1	E SUDVEV	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NOMBER.	A. BUILDING <u>00</u> B. WING		00		5/18/2017	
				STREET	ADDRESS, CITY, STATE, ZIP COE		0,2011	
NAME OF I	PROVIDER OR SUPPLIE	R			R MLK BLVD			
	L HOME HEALTH				RSON, IN 46013			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE	
G 0250	484.52(b) CLINICAL RECC							
Bldg. 00		, appropriate health						
Diug. 00		presenting at least the						
	scope of the prog	gram, review a sample of						
		losed clinical records to						
		er established policies are						
	under arrangeme	hing services directly or						
			G 02	50	No response		09/04/2017	
	Based on record	l review and interview,	0.01				0,	
		ed to ensure the clinical						
		vas performed by						
		senting the scope of						
		, and failed to ensure						
		udits identified failure to						
		policies and to meet home						
		egulations for 2 of 2						
		l record audits reviewed						
	-	6), of a total sample of						
	`	o), of a total sample of						
	10.							
	The findings in	cluded:						
	1 2	rformance Improvement						
		wed on 5-17-17 at 9:30						
	AM. The polic	y stated, "Admiral Home						
	Health collects	data and monitors						
	performance in	at least the following						
	areas Quality	Improvement Data						
	Indicators ris	k						
	management/oc	currences(effectiveness of						
	fall reduction p	rogram and overall						
	-	e) customer complaints						
		action infection control						
	1							

NTERS FO	R MEDICARE & MEDI	CAID SERVICES			0	MB NO. 0938-03	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COMI	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF PROVIDER OR SUPPLIER ADMIRAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD ANDERSON, IN 46013				
(X4) ID	-	STATEMENT OF DEFICIENCIES	ID			(X5)	
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC	
	 control poter investigation medical record are systematica quarterly basis. professionals re- of care and serv agency review and closed record 2. A chart audit 4-18-17, for par- clinical record is had received ph health aide serv conducted by (of manager/ home documents wer the administrate (employee A). #1's clinical record specific to physe There was no d physical therap chart audit. Re failed to eviden agency failure to to perform an in to obtain a physion 	d reporting quality tially avoidable event home health compare review clinical records lly reviewed on a a group of health presentative of the scope vices provided by the a sample of both active rds." was documented on tient #1. Review of # 1 evidenced patient #1 sysical therapy and home vices. The chart audit was employee # G), the office health aide. The e signed, but not dated, by pr/nursing supervisor The chart audit of patient ord, lines 56-73, were sical therapy services. ocumentation of the ist's participation in the view of the chart audit ce the audit had identified o coordinate care, failure nitial assessment, failure sician's verbal start of care urnishing services, failure complete and accurate					
	-	assessment as required by failure to identify a diet					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP C	ODE	
ADMIRAL HOME HEALTH				DR MLK BLVD		
	-			RSON, IN 46013		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
	agency policy, patient's diet or plan, and failur therapy visits w of care frequen agency policy. 3. A chart audi 4-19-17, for par patient #6's clir patient #6 had n services only. ' conducted by (of manager/ home documents wer the administrate (employee A). ' #6's clinical rec participation of chart audit, and chart audit iden a complete meet of care, as requi failure to perfor and failure to o order prior to fu 4. The administs 5-18-17 at 2:56 signed the char them, but not d review. The additional patient audit additional chart audit additional complete meet of care, as requi	an of care, as required by failure to identify the a the home health aide care e to identify physical vere not provided per plan cy order, as required by t was documented on tient #6. Review of aical record evidenced received skilled nursing The chart audit was employee # G), the office thealth aide. The e signed, but not dated, by or/nursing supervisor The chart audit of patient cord failed to evidence the trailed to evidence the the failed to evidence the failed to evidence the the failed to evidence the failed to evidence the the failed to evidence the failed to evi				

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	<u>00</u>	COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R	STREET 5730 D ANDER			
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O of the agency's deficiencies, an the office mana	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) chart audits to identify d stated not being aware ger/home health aide rm all the agency's chart	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION	
G 0251 Bldg. 00	records for each receives home had adequacy of the appropriateness Based on obser- interview, the a agency's 60 day record identified the established inappropriatene of 2 patients on	uing review of clinical 60-day period that a patient ealth services to determine olan of care and of continuation of care. vation, record review, and gency failed to ensure the review of a clinical d the patient had attained	G 0251	No response	08/21/201	

	T OF HEALTH AND HU! R MEDICARE & MEDIC						FORM APPROVI DMB NO. 0938-03	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	IULTIPLE CO UILDING /ING	DNSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZI	P CODE		
ADMIRA	ADMIRAL HOME HEALTH				R MLK BLVD RSON, IN 46013			
(X4) ID				ID	PROVIDER'S PLAN OF O		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	IE APPROPRIATE	COMPLETI	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI		DATE	
	The findings inc	luded:						
	1. Review of the	e clinical record of						
		denced a start of care						
	· ·	nd contained a 1st						
		od of 3-4-17 to 5-2-17,						
	-	Skilled Nurse biweekly						
	until end of certi	fication period for						
	memory techniq	ue, monitor for						
	compliance with	DM (diabetes mellitus)						
	and follow B/P (blood pressure) readings						
	-	PRN (as needed) and med						
		up." Review of a plan of						
		recertification period of						
		, signed by the physician						
		nced an order for						
		iweekly until end of						
	certification peri							
	_	tor for compliance with						
	•	ellitus) and follow B/P						
	PRN (as needed)	readings and notify MD)."						
	2. Review of ski	lled nurse visit note						
		videnced "Medication set						
	up by patient wi							
		rrors made Blood						
	-	controlled Continues						
	to use calendar f	or reminders continues						
	to be complaint mellitus)."	with DM (diabetes						
	,	mmunication notes and						
	02-99) Previous Versions Ob	psolete Event ID:						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 05/18/2017		
NAME OF PROVIDER OR SUPPLIER ADMIRAL HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD ANDERSON, IN 46013			XODE	
(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 COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
	documentation t the physician pa established goals certification peri service was bein certification peri appropriate prior 4. An interview supervisor was of 1:30 PM. The a patient #10 "doo could probably of The nursing sup no skilled service the 2nd recertific patient had demo- with insulin adm goals by the end period. The nur- need to talk to (e	failed to evidence he agency had notified tient #10 had met s during the 1st fod on 4-19-17, no skilled ig furnished the 2nd fod, and discharge was r to recertification. with the nursing conducted on 5-18-17 at dministrator stated es well with insulin, I discharge [patient #10]." ervisor stated there was e being provided during cation period, as the onstrated competency hinistration and met other of the 1st certification sing supervisor stated, " I employee G), the office de on discharging."					
6 0332 Bldg. 00	either within 48 ho	MENT VISIT ment visit must be held ours of referral, or within 48 nt's return home, or on the					
		start of care date.	G 0		No responses		08/21/202

NTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-03	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CON JILDING ING	istruction 00	COM	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, Z	IP CODE		
	L HOME HEALTH			L	SON, IN 46013			
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO T DEFICIENCY	HE APPROPRIATE	COMPLETIC DATE	
		review and interview,						
		to ensure the registered						
		an initial assessment to						
	-	tients' immediate care						
	-	rt for 10 of 10 patients						
	(Patients #1-10).							
	The findings inc	luded:						
		e clinical record of						
	-	to evidence an initial						
		been performed to						
	-	tients' immediate care						
	needs and suppo	rt.						
		e clinical record of						
	-	to evidence an initial						
		been performed to						
	needs and suppo	tients' immediate care rt.						
	3. Review of th	e clinical record of						
		to evidence an initial						
	1	been performed to						
		tients' immediate care						
	needs and suppo							
		e clinical record of						
	-	to evidence an initial						
		been performed to						
	-	tients' immediate care						
	needs and suppo	rt.						
	5. Review of th	e clinical record of						

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COM	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD ANDERSON, IN 46013			CODE		
(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 COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
	 patient #5 failed assessment had be determine the particular for the particular for the patient #6 failed assessment had be determine the particular for the patient #7 failed assessment had be patient #7 failed assessment had be determine the particular for the patient #7 failed assessment had be determine the patient #7 failed assessment failed assessment #7 failed assessment failed assessment #7 failed assessment #7 failed assessment failed assessment #7 failed assessment failed assessment #7 failed as	to evidence an initial been performed to tients' immediate care rt. e clinical record of to evidence an initial been performed to tients' immediate care rt. e clinical record of to evidence an initial been performed to tients' immediate care						
	patient #8 failed assessment had b	e clinical record of to evidence an initial been performed to tients' immediate care rt.						
	patient #9 failed assessment had b	e clinical record of to evidence an initial been performed to tients' immediate care rt.						
	patient #10 failed assessment had b	ne clinical record of d to evidence an initial been performed to tients' immediate care rt.						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE L HOME HEALTH	ER	5730	T ADDRESS, CITY, STATE, ZIP (DR MLK BLVD ERSON, IN 46013	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 0334 Bldg. 00	supervisor state include perform within 48 hours the patients' im support. 484.55(b)(1) COMPLETION CASSESSMENT The comprehens completed in a ti with the patient's later than 5 caler care. Based on record the agency faile comprehensive and accurate fo # 7) and failed is comprehensive performed befor	assessment was complete r 1 of 10 patients (Patient to ensure the assessment was not re the establishment of a 4 of 10 patients (Patients	G 0334	No response		08/15/201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIEN AND PLAN OF CORRECTIO	· · · · · · · · · · · · · · · · · · ·	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF PROVIDER OR S		5730 DI	STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD ANDERSON, IN 46013		
PREFIX (EACH D	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION	ID PREFIX) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIC	
 comprehendated 2-17 completion patient #7 not completion patient #7 not completion patient #7 not completion evidenced Humalog, and Clonich had a score assessment prescribed medication assessment 15 pounds document according Patient #7 the nutrition loss of 10 months, wo of 3. 2. Review patient #1 of 3-15-17 3-15 to 5- comprehendated as a structure of the structure of th	 v of a start of care nsive assessment for patient #7, r-17, failed to evidence n of the nutritional status of The risk assessment scale was eted and was not scored. Plan of care medications patient #7 was taking Lipitor, Prevastatin, Levemir, dine. Patient #7 should have e of 1 on the nutrition risk t, for taking 3 or more e or over the counter ns. The comprehensive t evidenced patient #7 had lost in 1 month, and no ation the weight loss was to physician recommendation. should have been scored 2 on on risk assessment for weight or more pounds in the last 6 ith a total nutrition risk score v of the clinical record of evidenced a start of care date v, and a certification period of 13-17. The start of care nsive assessment was dated The first billable visit, which e start of care, was by a home e on 3-22-17. The 				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
			B. WING		05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP (CODE	
ADMIRA	L HOME HEALTH			DR MLK BLVD RSON, IN 46013		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIC APPROPRIATE DATE	
	establishment o	f a start of care date,				
		more than 5 days after the				
	start of care.					
	3. Review of the	ne clinical record of				
	patient #3 evide	enced a start of care date				
		a certification period of				
		. The start of care				
	-	assessment was dated				
		irst billable visit, which				
	health aide on 3	t of care, was by a home				
		assessment was				
	performed 1 day					
	-	f a start of care date,				
		more than 5 days after the				
	start of care.	-				
	4. Review of the	ne clinical record of				
	patient #5 evide	enced a start of care date				
	of 3-15-17, and	a certification period of				
		. The start of care				
	-	assessment was dated				
		irst billable visit, which				
		t of care, was by a home				
	health aide on 3					
	performed 2 da	assessment was				
	-	f a start of care date,				
		more than 5 days after the				
	start of care.					
	5. Review of th	e clinical record of patient				
		start of care date of				

