STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 B. WING		COMPLETED
		15K066	_		03/22/2017
NAME OF P	ROVIDER OR SUPPLIER	\		ADDRESS, CITY, STATE, ZIP CODE	
	DE MEDICAL COLL	ITIONS INC		TIST DRIVE	
	RE MEDICAL SOLU			/ILLE, IN 47448	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
G 0000	KEGOE/TOKT OK	LEG IDENTIF FING IN ORMATION	1710		DATE
0 0000					
Bldg. 00					
			G 0000		
	This visit was fo	r a home health agency			
	federal recertific	ation survey.			
	This was a partia	al extended survey on			
	3-17-2017.				
	· ·	-16-17, 3-17, 3-20, 3-21,			
	and 3-22-2017				
	Facility Number	: IN 012412			
	Medicaid Numb	er: 201013320			
	Census Service	Гуре:			
	_	d skilled admissions			
	previous 12 mon	iths			
		G1 :11 1			
	80	Skilled			
		Home Health Aide Only			
		sonal Care Only			
	113	Total			
	G	1			
	Survey samp	pie:			
	. n	d n . t			
		ord Review with home			
	visit				
		ord review without home			
	visit	_1			
	10 Tota	aı			
				l .	<u> </u>

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is 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.

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	OF CORRECTION IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2017
	PROVIDER OR SUPPLIER RE MEDICAL SOLUTIONS INC	25 ART	ADDRESS, CITY, STATE, ZIP CODE TIST DRIVE VILLE, IN 47448	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
G 0144 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on observation, record review and interview, the agency failed to ensure the clinical record or case conference notes documented the results of coordination of care activities between the agency and an outside provider for 5 of 6 patients who received care from more than one agency, of a total sample of 10 clinical records reviewed (Patient #1, 4, 6, 7, and 10). The findings included: 1. A policy titled "Coordination of Patient Services," last reviewed/revised 1-11-17, stated, "All personnel furnishing services shall maintain liaison to assure that their efforts are coordinated effectively and support the objectives	G 0144	The DON and ADON will conduct an in-service on 4/13/17 with the LCMS nursing staff regarding the necessity of documenting coordination of care between themselves and other health care provide in Communication notes and Recertification documentation at least once per episode. Documentation must include disciplines, frequency and services being provided. Through the Quality Assurance process(QA), the DON, ADON and designee will	e 3

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLE	
		15K066	B. W	ING		03/22/2	2017
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					IST DRIVE		
LIFE CAF	RE MEDICAL SOLU	JTIONS INC		NASHV	ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	,		DATE
		lan of Care. This may be			review all communication		
	_	rmal case conferences,			notes and re-certification		
	_	iplete, current Care			documentation to ensure	_	
	Plans, and writte	en and verbal			compliance. 10% of clinic	aı	
	interaction."				charts will be audited		
		1 0			quarterly by the DON to further monitor for		
		ecord of patient #1, start					
		-1-17, was reviewed and			compliance.		
		cian's written plan of					
		fication period of 2-1 to					
	4-1-17.						
		nome visit observation of					
	_	cal nurse (LPN) on 3-20-					
	17 at 8:00 AM, a	a registered nurse from					
	an outside medic	care agency, person H, a					
	registered nurse,	was observed in the					
	home. Person A	indicated making skilled					
	nursing visits for	r wound care, foley care,					
	and managemen	t of anticoagulation					
	PT/INR (Prothro	ombin Time and					
	International No	rmalized Ratio) lab tests					
	[blood tests to m	easure blood thinning].					
	Person A indicat	ed having made early					
	morning visits a	nd occasionally having					
	_	ncy LPN, employee B, as					
	person A was de	parting and employee B					
	was arriving.						