ENTERS FO	R MEDICARE & MEDIC				U	MB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	ξ		ADDRESS, CITY, STATE, ZIP C	ODE		
ADMIRA	ADMIRAL HOME HEALTH			R MLK BLVD RSON, IN 46013			
(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 COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
	 4-12 to 6-10-17. comprehensive a 4-12-17. The find defines the start health aide on 44 comprehensive a performed 6 day establishment of rather than not mestart of care. 6. On 5-18-17 a administrator/nut the agency had comprehensive a of care date, alth was furnished performed perfo	assessment was assessment was a start of care date, nore than 5 days after the assessment to be the start considered the date of the assessment to be the start hough no billable visit ursuant to a physician's ing supervisor verified sk assessment for patient					
1 0000 Bldg. 00	This visit was fo	r an Initial State	N 0000				
		y of a home health					

		ITERS FOR MEDICARE & MEDICAID SERVICES					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIEI	2	5730 D	ADDRESS, CITY, STATE, ZIP CODE R MLK BLVD RSON, IN 46013			
	-	TATEMENT OF DEFICIENCIES			(V5)		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLET DATE		
	Survey dates: 5 and 5-18-17	-15-17, 5-16-17, 5-17-17,					
	Facility # 01409	2					
	Unduplicated sk	illed admissions: 6					
	Unduplicated no	on-skilled admissions: 4					
		7 patients, 1 skilled care me health aide only					
	Discharged Patie	ents: 3					
	Home Visits wit	h record review : 4					
	Discharged reco	rds reviewed : 3					
	Total clinical ree	cords reviewed: 10					
1 0442 Bldg. 00	designated perso assume full legal for the operation of The governing bo (1) Appoint a qua (2) Adopt and pe bylaws or an acce (3) Oversee the r	ncy inagement A governing body, or n(s) so functioning, shall authority and responsibility of the home health agency. dy shall do the following: alified administrator. riodically review written eptable equivalent. management and fiscal					
	affairs of the hom Based on record	e health agency. review and interview,	N 0442	On 05/19/2017 By-Laws were signed, On 05/22/2017 Govern	05/22/20		

NTERS FO	R MEDICARE & MEDIC	AID SERVICES				0	OMB NO. 0938-0
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Α.	MULTIPLE C BUILDING WING	CONSTRUCTION <u>00</u>	_ COM	te survey pleted 8/2017
NAME OF	PROVIDER OR SUPPLIER	4			ADDRESS, CITY, STATE, ZIP CO	DE	
	L HOME HEALTH				DR MLK BLVD RSON, IN 46013		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	COMPLETI DATE
ind		bdy failed to adopt		ind	Body meet to adopt the	bv-Laws	DAIL
		rior to survey entrance			for agency.		
		-					
	for 1 of 1 home	nealth agency.					
	The findings inc	luded:			Governing Body will rev By-Laws Annually as we PAC committee will revi	ell as the	
	1. On 5-17-17 a	t:15 PM, the agency			annually.		
		f the names of the 2					
	-	governing body to			Administrator will be re	sponsible	
		ployee owner, and			for monitoring this corre		
		agency office manager.			action to ensure that this deficiency is corrected a not recur.	-	
	2. On 5-17-17. a	an unsigned and undated					
		"Bylaws of Admiral					
	Medical Home H						
	reviewed.	icultin inc., wub					
	ievieweu.						
		t 9:30 AM, a 2nd copy of					
		ent was presented, which					
	-	nature of one member of					
		dy, the agency's owner,					
	dated 9-6-16. T	ne office manager					
	(employee G) sta	ated the owner had					
	signed and dated	the bylaws the evening					
	of 5-17-17, and	locumented the date of					
	signature as 9-6-	16. Employee G stated,					
	-	ult I didn't get signature					
	in September."	0 0					
	4 0 5 15 15						
	4. On 5-17-17 a	,					
		rified the above findings					
		was no additional					
	documentation to	p provide to be reviewed.					
	1		1		1		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILE B. WING	DING	STRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R	5	730 DR	dress, city, state, zip code MLK BLVD ON, IN 46013		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETIO
TAG	REGULATORY OF	& LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
N 0444	410 IAC 17-12-1(
	Home health age						
Bldg. 00	administration/ma	nagement An individual need not be					
		ency employee or be					
	-	at the home health agency					
		as its administrator. The					
		o may also be the cian or registered nurse					
		ection (d), shall do the					
	following:						
		d direct the home health					
	agency's ongoing	functions.	11044				00/05/00
			N 0444	4			08/25/20
		review and interview,			Alternate Nursing Supervisor		
		r failed to organize and		á	and Alternate Administrator v	vill	
	•	y's ongoing functions to			be re-orientated to agencies		
		o ensure the orientation			policy and procedures and jo	b	
		administrator and		6	description.		
		g supervisor, and failure					
	•	ency had appointed a			On June 1, 2017 Quality		
		ent and performance			Assessment & Performance		
	improvement co	ommittee.			mprovement committee was formed. QAPI will meet at leas	.t	
	The findings inc	eluded:		E	Bi-monthly for 6 months then quarterly.		
	1. The administ	trator failed to organize					
		gency's ongoing functions			Alternate Nursing		
	-	e to ensure the orientation			Supervisor/Alternate		
		administrator and			Administrator will be monitored Director of Nursing/Administra		
	alternate nursing	g supervisor (See N 446).		,	which will meet with Governing Board quarterly to discuss		
		trator failed to ensure the		F	progress or lack of progress. T process will be used on all new		
	agency had appo			İ	nires to ensure compliance wi		
	assessment and	performance		l r	regulations.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDIN B. WING	le construction G <u>00</u>	СОМ	te survey pleted 8/2017
	PROVIDER OR SUPPLIE L HOME HEALTH	R	573	EET ADDRESS, CITY, STATE, ZIP C 80 DR MLK BLVD DERSON, IN 46013	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE A	OULD BE	(X5) COMPLETION DATE
	N 472).	ommittee (See N 456 and at 3 PM, the administrator ve findings.		Administrator will be re for monitoring these co actions to insure that d are corrected and will r	rrective eficiencies	
N 0445 Bldg. 00	may also be the s registered nurse shall do the follow (2) Maintain ong governing body a Based on record the administrator liaison between governing body ensure the orien administrator ar supervisor, failu governing body bylaws, and fail had appointed a	anagement (2) The administrator, who supervising physician or required by subsection (d), ving: bing liaison among the nd the staff. I review and interview, or failed to be an effective the staff and the , to include failure to tation for the alternate and alternate nursing are to ensure the had reviewed the agency ure to ensure the agency group of professional ablish the agency's	N 0445	Governing Body review By-Laws on 05/19/201 05/22/2017 Governing adopted By-Laws. On 05/29/2017 the Gov Board adopted a group professional personnel establish the agency's PAC adopted agency p PAC meetings will be e (6) months to evaluate systems are in place ai followed. PAC meeting annually after one (1) y meeting every six (6) m issues are identified.	7, on Body verning of to policies. policies. every six that nd s will go rear after nonths if no	08/25/2017

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/18/2017	
	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	STREET 5730 D	ADDRESS, CITY, STATE, ZIP CODE DR MLK BLVD RSON, IN 46013 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) not recur	(X5) COMPLETIC	
N 0446 Bldg. 00	 bylaws (See G 2. The administic agency's policies group of profess 153). 3. On 5-18-17 verified the about the administration/maximule 12 410 IAC 17-12-14 Home health age administration/maximule 12 410 IAC Sec. 1(c)(3) The also be the super registered nurse shall do the follow (3) Employ quality adequate staff examples administration for the administration adequate staff examples administration for the administration for the administration for the administration for the findings in the findings	trator failed to ensure the es were adopted by the sional personnel (See G at 3 PM, the administrator ve findings. (c)(3) ncy anagement 17-12-1(c)(3) administrator, who may vising physician or required by subsection (d), ving: fied personnel and ensure lucation and evaluations. I review and interview, or failed to ensure ducation for 1 of 1 istrator/alternate nursing bloyee B).	N 0446	Alternate Nursing Supervisor w be re-orientated to position on a on-going basis until skills competency checklist has beer achieved. Orientation will be on all aspect of the Alternate Nursing Supervisory job description. Director of Nursing will monitor and be responsible for compliance. Director of Nursing will report back to Governing Board with findings and recommendations	a ts	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	СОМ	e survey pleted 8/2017		
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP C DR MLK BLVD	CODE			
ADMIRA	L HOME HEALTH		AND	ERSON, IN 46013				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
	2. Review on 5- file for employe administrator an	ernate nursing supervisor. -17-17, of the personnel ee B, alternate nd alternate nursing lenced a date of hire of		Alternate Administrator re-orientated to job req and agency policies an aspects of Alternate Ac job description to assu competency with the sl needed for Alternate Administrator position l achieved.	quirements nd all dministrator re kills			
	self-assessment for employee B file failed to ev- orientation to sl to evidence doc establishment o competency for to the agency's documentation; of staff; orienta to include on ca	f registered nurse clinical skills; orientation	cal skillsThis process will be used workpersonnelnew hires to ensure compliancetation ofwith regulations. Administrs, failedback to the Governing Boaindfindings and recommendateensure deficiency will not recommendateorientationupervisionrocedureses to		ompliance nistrator will id report Board with ndations to	ith all ance tor will port d with ons to		
	evidence docun been provided a	sonnel file failed to nentation employee B had on orientation to the skills form the duties of the istrator.	on employee B had ntation to the skills e duties of the					
	3. Review of a job description "Alternate Administrator" evidenced employee B's signature dated 1-18-17. The job description stated, "Alternate Administrator will act as Administrator							

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	ULTIPLE CON VILDING NG	ISTRUCTION 00	CO	ate survey Mpleted 18/2017
NAME OF	PROVIDER OR SUPPLIE	ER	•		DDRESS, CITY, STATE, ZIP COD	E	
ADMIRA	L HOME HEALTH				MLK BLVD SON, IN 46013		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	,,		
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPP DEFICIENCY)	ROPRIATE	DATE
	in the absence of	of the Administrator."					
	4 Review of a	job description "Assistant					
		sing" evidenced it was					
		ed by employee B on					
	-	ted, "Assistant Director of					
		t as director of nursing in					
	-	director of nursing."					
	5. Employee B	was interviewed by					
		17 at 1:10 PM, regarding					
	-	to the role of alternate					
	administrator a	nd alternate nursing					
	supervisor, stat	ed "I would be back up to					
	(employee A).	I am learning process,					
	home health sy	stem is new to me I have					
	reviewed proce	ss paperwork as we					
	grow I would g	o out to do home visits I					
		et up and blood pressure					
		e orders I would follow					
	e	ld be on call if needed I					
		omplaints, issues with					
	1 2 1	y or home health aide, on					
		g and training I guess I					
		ll for (employee A)					
	-	trying to understand					
	-	erral" When asked					
		rent cases in agency,					
		ported I know there is a					
	-	ded physical therapy, a					
		ded additional testing a for rectal abscess					
		seizures 2 people need eds (sic medications) and					

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	UILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLII	ER			ADDRESS, CITY, STATE, ZIP CODE		
	L HOME HEALTH				R MLK BLVD SON, IN 46013		
					(301), 11 40013		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI		(X5)
TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETIC DATE
mo		sure)"Asked if		mo			DATE
	· ·	d nursing experience in					
		eplied "I have not been a					
		Surse." Denied having					
		ome visits during					
		d a self- assessment check					
		ving been present for any					
		tings. Denied having					
	current physica	6					
		sume the role of nursing					
	supervisor.	sume the role of hursing					
	Supervisor.						
	6 The adminis	strator/nursing supervisor,					
		as interviewed on 5-18-17					
		ated, "We need to set up					
		alth exam for (employee					
		(employee B) needs to					
		go with me on visits					
		ny home visitswe had					
		(employee B) said " it's					
	not my favorite	e thing to do (home visits)"					
	nursing is nu	ırsing We haven't been					
	assertive enoug	gh to have (employee B)					
	come in and do	it if needed we could					
	probably talk th	nrough things." Regarding					
	current patient	case conference					
	communication	n with employee B,					
	employee A sta	ated "we talk my patient					
		nged a bunch, (employee					
	B) he knows w	hat I do in a visit."					
		enied there was any					
	documentation	of case conference with					
	Employee B.						