	B. Review of	of the plan of care, visit					
		nunication notes, failed to					
	· ·	entation of the results of					
		care activities between					
	the two agencies						
	l		1				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 03/22/	ETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448				
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	documentation of when person A a communicated.	of the information shared and employee B					
	nursing supervising record document documentation of care activities stated morning redocument specificactivities for pattern conference had a supervision of care date of 9 and included a personal document specificactivities for pattern conference had a supervision of care date of 9 and included a personal document supervision of care date of 9 and included a personal document supervision of care date of 9 and included a personal document supervision of care date of 9 and included a personal document supervision of care date of 9 and included a personal document supervision of care activities stated morning redocument supervision of care activities stated morning redocument supervision of care activities stated morning redocument specification of care activities stated morning redocument specification of care activities for pattern supervision of care date of 9 and included a personal	or stated the clinical tation failed to evidence of results of coordination. The administrator meeting notes did not ic coordination of care ient #1 and a 60 day case not yet been held. The coordination of care ient #4, start -15-15, was reviewed hysician's written plan of fication period of 2-5 to					
	evidenced patier care services fro The plan of care communication documentation of	care activities between					
	nursing supervis record documen coordination of	or stated the clinical tation failed to evidence care activities. The atted morning meeting					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE A. BUILDING B. WING	OO OO	COMP	E SURVEY LETED 2/2017
	PROVIDER OR SUPPLIER		25 AF	ET ADDRESS, CITY, STATE, ZIP CODE RTIST DRIVE		
(X4) ID	RE MEDICAL SOLU	TATEMENT OF DEFICIENCIES	ID	HVILLE, IN 47448		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)) BE	COMPLETION DATE
		onference notes did not ic coordination of care ient #4.				
	of care date of 3 included a physi	record of patient #6, start -6-17, was reviewed and cian's written plan of fication period of 3-6 to				
	evidenced patier care services fro The clinical reco notes, and case of to evidence docu	of the plan of care in #6 received attendant in an outside agency. ord, communication conference notes, failed imentation of the results of care activities between is.				
	nursing supervis record document coordination of a administrator states notes and case co	17 at 4:00 PM, the or stated the clinical tation failed to evidence care activities. The ated morning meeting conference notes did not fic coordination of care ient #6.				
	of care date of 4 3-22-17,and incl	record of patient #7, start -20-15, was reviewed on uded a physician's are for the certification 4-8-17.				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		15K066	B. W	ING		03/22/2017	
NAME OF B			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		$\overline{}$
NAME OF P	PROVIDER OR SUPPLIER	L		25 ART	IST DRIVE		
	RE MEDICAL SOLU				ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ЭN
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	DATE	
		of the plan of care					
		at #7 received services					
		agency. The clinical					
		cation notes, visit notes,					
		ence notes, failed to					
		entation of the results of					
	coordination of	care activities between					
	the two agencies						
		17 at 4:00 PM, the					
	nursing supervisor stated the clinical						
		tation failed to evidence					
	coordination of o	care activities. The					
	administrator sta	ted morning meeting					
	notes and case co	onference notes did not					
	document specif	ic coordination of care					
	activities for pat						
	_						
	6. The clinical r	ecord of patient #10,					
	start of care date	of 10-2-13, was					
	reviewed and inc	cluded a physician's					
	written plan of c	are for the certification					
	period of 12-10-	16 to 2-7-17.					
	A. Review	of the plan of care					
	evidenced patien	at #10 received attendant					
	care services fro	m an outside agency.					
		ord communication notes,					
		ease conference notes,					
		e documentation of the					
		nation of care activities					
	between the two						
	Jetween the two	450110100.					
	B. On 3-22-	17 at 4:00 PM, the					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		15K066	B. WING		03/22/2017	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			TIST DRIVE		
LIFE CAF	RE MEDICAL SOLU	ITIONS INC		/ILLE, IN 47448		
(X4) ID	SUMMARY S	FATEMENT 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'	TE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
		or stated the clinical				
	record documentation failed to evidence					
	coordination of c	care activities. The				
	administrator sta	ted morning meeting				
		onference notes did not				
		ic coordination of care				
	activities for pati					
	activities for pati	π 10.				