STATEME	NT OF DEFICIENCIES OF CORRECTION	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION IG <u>00</u>	(X3) DAT COM	DMB NO. 0938-0391 TE SURVEY IPLETED 18/2017
	PROVIDER OR SUPPLIE	R	STR 573	EET ADDRESS, CITY, STATE, ZIP 30 DR MLK BLVD DERSON, IN 46013	_	10/2017
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
N 0456 Bidg. 00	be responsible for assurance progra following: (1) Objectively a and evaluate the appropriateness of (2) Resolve iden (3) Improve patie Based on record the administrato on-going quality performance im program to inclu- points by a QAI home health ago The findings ind 1. A policy "Pe Plan" was revie AM. The policy Health collects	ncy anagement) The administrator shall r an ongoing quality am designed to do the nd systematically monitor quality and of patient care. tified problems. ent care. I review and interview, or failed to implement an y assurance and provement (QAPI) ude review of agency data PI committee for 1 of 1 ency.	N 0456	On June 1, 2017 a QA committee was formed will meet at least Bi-r 6 months, then quarte after to ensure complia reviewing patient satisfaction, patient ne appropriateness of ca agency issues. Administrator will mor compliance of commit report back to governit ensure deficiency will Meeting minutes will to all meetings. Operation will monitor for complia Operation Manager with the second seco	d and nonthly for erly there ance on: eds, re and any hitor for tee and ng board, to not recur. be taken at in Manager ance.	08/25/201

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	È É	ULTIPLE CO JILDING	ONSTRUCTION 00		E SURVEY PLETED
			B. W.	NG		05/1	8/2017
NAME OF	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CO	DE	
ADMIRA	L HOME HEALTH				R MLK BLVD RSON, IN 46013		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG	× ×	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE PROPRIATE	COMPLETIO DATE
	Indicators risk management/oco fall reduction pro occurrences rate patient satisfa surveillance and control potent investigation I medical record r are systematical quarterly basis professionals rep of care and servi agency review a and closed recor 2. Review of ag documents failed the QAPI comm 3. On 5-18-17 a administrator ve committee had r data points relate patient care, app had not identifie problems.	currences(effectiveness of ogram and overall) customer complaints ction infection control reporting quality ially avoidable event home health compare eview clinical records ly reviewed on a a group of health oresentative of the scope ces provided by the sample of both active ds." ency administrative d to evidence meetings of ittee. t 3:00 PM, the rified the QAPI tot met to review agency ed to improvement in ropriateness of care, and d and addressed agency			back to Administrator witto ensure deficiency will		
l 0460 Bldg. 00		псу					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	r í	ILDING	00	COMPL	
			B. WI	NG		05/18/	2017
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
	L HOME HEALTH				R MLK BLVD RSON, IN 46013		
					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
-		(d) of this rule, shall:		_			
	(1) Be kept curre						
		y of the following:					
		inal history pursuant to IC					
	16-27-2. (B) Nursing lice	ise					
		ormance evaluations.					
	(D) Documentat	ion of orientation to the job.					
		luations required by this					
	(9) to fifteen (15)	be performed every nine months of active					
	employment.						
			N 04	460			08/25/201
	Based on record	I review and interview,			Re-orientation for the Alterna		
		d to ensure the alternate			Supervising Nurse will be or		
		mployee B, was oriented			the skilled Nurse visit and sk nurse documentation of hom		
		nd was ready to respond			visits, with Director of Nursin		
		es, provide guidance to			current patients home. Some	-	
	-	estions, and resolve			job training will be in the offic		
		reasonable amount of			for day to day operations.		
		llternate administrator,			Nursing skill competency is in	n	
		sure the alternate nursing			process to review basic skill required. Alternate		
		loyee B, was oriented to			Supervisory Nurse has been		
		prepared to assume the			attending client case		
	_	g supervisor if required,			conferences, QAPI meetings		
		ate nursing supervisor.			Pac meeting for more educat		
					on the day to day operations		
	The findings in	cluded:			Alternate Administrator has		
					been Re-orientated to job		
	1. Review of a	ob description "Alternate			description and has been		
		evidenced employee B's			attending QAPI meetings and	b	
		1-18-17. The job			PAC meetings on a regular		
	description state	-			basis to obtain additional education for day to day		
	-	vill act as Administrator			operations.		
		f the Administrator."					
		n and r talling tall.			Freelows D.L.		
					Employee B has given agency	/	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 00	(X3) DATE COMPI	
			B. WING		05/18	/2017
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP CODE		
	L HOME HEALTH			RSON, IN 46013		
X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	COMPLETION DATE
IAU		job description "Assistant		new physical and supplied		DATE
		sing" evidenced it was		agency with copy of 2015, 20)16	
		ad by employee B on		and new 2017 TB.		
	-	ted, "Assistant Director of		Tielden er stere hae haen mit		
	,	t as director of nursing in		Tickler system has been put place to reorganize missing it		
		•		or items that need updated in		
	ule absence the	director of nursing."		employee charts. Operation		
alter	2 11			Manager will monitor for		
	-	el file of employee B, the istrator and alternate		compliance. If out of compliant Administrator will be notified		
				Director will report back to	•	
	e 1	nursing supervisor, date of hire 1-18-17, and no first patient contact was reviewed				
	-					
		self-assessment of skills		This process will be utilized f	or oll	
		The personnel file failed		This process will be utilized for newly hired staff.	orali	
		cumentation of orientation				
		visits in the home, failed		Administrator/Director of Nurs		
		cumentation of home		will monitor for compliance a	nd	
		visit establishment of		report back to QAPI and Governing Body with any issu		
		d failed to evidence		to ensure deficiency will not r		
		the alternate administrator				
	position.					
	4. Employee B	was interviewed by phone				
		:10 PM, regarding her				
		ne role of alternate				
	administrator a	nd alternate nursing				
		ed "I would be back up to				
	-	I am learning process,				
		stem is new to me I have				
	-	ss paperwork as we				
	_	o out to do home visits I				
		et up and blood pressure				
		e orders I would follow				
		ld be on call if needed I				
	-	omplaints, issues with				

NTERS FO	R MEDICARE & MEDI	CAID SERVICES					OMB NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	, ,		ISTRUCTION	· /	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00		IPLETED
			B. WIN	IG		05/*	18/2017
NAME OF	PROVIDER OR SUPPLIE	R		STREET AI	DDRESS, CITY, STATE, Z	ZIP CODE	
					MLK BLVD		
ADMIRA	L HOME HEALTH			ANDERS	SON, IN 46013		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OI	F CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO	THE APPROPRIATE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC	Y)	DATE
		y or home health aide, on					
		g and training I guess I					
	would be on ca	ll for (employee A)					
	Right now I am	trying to understand					
	process for refe	rral" When asked					
	about the 7 curr	rent cases in agency,					
	Employee B rep	ported I know there is a					
		ded physical therapy, a					
	young lady nee	ded additional testing					
		a for rectal abscess					
		eizures 2 people need					
		eds (sic medications) and					
	-	sure)"Asked if					
	· ·	1 nursing experience in					
		plied "I have not been a					
		urse." Denied having					
		me visits during					
		•					
		a self- assessment check					
		ving been present for any					
		tings. Denied having					
	current physica	•					
		sume the role of nursing					
	supervisor.						
		trator/nursing supervisor,					
		as interviewed on 5-18-17					
		ted, "We need to set up					
		Ith exam for (employee					
		. (employee B) needs to					
	be mandated to	go with me on visits					
	has not made an	ny home visitswe had					
	discussion and	(employee B) said " it's					
	not my favorite	thing to do (home visits)"					
	-	rsing We haven't been					
		-	1				

STATEMEN	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	AID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE COMP 05/18	1B NO. 0938-039 SURVEY LETED /2017
	PROVIDER OR SUPPLIEI	R	5730	STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD ANDERSON, IN 46013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
	probably talk the current patient c communication employee A stat load hasn't chan B) he knows wh Employee A der	it if needed we could rough things." Regarding ase conference with employee B, ed "we talk my patient ged a bunch, (employee at I do in a visit." hied there was any of case conference with				
l 0472 Bldg. 00	Rule 12 Sec. 2(a) must develop, imp evaluate a quality performance impr program must refi- home health orga (including those s under arrangeme agency must take improvements in f performance acro The home health assessment and p	The home health agency oblement, maintain, and assessment and ovement program. The ect the complexity of the nization and services ervices provided directly or nt). The home health actions that result in the home health agency's ss the spectrum of care.	N 0472	QAPI committee has been	n put in	08/25/201
	1					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
					ADDRESS, CITY, STATE, ZIP CODE	00/10	2011
NAME OF	PROVIDER OR SUPPLIE	ER			R MLK BLVD		
ADMIRA	L HOME HEALTH			ANDEF	RSON, IN 46013		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		or failed to implement an			Bi-monthly for 6 months then quarterly.		
		y assurance and			quarterly.		
	-	nprovement (QAPI)					
		iled to ensure the clinical			Charts will now be audited by		
		vas performed by			appropriate discipline who has	6	
	personnel repre	senting the scope of			participated in care that was delivered. All paperwork will		
	agency services	s, and failed to ensure			show date audit was complete	ed.	
	clinical record	audits identified failure to					
	follow agency	policies and to meet home					
	health agency r	egulations for 2 of 2					
	patients' clinica	l record audits reviewed			New admission process is in place and will include initial		
	(Patient #1 and	#1 and 6), of a total sample of assessment and all verbal		ers			
	10.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			for start of care, prior to startin		
					services.	•	
	The findings in	cluded:				4	
					Admitting nurse was re-educa on plan of care and plan of ca		
	1. A policy "Pe	erformance Improvement			documentation to ensure that		
		ewed on 5-17-17 at 9:30			and all other areas are comple	eted	
		y stated, "Admiral Home			upon admission and as neede	ed.	
	-	data and monitors			Education of admitting nurse		
		at least the following			includes, transcription of diet order from plan of care and is		
	1	/ Improvement Data			included on home health aide		
	Indicators ris				care plan. Admitting		
					nurse/physical therapist have	e	
	-	ccurrences(effectiveness of			been re-educated on		
	-	rogram and overall			initial assessment process ar		
		e) customer complaints			having all verbal orders to be able to complete the	;	
	-	action infection control			comprehensive assessment.		
		d reporting quality			The medication list will include		
	-	ntially avoidable event			over the counter medications		
	-	home health compare			and prescription orders. The		
		review clinical records			comprehensive assessment	will	
	-	lly reviewed on a			be done completely and		
	quarterly basis.	a group of health			accurately.		
	professionals re	epresentative of the scope			Staff have been educated that	.+	

State Form

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CO DR MLK BLVD	ODE		
ADMIRA	L HOME HEALTH			RSON, IN 46013			
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFUGUEVA		(X5) COMPLETIC	
TAG	 of care and serv agency review a and closed reco 2. Review of a documents faile the QAPI comm 3. On 5-18-17 administrator ve committee had data points rela patient care, app had not identifie problems. 4. A chart audit 4-18-17, for pat clinical record a had received ph health aide serv conducted by (e manager/ home documents were the administrator (employee A). 	gency administrative ed to evidence meetings of nittee.	TAG	there should not be any visits with clients. Staff educated on document needs for missed visits other options of resche visit have been exhaus Notification of physician made for coordination of Director of Nursing will process to ensure com and report back to QA Governing Board with a deficiencies that are for ensure that this will not	y missed have been ation after all duling the ted. n will be of care. monitor pliance PI and any und to	DATE	
	failed to eviden agency failure t	view of the chart audit ce the audit had identified o coordinate care, failure nitial assessment, failure					