G 0158	484.18					
		F PATIENTS, POC, MED				
Bldg. 00	SUPER					
	Care follows a writ	•				
	•	eriodically reviewed by a				
		e, osteopathy, or podiatric				
	medicine.		G 0158	The procedures for SOC	04/13/2017	
	D 1	no to ondinant	0 0138	The procedures for SOC,		
		review and interview,		ROC and Re-Certification		
		I to implement its policy		have been reviewed by the	ne	
	-	ing care only when		ADON. The procedures		
	orders from the a	attending physician had		have been revised to		
	been obtained for	r 10 of 10 patients whose		include obtaining verbal		
		as reviewed (Patients		orders prior to providing		
		l on observation, record		care. Verbal orders will		
	,	view, the agency failed		include the SOC/ROC da	te,	
		n of care contained		disciplines, frequencies a	•	
	to chouse the plan	ii oi cait comaineu				

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-	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BU	A. BUILDING 00 B. WING		COMPL 03/22/	ETED
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE MEDICAL SOLU	TIONS INC			IST DRIVE ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	orders for oxyger patients with hor (Patients #4 and visit observations). The findings incl. 1. Policy, "Plan reviewed/revised and stated, "Hom furnished under to direction of the p. 2. Policy, Physis reviewed/revised and stated, "All r and services provordered by a physician in a time. 3. The clinical reviewed, start or contained a plan respite skilled numbers of the p. A. Reviewed comprehensive a 2-1-17, evidence with the attendinat 3:30 PM, the rethe comprehensive and the	ne therapy for 2 of 2 ne visit observations 5), of a total of 5 home s; uded: of Care," last 1-11-17, was reviewed ne care services are the supervision and natient's physician." cian Orders," last 1-11-17, was reviewed medications, treatments, yided to patients must be sician. The orders may elephone or in writing ntersigned by the nely manner." record of patient #1 was f care date of 2-1-17, and of care with orders for arsing services. of the start of care ssessment/OASIS dated d care was coordinated g physician. On 3-20-17 nursing supervisor stated we assessment was not		TAG	specific orders for care. Verbal orders will be documented in the clinical record, signed and dated the RN and faxed to the ordering physician for countersignature. The DO and ADON will conduct at in-service on 4/13/17 and provide written instruction RNCMs regarding the revision. The DON, ADOI and designee will review SOCs, ROCs and Re-Certifications to ensur compliance as part of the regular QA process.	ol by DN n to N all	DATE
ı	sent to the attend	ing physician and did					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 03/22	LETED
	PROVIDER OR SUPPLIER		25 AR	ADDRESS, CITY, STATE, ZIP COD TIST DRIVE VILLE, IN 47448	E	
(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 APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	not evidence phy of patient #1.	vician orders for the care				
	failed to evidence orders related to	of physician's orders e a physician's verbal disciplines, frequency of ic physician orders for nt #1.				
		of visit notes evidenced are was furnished on 2-2				
	of the electronic evidenced the plants 2-3-17, finalized attending physic	of the document history medical record system an of care was created on and faxed to the ian on 2-9-17, and signed physician on 2-9-17.				
	of care date of 1- and contained a certification peri	record of patient #2, start -24-13, was reviewed plan of care for the od 3-4 to 5-2-17, with I nursing and home ces.				
	comprehensive a 3-1-17, evidence with the attendin at 3:30 PM, the rather comprehensi	of the recertification assessment/OASIS dated ad care was coordinated ag physician. On 3-20-17 aursing supervisor stated we assessment was not ling physician and did				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15K066	B. W	ING		03/22/	2017
	PROVIDER OR SUPPLIER			25 ARTI	DDRESS, CITY, STATE, ZIP CODE IST DRIVE ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR not evidence phy	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) //sician orders for the care		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	failed to evidence related to disciple and specific care recertification as after expiration of certification period. C. Review skilled nursing for D. Review evidenced the plus signed by the att 17.	of orders on 3-3-17. of visit notes evidenced urnished care on 3-6-17. of the plan of care an of care orders were ending physician on 3-7-					
	of care date of 3 and contained a	record of patient #3, start -13-17, was reviewed plan of care with orders ag and home health aide					
	comprehensive a 3-13-17, evidence coordinated with On 3-20-17 at 3: supervisor stated assessment was	of the start of care assessment/OASIS dated and evidenced care was at the attending physician. 30 PM, the nursing at the comprehensive and sent to the attending at not evidence physician are of patient #3.					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	r í	LDING	nstruction <u>00</u>	(X3) DATE COMPI 03/22	ETED
	PROVIDER OR SUPPLIEF		•	25 ARTI	DDRESS, CITY, STATE, ZIP CODE IST DRIVE ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	failed to evidence related to disciplant specific care assessment of particle. C. Review	of visit notes evidenced furnished care on 3-13-17, th aide visit was					
	document histor medical record s of care was crea finalized and fax physician on 3-2 survey on 3-22-	of the plan of care y in the agency electronic system evidenced the plan ted on 3-17-17, and was ted to the attending 20-17. At time of exit of 17, the plan of care had ned by the attending					
	of care date of 9 and contained a certification per	record of patient #4, start -15-15, was reviewed plan of care for the tod 2-5 to 4-5-17, with d nursing and home ces.					
	comprehensive a 2-2-17, evidence with the attendir	of the recertification assessment/OASIS dated ed care was coordinated ag physician. On 3-20-17 nursing supervisor stated					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00	COMPLETED 03/22/2017	
	PROVIDER OR SUPPLIER		25 ART	ADDRESS, CITY, STATE, ZIP CODE FIST DRIVE VILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	-	mprehensive assessment ne attending physician.				
	failed to evidence related to disciple and specific care recertification as after expiration of certification periods.	of physician's orders e physician verbal orders ines, frequency of visits, orders based on the sessment of patient #4 of the previous od orders on 2-4-17. of visit notes evidenced a e furnished care on 2-6-				
	document history medical record sy of care was creat finalized and fax physician on 2-8	of the plan of care y in the agency electronic ystem evidenced the plan ed on 2-6-17, was ed to the attending -17, and was signed by ysician on 2-9-17.				
	of a registered nu 10 AM, the patie	home visit observation urse (RN) on 3-21-17 at nt was observed to be 2 liters per minute by				
	to evidence a phy	f the plan of care failed vsician order for oxygen, and method of delivery.				
	6. The clinical r	record of patient #5, start				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. W	ING		03/22/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t			IST DRIVE		
LIFE CAF	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of care date of 1	1-15-16, was reviewed					
	and contained a	plan of care for the					
	certification peri	od of 1-14 to 3-14-17,					
	with orders for s	killed nursing services.					
		C					
	A. Review	of the recertification					
	comprehensive a	assessment/OASIS, dated					
		ced care was coordinated					
	· ·	ng physician. On 3-20-17					
		nursing supervisor stated					
		ve assessment was not					
	sent to the attend						
	sent to the attene	mig physician.					
	B Review (of physician's orders					
		e physician verbal orders					
		lines, frequency of visits,					
	_	e orders based on the					
		ssessment of patient #5					
	after expiration of	-					
	certification peri	od orders on 1-13-17.					
	C Review o	of visit notes evidenced					
		furnished care on 1-14, 1-					
	1	17-17, prior to return of					
		with physician signature					
	dated 1-18-17.	with physician signature					
	uaicu 1-10-1/.						
	D During a	home visit observation					
	1	ient #5 on 3-21-17 at 12					
	_	was observed to have					
		via tracheotomy collar at					
	1 30 13	te. Review of the plan of					
	_	fication period of 1-14 to					
		-					
	3-14-1/, failed to	o evidence a physician					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2017			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448				
(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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE		
	order for oxygen method of delive	a, to include setting and erry.					
	of care date of 3 contained a plan	record of patient #6, start -6-17, was reviewed and of care with orders for nd home health aide					
	comprehensive a 3-14-17, evidence with the attendinat 3:30 PM, the attended the comprehensions sent to the attended to the att	of the start of care assessment/OASIS dated ced care was coordinated ag physician. On 3-20-17 nursing supervisor stated ve assessment was not ding physician and did vsician orders for the care					
	failed to evidend orders related to	of physician's orders the physician verbal disciplines, frequency of fic care orders based on of patient #6.					
	home health aide 3-14, 3-15, 3-17	of visit notes evidenced es had furnished care on , 3-18, 3-20, 3-21, and 3- lled nursing visit was					
	document histor	of the plan of care y in the agency electronic ystem evidenced the plan					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION G 00	COM	E SURVEY PLETED 2/2017	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448				
(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 THI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
		ted on 3-20-17, and was ed to the attending 2-17.					
	of care date of 4 and contained a certification peri	record of patient #7, start -20-15, was reviewed plan of care for the od of 2-8 to 4-8-17.					
	comprehensive a evidenced care v attending physic PM, the nursing follow-up compre	vas coordinated with the ian. On 3-20-17 at 3:30 supervisor stated the rehensive assessment was tending physician.					
	failed to evidence related to disciple and specific care follow-up assesses the expiration of	of physician's orders e physician verbal orders ines, frequency of visits, orders based on the ment of patient #7 after the physician orders on ification period which 7.					
		of visit notes evidenced ed on 2-8 and 2-9-17.					
	evidenced the at	of the plan of care tending physician signed orders on 2-14-17.					