	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDIN B. WING		STRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLI	ER			DDRESS, CITY, STATE, ZIP CODE		
	ADMIRAL HOME HEALTH				MLK BLVD		
	-				SON, IN 46013		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRC	BE	(X5) COMPLETIC
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION)	TAC	3	DEFICIENCY)	FRATE	DATE
	to obtain a phy	sician's verbal start of care					
	order prior to f	urnishing services, failure					
	-	complete and accurate					
		assessment as required by					
	-	failure to identify a diet					
	0 51 57	an of care, as required by					
		failure to identify the					
		n the home health aide care					
	-	e to identify physical					
	-	vere not provided per plan					
		cy order, as required by					
	agency policy.	ley order, as required by					
	ageney poney.						
		it was documented on					
	-	tient #6. Review of					
	-	nical record evidenced					
	^	received skilled nursing					
	5	The chart audit was					
	conducted by (employee # G), the office					
	manager/ home	e health aide. The					
	documents wer	e signed, but not dated, by					
	the administrat	or/nursing supervisor					
		The chart audit of patient					
	#6's clinical red	cord failed to evidence the					
	participation of	f a registered nurse in the					
	chart audit, and	l failed to evidence the					
	chart audit ider	ntified failure to document					
	a complete me	dication order on the plan					
	of care, as requ	ired by agency policy,					
	failure to perfo	rm an initial assessment,					
	and failure to o	btain a physician's verbal					
		urnishing services.					
	6. The adminis	trator was interviewed on					

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 05/18/2017	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00		
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE R MLK BLVD		
ADMIRA	L HOME HEALTH				RSON, IN 46013		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	them, but not de review. The ad supervisor coul of the agency's deficiencies, an the office mana	audits after reviewing ocumenting the date of ministrator/nursing d not explain the failure chart audits to identify d stated not being aware ger/home health aide rm all the agency's chart					
N 0484 Bldg. 00	Rule 12 Sec. 2(g services shall ma communications appropriately cor support the object The means of co results shall be d record or minutes Based on record the agency failed	ance improvement) All personnel providing intain effective to assure that their efforts nplement one another and stives of the patient's care. mmunication and the ocumented in the clinical s of case conferences. d review and interview, ed to ensure all agency linated care for 1 of 10 t #3).	N 04	184	DNR orders were placed in clients home, office chart, book. Home folder and offi chart now have stickers noting "DNR" to alert staff has been added to Plan of and home health aide can A case conference has ta place to make all staff aw DNR. Stickers will be put	on call ce f. DNR of Care re plan. iken are of	08/25/2011
		ed, "Advanced ich evidenced an effective was reviewed on 5-18-17			new patient charts, on ca and in home folders.		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	R		TADDRESS, CITY, STATE, ZIP CO	DDE		
ADMIRA	ADMIRAL HOME HEALTH			DR MLK BLVD RSON, IN 46013			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	FOTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD DE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
	Advanced Direct statement about medical decision provided in acc directives pendit physician Ag [sic education] Advance Direct patient has advation include - not to written and sign not resuscitate) AND, (allow nation obtained from to the patient's clint honored by the to the admission The original aut DNR/DNI/ANI visible location per patient/care of the physician patient's in-hom placed in the pati- a copy sent to the	d stated, "Purpose ctives. Refer to a written out how individual wants ns made care will be ordance with the advance ing orders from patients gency will provide staff on issues concerning tives Procedure: If a ance directives which be resuscitated, then a ned order for DNR (do , DNI (do not intubate), atural death) must be he physician and placed in nical record prior to being agency Order is added in 485 [plan of care] thorization/consent D will be posted in a in the patient's home as giver request, and a copy t's order maintained in the ne chart/folder. Copies are atient's clinical record and he physician. On call et patient status.		Therapist re-educated of sure admission process complete and accurate assessment to start of of All staff have been re-e on coordination of care to include, client, careg representatives and phy ensure this deficient pra- not recur. Director of Nursing wi new admission paperw admission has been co to ensure compliance. Director of Nursing wi QAPI and Governing E deficiencies, to ensure this deficiency will not n	s is from initial care. ducated process ivers, ysicians to actice will Il audit all vork when ompleted Il report to Board with e that		
	the request by r conferences, ca medical records	D order in the on-call bal and written					

AND PLA	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R	5730 D	ADDRESS, CITY, STATE, ZIP C R MLK BLVD	ODE	
	AL HOME HEALTH			RSON, IN 46013		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH		(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIC DATE
	aide (HHA), em on 5-16-17 at 11 prior to entering patient was a DI Observation of p to evidence the required by agen A. Review patient #3 on 5- of care date of 3 plan of care for 23-17 to 5-21-17 on 4-12-17, with DNR (do not res B. Review of evidence docum DNR status. 3. On 5-18-17 a administrator/m the above findin	of the clinical record of 16-17, evidenced a start -23-17, and contained the certification period 3- 7, signed by the physician n order "Pt [patient] is a suscitate)." of the on call log failed to the on call log failed to the on failent #3's				

ENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-0391	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> B. WING		COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE L HOME HEALTH	R R STATEMENT OF DEFICIENCIES	5730	ET ADDRESS, CITY, STATE, ZIP CODE DR MLK BLVD ERSON, IN 46013	E (X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
N 0486 Bidg. 00	Rule 12 Sec. 2(h) shall coordinate it or social service p patient. Based on home review, and inter to document coor activities with a of 10 patients (F The findings inco 1. Review of the #5 on 5-15-17, c document dated documentation ' arthritis, hyperter 11 X [times] in by the nursing s The document ef falls had started week after a doc when the doctor medications; Bu by mouth, 3 tim was added; and from 110/12.5 n	ance improvement The home health agency is services with other health providers serving the visit observation, record rview, the agency failed ordination of care n outside provider for 1 Patient #5).	N 0486	Home health aide re-educ about coordination of care there is another agency se same client) All Staff educ using communication form inform appropriate staff of pertinent patient information Director of Nursing will mo this through weekly case conference meetings to en- shared information is give appropriate staff members Director of Nursing will m for compliance and repor- findings to QAPI/Governin to prevent deficiency from recurring.	e. (When ervicing cated on n to on. onitor nsure all en to s. onitor rt any ng Body	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDIN		RUCTION	. ,	E SURVEY PLETED
	or conduction		B. WING			05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	R			RESS, CITY, STATE, ZIP COD	E	
ADMIRA	L HOME HEALTH				MLK BLVD N, IN 46013		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAC	((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETIC DATE
	Known side eff	ects of Buspirone and					
	Hyzaar are dizz	iness or lightheadedness.					
	A. Review	of a document dated 2-14					
	-17, titled "offic	ce visit" evidenced					
		by patient # 5's physician					
		daughter with breast					
		ping well plan:					
		n-HCTZ (a blood pressure					
		y buspar for anxiety (an					
		discontinue furosemide continue tramadol (a pain					
	medication)."	continue tramador (a pain					
	B. Review	of a comprehensive adult					
	nursing assessn	nent dated 3-15-17,					
		ne nursing supervisor,					
		are coordination boxes					
	were checked for	or physician and aide.					
	C. Review	of patient #5's plan of					
		a start of care date of 3-15					
		fication period of 3-15-17					
		n order for "Home health					
		ours per day, 2 times a					
		s (activities of daily					
	living) and ligh						
	-	e (RN) to do supervisory onth." The established					
		patient will be free from					
	falls or falls will	•					
	D. During	an interview with the					
	-	sor, who admitted patient					

	R MEDICARE & MEDI			LE CONSTRUZ	TION		MB NO. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDIN	LE CONSTRUC	LIION	(X3) DATE SURVEY COMPLETED 05/18/2017	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN B. WING	ig <u>00</u>			
NAME OF	PROVIDER OR SUPPLIE	CR	STREET ADDRESS, CITY, STATE, ZIP COL			DE	
				30 DR MLK			
ADMIRA	L HOME HEALTH		AN	DERSON,	IN 46013		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFI	CROS	CH CORRECTIVE ACTION SHO SS-REFERENCED TO THE API	ULD BE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION)	TAG	3	DEFICIENCY)		DATE
		he health aide (employee					
		at 3:55 PM, the nursing					
	supervisor state	d not having considered					
	providing skille	ed nursing services for					
	patient #5 to as	sess the development of					
	frequent falls 1	week after prescribed					
	medication char	nges (2-14-17), and not					
	having consider	red a physical therapy					
	•	ess possible gait					
		nd safe transfers.					
	-	e HHA stated having met					
		are provider from an					
		r, who told employee F,					
	-	ved skilled nursing and					
	-	y services from the					
		Employee F could not					
		of the other agency, and					
	stated not havin						
		the nursing supervisor.					
		pervisor reported the					
	- ·	d the patient for home					
		rices only, and there there					
		ordination of care with the					
		The HHA failed to					
		with the supervising RN					
		ledge of an outside					
	-	led nursing and physical					
	therapy service	s for patient #5.					
	E. On 5-18	8-17 at 9:30 AM, during					
		view, patient #5 stated the					
	-	side provider and					
		vices provided by the					
		illed nursing and physical					
	agency were sk	med nursing and physical					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 00 COMPLETED B. WING 05/18/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5730 DR MLK BLVD ADMIRAL HOME HEALTH ANDERSON, IN 46013 (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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE therapy. 2. On 5-18-17 at 3:00 PM, the administrator/nursing supervisor verified the above findings and stated not having any further documentation to present for review. N 0504 410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Bldg. 00 Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the followina: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Governing Body and QAPI N 0504 08/25/2017 approved revised consent for Based on record review and interview, treatment to include frequencies State Form Event ID: ABKF11 Facility ID: 014092 If continuation sheet Page 107 of 147

PRINTED:

08/25/2017

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	ËR	5730 D	ADDRESS, CITY, STATE, ZIP CODE		
ADMIRA	L HOME HEALTH		ANDE	RSON, IN 46013		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETIO	
	advance of the visits for the dis care for 2 of 10	ed to advise the patient in frequency of proposed sciplines to be provided patients (Patients #3 and		of proposed visits. All curren clients were given new conse forms.		
	patient # 3, evid of 3-23-17, and for the certifica 5-13-17, with on (HHA) services weeks. Review document "Ad evidenced "The following Disci home health aid admission docu 3-23-17, by the (employee A),	cluded: ne clinical record of denced a start of care date contained a plan of care tion period 3-15- to rder for home health aide s 2 times a week for 8 of an admission miral Home Health" Plan of Care involves the ipline(s):" and the box for de was checked. The ment, signed and dated registered nurse and by patient #3, failed frequency of proposed		Director of Nursing will audit admission chart for complian and report to QAPI and Governing Body of any deficiencies found, to ensure deficiency is corrected and w not recur.	e	
	patient # 7, evid of 2-17-17, and for the certifica 4-17-17, with o visits 1 time a v times a week for admission docu	ne clinical record of denced a start of care date contained a plan of are tion period of 2-17 to rder for skilled nursing week for 1 week, then 2 or 8 weeks. Review of an ument "Admiral Home ced "The Plan of Care				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R		5730 D	address, city, state, zip cod PR MLK BLVD RSON, IN 46013	Ε	
(X4) ID PREFIX TAG N 0522	(EACH DEFICIE REGULATORY O involves the fol The box for ski The admission o dated 2-17-17, 1 (employee # A) to evidence the visits. 3. On 5-18-17 a supervisor state provide the pati frequency of pr			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
Bldg. 00	Rule 13 Sec. 1(a a written medical and periodically r dentist, chiroprac podiatrist, as follo Based on record the agency faile made in accord orders for 1 of 1 The findings in 1. Review of th patient #1, evid	d review and interview, ed to ensure visits were ance with plan of care 10 patients (Patient #1).	N 0	522	Staff re-educated on miss and educated on docume of missed visit. Staff educ explaining to client/careg importance of keeping all appointments. Case man will be responsible for mis visits and the correct documentation. 10% of agency charts wil audited randomly quarter compliance by Director or	entation cated on jiver the future agers ssed ssed I be ly for	08/25/2017