	9. The clinical r	ecord of patient #8, start					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2017			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448				
(X4) ID PREFIX TAG	SUMMARY S (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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	and contained a	-11-17, was reviewed plan of care with orders ng and home health aide					
	comprehensive a 1-11-17, evidend with the attendir at 3:30 PM, the the comprehensi sent to the attend	of the start of care assessment/OASIS dated and care was coordinated ag physician. On 3-20-17 and supervisor stated assessment was not ding physician and did assician orders for the care					
	failed to evidence related to disciple	of physician's orders the physician verbal orders tines, frequency of visits, to orders based on the tient #8.					
	home health aid 1-23, 1-24, 1-25 1-30, 1-31, 2-1,	of visit notes evidenced e visits were furnished on , 1-26, 1-27, 1-28, 1-29, 2-2, 2-3, 2-4, and 2-5-17, ng care was furnished on 0-17.					
	evidenced the at	of the plan of care tending physician signed orders on 2-6-17.					
	10. The clinical start of care date	record of patient #9, of 3-13-17, was					

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	OF CORRECTION OF CORRECTION 15K066	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 03/22/2017		
	PROVIDER OR SUPPLIER RE MEDICAL SOLUTIONS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	reviewed and contained a plan of care with orders for home health aide services.					
	A. Review of the start of care comprehensive assessment dated 2-7-17, evidenced care was coordinated with the attending physician. On 3-20-17 at 3:30 PM, the nursing supervisor stated the comprehensive assessment was not sent to the attending physician and did not evidence physician orders for the care of patient #9.					
	B. Review of physician's orders failed to evidence physician verbal orders related to disciplines, frequency of visits, and specific care orders based on the assessment of patient #9.					
	C. Review of visit notes evidenced home health aide visits were furnished on 3-14, 3-15, and 3-16-17.					
	D. Review of the plan of care evidenced the attending physician signed the plan of care orders on 3-22-17.					
	11. The clinical record of patient #10, start of care date of 10-2-13, was reviewed and contained a plan of care for the certification period of 12-10-16 to 2-7-17, with orders for skilled nursing and home health aide services.					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION G 00	COM	TE SURVEY PLETED 22/2017		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO	TION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
	A. Review of comprehensive at 12-9-16, evidence with the attending at 3:30 PM, then the comprehensistent to the attendormal B. Review of failed to evidence related to disciple and specific care follow-up assess the expiration of the previous plan period plan which care was furnish on 12-11-16, by skilled nurse on furnished by a hoskilled nurse on D. Review of the previous plan the previous plan which care was furnish on 12-11-16, by skilled nurse on furnished by a hoskilled nurse on the previous plan the previous plan which care was furnish to 12-11-16, by skilled nurse on the previous plan the previous plan which care was furnish to 12-11-16, by skilled nurse on the previous plan the plan the previous plan the previous plan the previous plan the plan the previous plan the previous plan the previous plan the pr	of the recertification assessment/OASIS dated bed care was coordinated ag physician. On 3-20-17 mursing supervisor stated we assessment was not ding physician. of physician's orders be physician verbal orders lines, frequency of visits, a orders based on the linest of patient #10 after of the physician orders on an of care certification beh expired on 12-9-16. of visit notes evidenced by a home health aide and 12-12-16, and care was ome health aide and 12-13-16. of the plan of care tending physician had						
		at 4:00 PM, the nursing I the agency staff had						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILE		NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or correction	15K066	B. WING	ING	00	03/22/	
		101.000		TDEET A	DDRESS, CITY, STATE, ZIP CODE	00/22/	
NAME OF P	ROVIDER OR SUPPLIER				IST DRIVE		
LIFE CAF	RE MEDICAL SOLU	TIONS INC	NASHVILLE, IN 47448				
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAU		the above patients	1	AU			DATE
		ining specific physician					
		ciplines, frequency of					
		ic care orders by verbal					
		order at the time of the					
		prior to the return of a					
		plan of care with written					
	orders for care.	1					
G 0159	484.18(a)						
	PLAN OF CARE						
Bldg. 00		eveloped in consultation aff covers all pertinent					
		ng mental status, types of					
	•	oment required, frequency					
		s, rehabilitation potential,					
		ns, activities permitted, nents, medications and					
		ifety measures to protect					
	against injury, inst	ructions for timely					
	discharge or referr	al, and any other					
	appropriate items.		G 0159	,	The ADON reviewed the		04/13/2017
	Rased on record	review and interview,	0.013	<i>'</i>	procedure for determining	,	0 4 /13/201/
		to ensure the plan of			the SOC date. The SOC	1	
	• •	entified the start of care			date is the date of the firs	t I	
	•	ation period(s) for 6 of			billable visit. Establishing	•	
		• • • • • • • • • • • • • • • • • • • •			the SOC date as the first		
	10 patients whose clinical record was reviewed (Patients # 1, 4, 6, 7, 8, and 9);				billable visit was added to		
	10 viewed (1 dileli	ω 11, 11, 0, 11, 0, and 7 <i>J</i> ,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ΓED	
		15K066	B. W	ING		03/22/20	017
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			IST DRIVE		
LIFE CA	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
							075)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	1,	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ΓE '	DATE
1710				ind	the admission process C	\n	DATE
		ture plan of care orders			the admission process. C 4/13/17 the DON and	""	
	_	uency of visit order					
	_	o (0) for 1 of 10 patients			ADON are providing writt		
		ecord was reviewed			and verbal instructions fo		
	(Patient #10).				determining the SOC date	e	
	The findings included:				to RNCMs. The DON,		
					ADON and their designed	9	
					will review all SOCs to		
	1. Policy, "Plan of Care," last				ensure that SOC date is		
	reviewed/revised 1-11-17, was reviewed				correct and that the dates	}	
	and stated, "An individualized Plan of				of the certification period		
	Care signed by a physician shall be				are appropriate for the S0	DC	
		h patient receiving home			date.		