	R MEDICARE & MEDIC					OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 UILDING	ONSTRUCTION 00	COM	te survey Ipleted 1 8/2017
NAME OF	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP (CODE	
ADMIRA	L HOME HEALTH			OR MLK BLVD RSON, IN 46013		
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE . DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
	 5-13-17, with or services 2 times Review of physicevidenced 1 visicevidenced 1 visicevidenced 1 visicevidenced 1 visicevidences failed to experiment to experiment the service of the s	period of 3-15 to ders for physical therapy a week for 4 weeks. cal therapy visit notes t was made the week of on 3-31-17. The visit vidence 2 physical ere made as ordered. t 3 PM, the administrator bove finding and stated ther documentation to iewed.		Nursing/Designee wh to QAPI and Governin any issues, to ensure practice does not recu	g Body with deficient	
I 0524 Bldg. 00	Patient Care					

	OR MEDICARE & MEDIC			CONSTRUCTION		AB NO. 0938-0391
	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	· · ·	E SURVEY
IND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	<u>00</u>		leted 3/2017
			STRE	ET ADDRESS, CITY, STATE, ZIP COD		-
NAME OF	PROVIDER OR SUPPLIE	R		DR MLK BLVD		
ADMIR/	AL HOME HEALTH		AND	ERSON, IN 46013		
X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX	Ϋ́,	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPF	LD BE ROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	referral. (xii) Therapy mo treatment.	dalities specifying length of				
	(xiii) Any other a	ppropriate items.				
	, , , , , , , , , , , , , , , , , , , ,		N 0524	Staff re-educated on adm	ission	08/25/2017
	Based on observ	vation, record review, and		process to ensure that all		
		gency failed to ensure the		listed on Plan of Care. A		
		luded all durable medical		will be maintained through plan of care dates by	n out the	
	-	itional requirement,		communicating with the p	atients	
		ation order, safety		doctor.		
	-	discharge plan for 10 of				
		ients #1-10), and failed to		Staff re-educated on nut		
	-	of care start of care date		requirements on Plan of and to verify diet by patie		
	-	periods were correct for		doctor to ensure coordin		
		•		care.		
	-	whose clinical record				
	was reviewed (I	Patients # 1, 3, 5 and 9).		Staff re-educated on pro	per	
	T1 (* 1' '	1 1 1		medication list upon adn		
	The findings inc	cluded:		Medication orders will b		
				complete to include rout over the counter medica		
		e clinical record of		To maintain accuracy th		
	-	enced a start of care date		out the plan of care staff	-	
		contained a plan of care		communicate with patier		
		tion period of 3-15-17 to		doctor to verify orders for	r	
	5-13-17.			accuracy.		
	Δ Review	of nutritional requirement		Staff re-educated on saf	ety	
		e", durable medical		measures on plan of car		
		supplies evidenced		re-educated on docume		
	"walker", Medie			and education that will b	-	
				to client/caregiver on sa measures.	liety	
		/Route, evidenced		הופמטובס.		
		n antibiotic) 300 mg/4 ml		Staff re-educated on dis	charge	
		P.O. (by mouth)." Safety		planning. Discharge plan	-	
	Measure eviden			will start with client upon		
	<u>^</u>	bals/rehabilitation		admission and re visited		
	Potential /Disch	arge Plans evidenced		re-certification, resumpti	ons and	

State Form

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI B. WIN	LDING	00	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	ER	- I		ADDRESS, CITY, STATE, ZIP CODE		
	AL HOME HEALTH				R MLK BLVD RSON, IN 46013		
	-				(30h, in 40013		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	Ρ	ID REFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETIC DATE
	"independence	in transfers and is steady			case conferences.		
	on feet without Independence w daily living), pe light housekeep walking on a w needs. Remain and hospitalizat B. During a home health a 2 PM, patient # was administered mouth. A cane concentrator, or were observed a C. Review to evidence the concentrator, or failed to eviden oxygen safety a	use of furniture. with all ADL's (activity of ersonal care, transfers and bing. Independence with alker if that is what she free from falls, injuries tion." home visit observation of tide (HHA) on 5-17-17, at 1 stated the Tobramyacin ed by nebulizer, not by , a nebulizer, an oxygen xygen tubing and cannula, in the home. of the plan of care failed cane, nebulizer, oxygen xygen tubing and cannula, ice fall precautions and as safety measures, failed iet order, and failed to			Staff re-educated on adm process that start of care first billable date of servic The Director of Nursing wi responsible for monitoring corrective actions to ensur this deficiency is corrected will not recur. Director will back to QAPI/Governing B with any findings.	is the ces. Il be the re that I and report	
	2. Review of th patient# 2, evid of 3-15-17, and for the certifica 5-13-17. Diag Thrombocytope	ne clinical record of enced a start of care date contained a plan of care tion period of 3-15-17 to noses included of enia (a disease that alters tor of the blood and					

NTERS FO	T OF HEALTH AND HU! R MEDICARE & MEDIC NT OF DEFICIENCIES		(X2) M	ULTIPLE CO	DNSTRUCTION		RM APPROVE IB NO. 0938-03 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	ì í	JILDING	<u>00</u>	COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE	-	
ADMIRA	L HOME HEALTH				R MLK BLVD RSON, IN 46013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	3E	(X5) COMPLETIC DATE
	medications evid "Hydrochlorthia Lisinipril, Rantic Clonidine and V goals included " hospitalizations Patient will be a medications on or reminders/cues of Patient will have importance of m to not miss any of B. During he registered nurse AM, patient #2 s following medic the plan of care " Aspirin and 65 m (aspirin is an ant decreases the clo caffeine can incer freeze (a topical joint pain, and p fiber medication C. The nurs -18-17 at 3 PM, document all the #2 on the plan or 3. Review of the	zide, Metroprolol, dine, Citralopram, itamin D3." Established Patient will be free from and falls with injury. ble to set up all own and will have established in the home. e understanding of edications and the need doses." ome visit observation of a (RN) on 5-16-17 at 11 stated taking the ations not evidenced on "B.C. packets (845 mg of ng of caffeine) for pain, ii-platelet medication and otting of the blood, rease blood pressure), bio pain medication) for polyethylene glycol (a) for constipation." ing supervisor stated on 5 having failed to e medications for patient f care.	ABKF11	Facility	ID: 014092 If continuatio		ge 113 of 1

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		î î	JILDING	NSTRUCTION 00	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF	2		5730 DF	DDRESS, CITY, STATE, ZIP R MLK BLVD SON, IN 46013	CODE	
(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 CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
		ntained a plan of care for period of 3-23-17 to					
		of durable medical enced "walker, cane, l chair."					
	HHA, on 5-16-1 was observed to	ome visit observation of a 7 at 11 AM, patient #3 have a "medical ety/emergency call					
		of the plan of care failed nedical guardian as equipment.					
	#4, evidenced a 2-15-17, and con	e clinical record of patient start of care date of ntained a plan of care for period of 2-15-17 to					
	requirements even established goals breath resolution client is using th positive airway p correctly. Client effects. Client w and hospitalizati	of the nutritional idenced "none," is included "shortness of in is the goal and that the e CPAP (continuous pressure) machine will have no adverse ill remain free from falls ons and injuries. Client eturn to her own home					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
			B. WING	<u></u>	05/18/2017
NAME OF	PROVIDER OR SUPPLIE	CR.		T ADDRESS, CITY, STATE, ZIP	CODE
ADMIRA	L HOME HEALTH			DR MLK BLVD ERSON, IN 46013	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE COMPLETIO DATE
	independently.'	•			
	B. Review	of the plan of care failed			
		CPAP machine as durable			
	medical equipm	nent, failed to evidence an			
		d failed to evidence a			
	discharge plan.				
	5. The clinical i	record of patient # 5 was			
		evidenced a start 3-15-17,			
	and a plan of ca	are for the certification			
	period of 3-15-	17 to 5-13-17. Review of			
	the plan of care	Goals/Rehabilitation			
	potential/discha	arge plans evidenced			
	-	free from falls or falls			
	will decrease. P	Patient will not have any			
		or injuries. ADLs and			
	-	met." The plan of care			
		ce a discharge plan for			
	patient #5.	ee a albenaige plan for			
	6 The clinical	record of patient #6			
		care was reviewed,			
	-	rt of care date of 2-17-17,			
		plan of care for the			
		•			
	-	riod of 2-17-17 to			
	-	atient had diagnosis of			
	dependent.	s mellitus and was insulin			
	A The play	n of care evidenced durable			
	-	nent (DME) of "none".			
		requirement section			
	evidenced "non	-			

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	ULTIPLE CO JILDING NG	COM	(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIEF			5730 DF	NDRESS, CITY, STATE, ZIP (R MLK BLVD SON, IN 46013	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX C TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE	
	nursing assessm evidenced patier and Diabetic die Lantus 30 units monitored by and competen glucometer." C. The plan evidence a diet of glucometer, need supplies. D. Review Goals/Rehabilita plans evidenced take medications understanding w medication. Clie effects. Patient w hospitalization". to evidence a dis #6	selfTID (3 times daily) cy with use of of care failed to order, and DME of a dles, and diabetic testing of the tion potential /discharge "Goal is that patient will as ordered and have an hy she is on each nt will have no adverse vill be free from The plan of care failed acharge plan for patient						
	reviewed and ev date of 2-17-17,	ecord of patient #7, was idenced a start of care and contained a plan of fication period of 17.						
	A. DME on evidenced "none	the plan of care						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED B. WING 05/18/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5730 DR MLK BLVD ADMIRAL HOME HEALTH ANDERSON, IN 46013 (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) TAG DATE TAG B. The Goals /Rehabilitation potential /discharge plans evidenced "Patient will remain compliant with medications as ordered by MD and remain free from adverse effects. Patient will remain free from injuries and hospitalizations." C. The plan of care failed to evidence DME of a glucometer, needles, and diabetic testing supplies and failed to evidence a discharge plan. 8. The clinical record of patient #8, was reviewed and evidenced a start of care of 4-11-17, and contained a plan of care for the certification period of 4-11-17 to 6-9-17. The patient had a diagnosis of obstructive sleep apnea. The order section of the plan of care evidenced "Pt just received CPAP machine and requires teaching and care of machine." A. Review of the plan of care DME evidenced "none". B. Review of the Goals /Rehabilitation potential /discharge plans evidenced "Goal is that patient will be confident in use of CPAP, BP will continue to be controlled, pain will be better controlled and more comfortable. Will notify MD as needed. Will remain free of injury and have no State Form Event ID: ABKF11 Facility ID: 014092 If continuation sheet Page 117 of 147

PRINTED:

08/25/2017

STATEME	FOR MEDICARE & MEDICAID SERVICES MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA .AN OF CORRECTION IDENTIFICATION NUMBER:		r í	JILDING ING	NSTRUCTION 00	CO	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF	2		5730 DF	DDRESS, CITY, STATE, ZII R MLK BLVD SON, IN 46013	P CODE		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
	nutritional requi D. The plan patient #8's diet, glucometer, need supplies, and fai discharge plan. 9. Review of the # 9 evidenced a 4-12-17, and con the certification 6-10-17. A. Review requirements evi B. Review nursing assessm evidenced the N "regular" as pati C. Review of /Rehabilitation p evidenced "Will oversight and be free from injury hospitalizations. and comply with	of care evidenced for rements "none". of care failed to evidence DME and supplies of dles, diabetic testing led to evidence a clinical record of patient start of care date of ntained a plan of care for period of 4-12-17 to of the nutritional idenced "none". of the comprehensive ent dated 4-12-17, utritional requirement ent #9's diet. of the Goals potential /discharge plans be compliant with ADL o dor free daily. Will be and no falls and no Will be free of seizures a medication reminders."						
	D. The plan	of care failed to evidence						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. E	MULTIPLE CO BUILDING VING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF		•	5730 DI	NDDRESS, CITY, STATE, ZIP R MLK BLVD SON, IN 46013	CODE	
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETIC DATE
		failed to evidence a					
	patient #10 evide of 3-4-17, and co for the certificati 5-2-17, and a pla	e clinical record of enced a start of care date ontained a plan of care ion period of 3-4-17 to in of care for the od of 5-3-17 to 7-3-17.					
		of DME evidenced					
	nursing assessme evidenced "Diab diet injectable Humalog mor The plan of care patient #10's glu	of a comprehensive adult ent dated 3-4-17, etes type 2, diabetic medication, Lantus hitored by self bid." failed to evidence cometer, diabetic test es as DME and supplies.					
	/Rehabilitation p evidenced "Goal take all medicati ordered and have she is on each m will have no adv	ew of the Goals ootential /discharge plans is that pt. [patient] will on on time and as e an understanding why edication. Pt [patient] erse reaction. Pt [patient] hospitalization."					
	-	of care failed to arge plan for patient #10.					

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES I OF CORRECTION	AID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. B	MULTIPLE CO SUILDING /ING	DNSTRUCTION 00	(X3) DA COM	0MB NO. 0938-03 TE SURVEY 1PLETED 18/2017	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP (5730 DR MLK BLVD ANDERSON, IN 46013			CODE		
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETIO DATE	
	 patient #1 evider of 3-15-17, and a 3-15 to 5-13-17. comprehensive a 3-15-17. The fin defines the start health aide on 3- comprehensive a performed 7 day establishment of rather than not n start of care. 12. Review of th patient #3 evider of 3-23-17, and a 3-23 to 5-21-17. comprehensive a 3-23-17. The fin defines the start health aide on 3- comprehensive a 3-23-17. The fin defines the start health aide on 3- comprehensive a performed 1 day establishment of rather than not n start of care. 13. Review of th patient #5 evider of 3-15-17, and a 	assessment was s prior to the a start of care date, hore than 5 days after the ne clinical record of need a start of care date a certification period of The start of care assessment was dated st billable visit, which of care, was by a home -24-17. The assessment was						
	comprehensive a	ssessment was dated st billable visit, which						

NTERS FO	R MEDICARE & MEDIC	AID SERVICES				(OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		UILDING	nstruction 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF 1	PROVIDER OR SUPPLIEF	-			DDRESS, CITY, STATE, ZIP	CODE	
ADMIRA	L HOME HEALTH				R MLK BLVD SON, IN 46013		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	COMPLETIC DATE
	defines the start health aide on 3-	of care, was by a home					
	comprehensive a						
	performed 2 day						
	-	a start of care date,					
		nore than 5 days after the					
	start of care.						
	14. Review of th	e clinical record of					
	patient #9 evider	nced a start of care date					
	of 4-12-17, and	a certification period of					
	4-12 to 6-10-17.	The start of care					
	comprehensive a	assessment was dated					
	4-12-17. The fin	st billable visit, which					
	defines the start	of care, was by a home					
	health aide on 4-	18-17. The					
	comprehensive a	assessment was					
	performed 6 day	s prior to the					
		a start of care date,					
	rather than not n start of care.	nore than 5 days after the					
	15. On 5-18-17	at 3 PM, the					
	administrator/nu	rsing supervisor verified					
	the above findin	gs and stated there was					
	no further docur	nentation to present to be					
	reviewed.						
0527	410 IAC 17-13-1(a	a)(2)					
	Patient Care	· · ·	1				1

PRINTED: 08/25/2017 FORM APPROVED OMB NO. 0938-0391

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

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI B. WING	DING	00	COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE L HOME HEALTH		Ę	5730 D	ADDRESS, CITY, STATE, ZIP CODE R MLK BLVD RSON, IN 46013		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ENCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	1	ſAG	DEFICIENCY)	DATE	
Bldg. 00	professional staf shall promptly all for the medical c	a)(2) The health care f of the home health agency ert the person responsible component of the patient's ges that suggest a need to plan of care.	N 052	7	Staff re-educated on	08/25/2017	
	Based on obser	vation, record review, and			appropriateness of skilled need	d	
	interview, the a			and coordination of care with clients doctor to include discha	arge		
	physician the p			plans by communicating with			
	established goa	ls, which suggested a need			doctors office .		
	to alter the med	lical plan of care to					
	include dischar	ge, for 1 of 10 patients			Director of nursing/Designee w	vill	
	whose clinical	record was reviewed			monitor through weekly case		
	(Patient #10).				management meetings to valid	late	
	The findings in	cluded:			skill care needs are present. Doctors will be notified of changes in level of care.		
	1. Review of the	he clinical record of					
	patient # 10, ev	videnced a start of care			Director of Nursing will report t		
	date of 3-4-17,	and contained a first			QAPI and Governing Body with any findings and deficiencies to		
	certification pe	riod of 3-4-17 to 5-2-17,			prevent this deficiency from	0	
	with order for "	'Skilled Nurse biweekly			recurring.		
	until end of cer	tification period for					
		que, monitor for					
	compliance wit	th DM (diabetes mellitus)					
	and follow B/P	(blood pressure) readings					
	and notify MD	PRN (as needed) and med					
	(medication) se	et up." Review of a plan of					
		ond recertification period					
	of 5-3-17 to 7-1	1-17, signed by the					
		8-17, evidenced an order					
		rse biweekly until end of					
	certification pe	riod for memory					
	technique, mon	itor for compliance with					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			CON	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	ĒR			DDRESS, CITY, STATE, 2	ZIP CODE		
					R MLK BLVD			
ADMIRA	L HOME HEALTH			ANDER	SON, IN 46013			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX (EACH		(EACH CORRECTIVE ACT	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	DM (diabetes n	nellitus) and follow B/P) readings and notify MD					DATE	
	dated 4-19-17, up by patient w oversight. No o pressure is well to use calendar	tilled nurse visit note evidenced "Medication set ith skilled nurse errors made Blood controlled Continues for reminders continues t with DM (diabetes						
	physician order documentation the physician p established goa certification per service was bei certification per	ommunication notes and rs failed to evidence the agency had notified atient #10 had met ls during the 1st riod on 4-19-17, no skilled ng furnished the 2nd riod, and discharge was or to recertification.						
	supervisor was 1:30 PM. The patient #10 "do could probably The nursing sup no skilled servi the 2nd recertif patient had den with insulin adu	v with the nursing conducted on 5-18-17 at administrator stated bes well with insulin, I discharge [patient #10]." pervisor stated there was ce being provided during ication period, as the nonstrated competency ministration and met other d of the 1st certification						

ENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-0
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/18/2017
	PROVIDER OR SUPPLIEI	2	5730 D	ADDRESS, CITY, STATE, ZIP CODE R MLK BLVD SSON, IN 46013	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLET DATE
	need to talk to (sing supervisor stated, " I employee G), the office de on discharging."			
l 0542 Bldg. 00	services are limite purposes of pract setting, the registe following: (C) Initiate the pla revisions. Based on record the agency failed nurse (RN) case necessary revision		N 0542	Staff re-educated to the proces of accurately documenting all forms of DME/Medication to include Rate/order/delivery method/instruction for use and communicate with patients doc with any findings.	to
	patient #1, evide	luded: e clinical record of enced a start of care date contained a plan of care		Staff re-educated on start of ca dates/ re-certification dates. SC are always the first billable visit Staff re-educated on the need t	DC t.
	for the certificat 5-13-17.	of the plan of care		revise plan of care with any additional orders from patients doctor in regards to diet, discharge planning, goals, and any changes are communicate	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
	L HOME HEALTH				R MLK BLVD RSON, IN 46013		
	-						-
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE 'RIATE	(X5) COMPLETIO DATE
IAU		· · · · · · · · · · · · · · · · · · ·		IAU	to the doctor.		DATE
	oxygen at night to evidence and registered nurse to the plan of ca order for oxyge and instructions B. Review the first billable health aide (HH defines establis The RN failed to plan of care to o	of visit notes evidenced e visit was by a home IA) on 3-22-17, which hment of the start of care. to initiate revision of the correct the start of care , and the certification			Admission process will me requirements of how to co admit patient from initial assessment to start of care Director of Nursing will mo through auditing all new admissions to ensure proce followed and done correct Director of Nursing will followith the QAPI and the Gove Board with any findings, to prevent the recurrence of the deficiency.	rrectly e. nitor ess is y. w up erning	
	evidenced a Nu "None." The R revision of the p nutritional requ The plan of car goals/rehabilita section failed to plan for patient initiate revision document a dise D. Review 3-13-17, for patient initial assessme	of the plan of care tritional Requirement of N failed to initiate plan of care to document a irement for patient #1. e tion/discharge plans o evidence any discharge #1. The RN failed to a of the plan of care to charge plan for patient #1. of the referral order, dated tient #1 was to "evaluate ent #1 had not had an ent or physician orders for 7. The RN failed to					

NTERS FO	R MEDICARE & MEDIC	AID SERVICES			· · · · · ·	OMB NO. 0938-03		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	JILDING	nstruction 00	CON	te survey 1pleted 18/2017	
NAME OF	PROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZI MLK BLVD	IP CODE		
ADMIRA	L HOME HEALTH			ANDERS	SON, IN 46013			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	HE APPROPRIATE	COMPLET DATE	
	initiate revision	to the referral order to						
	clarify the order	was to evaluate only for						
	the appropriaten	ess of home health						
	agency services.							
	2. Review of the	he clinical record of						
	patient #2, evide	enced a start of care date						
	of 3-15-17, and	contained a plan of care						
	for the certificat	ion period of 3-15 to						
	5-13-17.							
	A. Review	of the plan of care						
	narrative eviden	ced patient #2 had a						
	diagnosis of wei	ght loss. The RN failed						
	to initiate revisio	on to the plan of care to						
	include monitori	ng of weight as an						
	appropriate nurs	ing order.						
	B. Review o	f the referral order, dated						
	3-13-17, for pati	ent #2 was to "evaluate						
	and treat." Patie	nt #2 had not had an						
	initial assessmen	nt or physician orders for						
	care on 3-13-17.	The RN failed to						
	initiate revision	to the referral order to						
	clarify the order	was to evaluate only for						
	the appropriaten	ess of home health						
	agency services.							
	3. Review of the	e clinical record of						
	patient #3, evide	nced a start of care date						
	of 3-23-17, and	contained a plan of care						
	for the certificat	ion period of 3-23 to						
	5-21-17.							

	R MEDICARE & MEDI	-				OMB NO. 0938-039		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î		NSTRUCTION		TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII B. WIN		00		MPLETED 18/2017	
			<u> </u>	STREET A	DDRESS, CITY, STATE, ZII	P CODE		
	PROVIDER OR SUPPLIE	K			R MLK BLVD			
ADMIRA	L HOME HEALTH			ANDER	SON, IN 46013			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	IE APPROPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		a home visit observation						
		17-17 at 11 AM, patient						
	#3 was observe	d to have a "medical						
	guardian" devic	e. Patient #3 stated using						
	the medical gua	rdian device.						
	R Review	of the plan of care						
		nced patient #3 had						
		l equipment of walker,						
		zed wheel chair. The RN						
		revision of the plan of						
		nt the durable medical						
	equipment of a	medical guardian.						
	B. Review	of visit notes evidenced						
	the first billable	e visit was by a home						
		IA) on 3-24-17, which						
		hment of the start of care.						
		o initiate revision of the						
		correct the start of care						
	-							
		, and the certification						
	period to 3-24 t	0 5-22-17.						
	4. Review of t	he clinical record of						
	patient #4, evid	enced a start of care date						
	of 2-15-17, and	contained a plan of care						
	for the certifica	tion period of 2-15 to						
	4-15-17.	-						
	A Review	of the plan of care failed						
		scharge plan for patient						
	-	red nurse failed to initiate						
	-	plan of care to document a						
	discharge plan.							

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED B. WING 05/18/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5730 DR MLK BLVD ADMIRAL HOME HEALTH ANDERSON, IN 46013 (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 DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG B. Review of the referral order, dated 2-13-17, for patient #4 was to "evaluate and treat." Patient #4 had not had an initial assessment or physician orders for care on 2-13-17. The RN failed to initiate revision to the referral order to clarify the order was to evaluate only for the appropriateness of home health agency services. 5. Review of the clinical record of patient #5, evidenced a start of care date of 3-15-17, and contained a plan of care for the certification period of 3-15 to 5-13-17. A. Review of the plan of care failed to evidence a discharge plan for patient #5. The RN failed to initiate revision to the plan of care to document a discharge plan. B. Review of visit notes evidenced the first billable visit was by a home health aide (HHA) on 3-17-17, which defines establishment of the start of care. The RN failed to initiate revision of the plan of care to correct the start of care date to 3-17-17, and the certification period to 3-17 to 5-15-17. C. Review of the referral order, dated 2-14-17, for patient #5 was to "evaluate State Form Event ID: ABKF11 Facility ID: 014092 If continuation sheet Page 128 of 147

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08/25/2017

	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER:		A. E	AULTIPLE CO BUILDING VING	COM	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD ANDERSON, IN 46013			
(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 (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE
	and treat." Patie initial assessmer care on 2-14-17. initiate revision clarify the order the appropriaten agency services. 6. Review of th patient #6, evide of 2-17-17, and of for the certificate 4-17-17. A. Review to evidence a dis #6. The RN faile the plan of care to plan. B. Review of evidenced an ord spray as needed allergies). The r evidence the stree and how often th needed medicati	nt #6 had not had an at or physician orders for The RN failed to to the referral order to was to evaluate only for ess of home health e clinical record of nced a start of care date contained a plan of care ton period of 2-17 to of the plan of care failed techarge plan for patient ed to initiate revision to to document a discharge of the plan of care ler for Flonase nasal (a medication to treat medication order failed to ength of the spray ordered te interval for the as					
	3-13-17, for pati and treat." Patie initial assessmer care on 3-13-17.	ent #1 was to "evaluate nt #6 had not had an at or physician orders for The RN failed to to the referral order to					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	JILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF	2		STREET A 5730 DF ANDER	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	CF		(EACH CORRECTIVE ACTIO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
	 clarify the order the appropriaten agency services. 7. Review of the patient #7, evide of 2-17-17, and for the certificat 4-17-17. A. Review to evidence a dise 	was to evaluate only for ess of home health		TAG			DATE
	plan. B. Review 2-15-17, for pati and treat." Patie initial assessmen care on 2-15-17. initiate revision clarify the order	to document a discharge of the referral order, dated ent #7 was to "evaluate ent #7 had not had an nt or physician orders for The RN failed to to the referral order to was to evaluate only for ess of home health					
	8. Review of the patient #8, evide of 4-11-17, and for the certificat 6-9-17.	the clinical record of enced a start of care date contained a plan of care ion period of 4-11 to					
		of the plan of care ced patient #8 used a					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ER: A. BUILDING B. WING		<u>00</u>) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF	t		5730 DF	DDRESS, CITY, STATE, ZIP C R MLK BLVD SON, IN 46013	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
	CPAP (continuo pressure) machin failed to evidence durable medical registered nurse to the plan of ca the CPAP as dur B. Review to evidence a dis #8. The RN fail the plan of care plan. B. Review 4-10-17, for patie and treat." Patie initial assessmen care on 4-10-17. initiate revision clarify the order the appropriaten agency services.	us positive airway ne. The plan of care be the CPAP machine as equipment and the failed to initiate revision re to update to include to update to include able medical equipment. Sof the plan of care failed scharge plan for patient ed to initiate revision to to document a discharge Sof the referral order, dated ent #8 was to "evaluate ent #8 had not had an at or physician orders for The RN failed to to the referral order to was to evaluate only for ess of home health						
	patient #9, evide of 4-12-17, and	e clinical record of enced a start of care date contained a plan of care ion period of 4-12 to						
	to evidence a nu patient #9, and t	of the plan of care failed tritional requirement for he registered nurse failed on to the plan of care to						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 05/18/2017		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 5730 DR MLK BLVD ANDERSON, IN 46013					
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	B. Review of to evidence a dis #9. The RN fail the plan of care to plan. C. Review of 4-11-17, for pati and treat." Patie initial assessment	e an nutrition order. of the plan of care failed charge plan for patient ed to initiate revision to to document a discharge of the referral order, dated ent #9 was to "evaluate nt #9 had not had an it or physician orders for The RN failed to						
	 initiate revision clarify the order the appropriaten agency services. 10. Review of t patient #10, evid of 3-4-17, and co 	to the referral order to was to evaluate only for ess of home health he clinical record of enced a start of care date ontained a plan of care						
	5-2-17. A. Review narrative evidend diabetic and test The RN failed to							
		of the referral order, dated nt #10 was to "evaluate						

STATEME	ITERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					
	PROVIDER OR SUPPLIEF		5730	et address, city, state, zip co) DR MLK BLVD)ERSON, IN 46013	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
	care on 3-2-17. revision to the re order was to eva appropriateness services. 11. On 5-18-17 administrator/nu the above findin	at or physician orders for The RN failed to initiate efferral order to clarify the luate only for the of home health agency at 3 PM, the rsing supervisor verified gs and stated there was hentation to present to be				
N 0543 Bldg. 00	services are limited purposes of pract setting, the registed following: (D) Initiate appro- rehabilitative nurs Based on observ- interview, the ag registered nurse oxygen precaution	(1)(D) Except where d to therapy only, for ce in the home health ered nurse shall do the priate preventive and ing procedures. ation, record review, and gency failed to ensure the (RN) implemented ons for 1 of 2 patients rapy (Patient #1), and	N 0543	Nursing re-educated or measures regarding ox and weight loss. Re-edu was given on how to ap document and commun the patients doctor and the patient/caregiver.	ygen use ucation ppropriately nicate with	08/25/201

	T OF HEALTH AND HU!					M APPROVED
	R MEDICARE & MEDIC				_	8 NO. 0938-0391
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLE	
			B. WING		05/18/2	2017
NAME OF	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE		
				OR MLK BLVD		
ADMIRA	L HOME HEALTH		ANDE	RSON, IN 46013		
(X4) ID	SUMMARY STATEMENT 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	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	implemented nu	rsing interventions to		scope of services to include,		
	monitor the weig	ght of a patient with the		appropriate preventive nursing	g	
	diagnosis of wei	ght loss for 1 of 1 patient		measures and rehabilitative		
	•	of weight loss (Patient		measures.		
	#2), of a total sat	•				
	$\pi 2$, or a total sat					
	The findings in a	1 4 - 4.		10% of agency charts will be		
	The findings inc	luded:		randomly audited for compliar		
				every quarter until 100% are i	n	
	•	visit observation of a		compliance.		
		e for patient #1 on				
	5-17-17 at 2 PM, an oxygen concentrator					
	was observed in the home. Patient #1	the home. Patient #1				
	stated using it at	night. Review of the		Director of Nursing will be		
	plan of care faile	ed to evidence the RN		responsible for audit and		
	-	d oxygen precautions as a		informing QAPI/Governing Bo	-	
	safety measure.			of any deficiencies to prevent deficiency from recurring.		
				densiency nom recurring.		
	2 Review of the	e plan of care for patient				
		liagnosis of weight loss.				
		tilled nursing orders				
		•				
		ed Nursing 1 time a				
		tion set up, B/P (blood				
	• ·	oring at each visit." The				
	-	element monitoring of				
	weight as an app	propriate nursing				
	preventative and	rehabilitative measure.				
	3. On 5-18-17 a	t 3 PM, the				
	administrator/nu	rsing supervisor verified				
		g and stated there was no				
		tation to present to be				
	reviewed.	initial to present to be				
I	I		I	I	I	

If continuation sheet Page 134 of 147

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED B. WING 05/18/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5730 DR MLK BLVD ADMIRAL HOME HEALTH ANDERSON, IN 46013 (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) TAG DATE TAG N 0545 410 IAC 17-14-1(a)(1)(F) Scope of Services Bldg. 00 Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Patient assessment guidelines N 0545 08/25/2017 were reviewed and put into place. Based on record review and interview. All "at risk" patients charts are the agency failed to ensure the registered coded and identified through case nurse implemented agency policy to color conference meetings with staff, code mark the clinical record of patient's client/caregiver and through assessment and communication at risk for a fall for 2 of 2 patients at risk with patients doctor. for falls (Patients #3 and 5), of a total sample of 10. Director of nursing/Designee will audit 10% of charts quarterly to The findings included: monitor for compliance. 1. Policy, "Patient Assessment Director of Nursing will be Guidelines," with date of board approval responsible for monitoring these corrective actions to ensure that of 9-6-17, stated, "It is the responsibility this deficiency is corrected and of of the patient's nurse or therapist to will not recur. routinely assess the patient for the need for appropriate interventions related to fall prevention ... A color code is placed on the patient's chart and on the patient assignment board, if applicable. This will alert agency personnel that the patient is "At Risk." 2. Review of the clinical record of patient #3 failed to evidence any color code had been placed on the chart. 3. Review of the clinical record of State Form Event ID: ABKF11 Facility ID: 014092 If continuation sheet Page 135 of 147

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08/25/2017

ENTERS FO	R MEDICARE & MEDIC	AID SERVICES			FORM APPROVED OMB NO. 0938-0391 X3) DATE SURVEY COMPLETED 05/18/2017	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00		
	PROVIDER OR SUPPLIEI	2	5730 D	address, city, state, zip code pr MLK BLVD RSON, IN 46013		
(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 APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
I 0546 Bldg. 00	 code had been p 4. On 5-18-17 a administrator/nu the above findin policy had not b 410 IAC 17-14-1(a Scope of Services Rule 14 Sec. 1(a) services are limite purposes of pract setting, the registe following: (G) Inform the ph appropriate medic the patient's cond the patient and fa and related needs programs, and su nursing personne Based on observinterview, the ag physician the pa established goals to alter the media include discharg 	rising supervisor verified gs and stated agency een implemented. a)(1)(G) (1)(G) Except where ed to therapy only, for ice in the home health ered nurse shall do the ysician and other cal personnel of changes in ition and needs, counsel mily in meeting nursing participate in inservice pervise and teach other the tient, record review, and gency failed to alert the tient had attained the s, which suggested a need cal plan of care to e, for 1 of 10 patients ecord was reviewed	N 0546	Nursing re-educated on recognizing when goals are me by patient and when to appropriately discharge. Doct will be notified of changes for coordination of care. During weekly case conferenc patient level of care will be discussed to assess progress toward goals met and including possible discharge. Patients	or es	08/25/201
	1. Review of the	e clinical record of denced a start of care		physician will be notified of all findings to ensure coordination care.	n of	

	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	r í	UILDING	DNSTRUCTION 00	СОМ	te survey pleted 8/2017
			D. ()		ADDRESS, CITY, STATE, ZIP	_	0/2017
	PROVIDER OR SUPPLIEF			5730 D	R MLK BLVD RSON, IN 46013		
(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 CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	date of 3-4-17, a certification peri with order for "S until end of certi memory techniq compliance with and follow B/P (and notify MD F (medication) set care for the seco of 5-3-17 to 7-1- physician on 5-8 for "Skilled Nur certification peri technique, monit DM (diabetes m	nd contained a first od of 3-4-17 to 5-2-17, Skilled Nurse biweekly fication period for ue, monitor for DM (diabetes mellitus) blood pressure) readings PRN (as needed) and med up." Review of a plan of nd recertification period -17, signed by the -17, evidenced an order se biweekly until end of od for memory tor for compliance with ellitus) and follow B/P readings and notify MD			Director of nursing w responsible for monit corrective actions to deficiency is correcte not recur.	oring these ensure this	
	dated 4-19-17, e up by patient wir oversight. No en pressure is well to use calendar f	lled nurse visit note videnced "Medication set th skilled nurse rors made Blood controlled Continues for reminders continues with DM (diabetes					
	physician orders documentation t the physician pa established goals	mmunication notes and failed to evidence he agency had notified tient #10 had met s during the 1st od on 4-19-17, no skilled					

ENTERS FO	R MEDICARE & MEDI	CAID SERVICES				(OMB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)]	MULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		BUILDING	00	COM	IPLETED
			В. У	WING		05/*	18/2017
NAME OF	PROVIDER OR SUPPLIE	D		STREET A	ADDRESS, CITY, STATE, ZI	P CODE	
					R MLK BLVD		
ADMIRA	L HOME HEALTH			ANDER	SON, IN 46013		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	service was bei	ng furnished the 2nd					
	certification per	riod, and discharge was					
	appropriate pric	or to recertification.					
	4. An interviev	with the nursing					
		conducted on 5-18-17 at					
	<u>^</u>	administrator stated					
		bes well with insulin, I					
	-	discharge [patient #10]."					
		pervisor stated there was					
		ce being provided during					
		ication period, as the					
	-	ionstrated competency					
		ninistration and met other					
	goals by the end	d of the 1st certification					
	period. The nu	rsing supervisor stated, " I					
	need to talk to (employee G), the office					
	manager to dec	ide on discharging."					
0547	110 100 17 14 4	(a)(1)(H)					
0047	410 IAC 17-14-1 Scope of Service						
Bldg. 00) (1)(H) Except where					
		ed to therapy only, for					
	purposes of prac	tice in the home health					
		tered nurse shall do the					
	following:						
		carry out physician, iatrist, dentist and					
	optometrist order						
	T ODIOIDEUISI OIDE	S total and whilen					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED
			B. W.	ING		05/18/2017
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE	
ADMIRA	L HOME HEALTH				R MLK BLVD RSON, IN 46013	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	NIO	TAG	Consent for treatment form has	DATE
	Deced on recom	d marriers and interview	N 0	547	been revised to include	6 08/25/20
		d review and interview,			frequencies. Admitting	
		ed to ensure the registered			nurse/Physical Therapist will u	
	-	a verbal order for quencies, and care orders			new form on all new admission	S.
		are for 9 of 10 patients				
		Patient #1, 2, 3, 4, 5, 6, 7, 8, and 10) and			Staff re-educated on new	
		the registered nurse			admission process to include	
		bal order to continue			verbal orders and frequencies. This education also includes	
	-	s to include disciplines,			recerts/resumptions, to ensure	
		d care orders for 2 of 2			that all orders are in place at tir	ne
	-	vice more than 60 days			of starting services.	
	(Patients #1 and	•				
					Director of Nursing/Designee w	
	The findings in	cluded:			audit 100% of admission, rece and resumption charts for	rt
	1 Poviow of a	a policy, "Physician			compliance.	
		of board approval				
		9-6-17, stated, " Agency				
		sic Will] administer			Director of Nursing will be	
	-	atments only as ordered			responsible for audit and informing QAPI/Governing Bo	dv
	by the physician	2			of any findings to prevent deficiency from recurring.	uy .
	2. Review of t	he physician's orders in				
	the clinical reco	ord of patient #1 failed to				
	evidence the reg	gistered nurse had				
	-	bal order for disciplines,				
		d care orders prior to				
	furnishing servi	ices.				
	A. Review	of visit notes evidenced				
	care visits were	furnished by the nurse on				
		3-22-17, prior to obtaining				
		prization for care. Visit				

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		05/18/2017
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZII	P CODE
				DR MLK BLVD	
	L HOME HEALTH		ANDI	ERSON, IN 46013	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE
	notes evidenced	I the registered nurse had			
		ication set up and			
	monitored vital	-			
	B. The pla	n of care evidenced			
	signature of the	attending physician dated			
	4-3-17.				
	C Review	of physician's order about			
		rtification on 5-1-17,			
		ce a physician's order to			
		As of 5-18-17, the			
		ot signed the plan of care.			
		aide furnished care on 5-			
		alde furnished care on 3-			
	17-17.				
	3. Review of t	he physician's orders in			
		ord of patient #2 failed to			
		gistered nurse had			
		bal order for disciplines,			
	-	d care orders prior to			
	furnishing servi	•			
		of visit notes evidenced			
	care visits were	furnished by the nurse on			
	3-22, 3-29, and	3-22-17, prior to			
	obtaining physi	cian authorization for			
	care. Visit note	s evidenced the registered			
	nurse had perfo	rmed medication set up.			
	-	notes evidenced the home			
	health aide (HH	(A) had furnished			
		ADLs (activities of daily			
		Ls (instrumental			
		ly living) during care			
	detry tiles of dar	ry mynig) during ouro			

STATEME	ERS FOR MEDICARE & MEDICAID SERVICES 'ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF	2		5730 DF	ADDRESS, CITY, STATE, ZIP R MLK BLVD SON, IN 46013	CODE		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	visits on 3-17, 3 -17.	-19, 3-23, 3-27, and 3-30						
	-	of care evidenced attending physician dated						
	the clinical recon- evidence the reg requested a verb	e physician's orders in rd of patient #3 failed to istered nurse had al order for disciplines, care orders prior to ces.						
	the HHA had fur ADLs and IADI	of visit notes evidenced mished assistance with S during care visits on 3- -31, 4-3, 4-5, 4-7, 4-9,						
	-	of care evidenced attending physician dated						
	the clinical recon- evidence the reg requested a verb	he physician's orders in rd of patient #4 failed to istered nurse had al order for disciplines, care orders prior to ces.						
	care visits were	of visit notes evidenced furnished by the nurse on 7, prior to obtaining						

	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			COM	(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP C 5730 DR MLK BLVD ANDERSON, IN 46013			ODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE . DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
	notes evidenced assessed vital sig patient on the us (continuous posiduring visits. B. The plan signature of the 2-28-17. 6. Review of the the clinical recon- evidence the reg requested a verb	ization for care. Visit the registered nurse had gns, and instructed the e of CPAP machine tive airway pressure) of care evidenced attending physician dated e physician's orders in rd of patient #5 failed to istered nurse had al order for disciplines, care orders prior to ces.						
	care visits for as IADLs were furn 17 and 3-22-17. B. The plan signature of the s	of visit notes evidenced sistance with ADLs and hished by the HHA on 3- of care evidenced attending physician dated						
	the clinical recorr evidence the reg requested a verb	e physician's orders in rd of patient #6 failed to istered nurse had al order for disciplines, care orders prior to ces.						

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CON	STRUCTION	(X3) DA	ATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	CO	MPLETED
			B. WING			05/	/18/2017
NAME OF	PROVIDER OR SUPPLIE	R			DRESS, CITY, STATE, ZIP CO	ODE	
					MLK BLVD		
ADMIRA	L HOME HEALTH		A	NDERS	ON, IN 46013		
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORF		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREI		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)	TA	.0	DEFICIENCET		DATE
		of visit notes evidenced					
		furnished by the nurse on					
		3-7-17, prior to obtaining					
		rization for care. Visit					
		I the registered nurse had					
	performed med	ication set up.					
	B. The pla	n of care evidenced					
	-	attending physician dated					
	3-9-17.						
	8. Review of t	he physician's orders in					
	the clinical reco	ord of patient #7 failed to					
	evidence the reg	gistered nurse had					
		bal order for disciplines,					
	-	d care orders prior to					
	furnishing servi	-					
	A Review	of visit notes evidenced					
		furnished by the nurse on					
		2-27-17, prior to					
		cian authorization for					
	0.1	s evidenced the registered					
		rmed medication set up					
	and monitored						
		in signs.					
	B. The plat	n of care evidenced					
	signature of the	attending physician dated					
	2-28-17.						
	9 Review off	he physician's orders in					
		ord of patient #8 failed to					
		gistered nurse had					
		-					
	requested a veri	bal order for disciplines,					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIEF			5730 DF	ddress, city, state, zip R MLK BLVD SON, IN 46013	P CODE		
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	frequencies, and furnishing service	care orders prior to ces.						
	care visits were 3-11-17, prior to authorization for	•						
	-	of care evidenced attending physician dated						
	the clinical recon evidence the reg requested a verb	the physician's orders in and of patient #10 failed to istered nurse had al order for disciplines, care orders prior to ces.						
	care visits were 3-9, 3-16, and 3- physician author	-						
	-	of care evidenced attending physician dated						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/18/2017	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CO	DE	
	L HOME HEALTH			DR MLK BLVD RSON, IN 46013		
		STATEMENT OF DEFICIENCIES				(V5)
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	the time of rece failed to evider continue care. plan of care or of D. Review registered nurse when the RN m compliance with and medication 12. On 5-18-17 supervisor verif and stated the a include calling furnishing serv order for discip care orders. Th stated the first se patients 1, 2, 3, occurred upon care, up to 30 d begun providin services stated include obtainin continue servic of the previous nursing supervisi	 v of physician's order about ertification on 5-2-17, are a physician's order to The physician signed the ders on 5-8-17. v of visit notes evidenced a evisit note dated 5-3-17, nonitored patient #10 the diabetes mellitus diet and took vital signs. 7 at 3 PM, the nursing fied the above findings agency practice did not the physician prior to ices to obtain a verbal olines, frequencies, and he nursing supervisor signed order for care for 4, 5, 6, 7, 8, and 10 return of a signed plan of lays after the agency had g care. The nursing the agency practice did not ng a verbal order to es prior to the expiration certification period. The isor stated there was no entation to present to be 				

STATEME	R MEDICARE & MEDI- NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	OMB NO. 0938-0391 X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIE	R	5730 E	ADDRESS, CITY, STATE, ZIP CODE DR MLK BLVD RSON, IN 46013		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
N 0550 Bldg. 00	services are limit purposes of praces setting, the regis following: (K) Delegate dur practical nurses appropriate. Based on record the registered n nutritional requi home health aid patients who re services (Patier The findings in 1. Review of th patient #1, evid of 3-15-17, and for the certifica 5-13-17, with o services. Revie care plan, dated 5-11-17, failed requirement (di 2. On 5-18-17 a	 (1)(K) Except where ed to therapy only, for tice in the home health tered nurse shall do the ties and tasks to licensed and other individuals as d review and interview, urse failed to include a irement on the prepared a de care plan for 1 of 6 ceived home health aide tit#1) cluded: ne clinical record for enced a start of care date contained a plan of care tion period of 3-15 to rder for home health aide t3-15-17, and updated on to evidence a nutritional 	N 0550	Re-educated admitting Nurse/Physical Therapy sta obtain diet order on all admission/Re-cert/Resumpt through communication wit patient and the patients doc Director of Nursing will audi newly admitted/Re-certs/Resumpt charts for compliance and a will be on going. Director of Nursing will be responsible for audits and informing QAPI/Governing of any findings to prevent deficiency from recurring.	tions h the tor. t ion audits	08/25/2017

PRINTED: 08/25/2017 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FOR	R MEDICARE & MEDIC.	AID SERVICES				OM	B NO. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/18/2017	
	PROVIDER OR SUPPLIER			5730 DR	DDRESS, CITY, STATE, ZIP CODE R MLK BLVD SON, IN 46013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	stated there was documentation to	no further o present for review.					

State Form

 Event ID:
 ABKF11
 Facility ID:
 014092
 If continuation sheet
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