	•	s. The Plan of Care shall			The ADON reviewed the		
		full to include: a. All			procedure for documentir	ng	
	^	sis(es), principle and			frequencies of visits.		
		ding date of onset. b.			Frequencies of zero "0" h	ad	
					been included. Ranges th	nat	
		c. Type, frequency, and			include a frequency of ze	ro	
		isits/services t. Other			are not allowed. On 4/13/	17	
	appropriate item	S."			the DON and ADON will		
	2 The alimical	record of nations #1 start			provide written and verba	ı	
		record of patient #1, start			instructions to all RNCMs	,	
		-1-17, (defined as the			with notification that		
		t), was reviewed on			frequency of "0" is not		
		inical record evidenced a			allowed; if no visit is to be	,	
		of care with a start of			made during any week in		
	· ·	and certification period			the episode, that week w		
	2-1 to 4-1-17, w	ith orders for skilled			be omitted in the orders f		
	nursing (SN) ser	vices.			frequencies. The DON,	-	
					ADON and their designed	,	
	A. Review	of assessments evidenced			will review all SOCs, RO		
	a start of care co	omprehensive			and Re-Certifications to		
	assessment/OAS	SIS was performed on 2-1			ensure that frequencies of	of O	
	-17.	•			are not included.	''	
					are not included.		

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	NT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	G 00	COM	TE SURVEY MPLETED
		15K066		EET ADDRESS, CITY, STATE, 2		22/2017
	PROVIDER OR SUPPLIE			ARTIST DRIVE	ZII CODE	
LIFE CA	RE MEDICAL SOL	JTIONS INC	NAS	SHVILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	evidenced the filicensed practice correct start of correc	of the visit notes rst billable visit was by a al nurse on 2-2-17. The care date should have d the correct certification ave been 2-2 to 4-2-17. record of patient #4, start 0-15-15, (defined as the it), was reviewed on inical record evidenced a of care with a start of and certification period 15, with orders for SN				
	a start of care co	of assessments evidenced omprehensive SIS was performed on 9-				
	evidenced the fi SN on 10-20-15 date should have	of the visit notes rst billable visit was by a . The correct start of care e been 10-20-15, and the tion period should have o 12-18-15.				
	of care date 3-6-billable visit), w The clinical reco	record of patient #6, start -17, (defined as the first ras reviewed on 3-21-17. ord evidenced a of care with a start of				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066						(X3) DATE SURVEY COMPLETED 03/22/2017		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
		nd certification period ith orders for SN and						
	a start of care co	of assessments evidenced imprehensive GIS was performed on 3-						
	evidenced the firskilled nurse on start of care date 17, and the corre	of the visit notes rst billable visit was by a 3-14-17. The correct e should have been 3-14- ect certification period in 3-14 to 5-12-17.						
	of care date 4-20 billable visit), w The clinical recomplysician's plan care of 4-20-15,	record of patient #7, start 0-15(defined as the first as reviewed on 3-22-17. ord evidenced a of care with a start of and certification period with orders for SN and						
	a start of care co	of assessments evidenced imprehensive SIS was performed on 4-						
	evidenced the fir registered nurse	of the visit notes rst billable visit was by a on 4-30-15. The correct should have been 4-30-						

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	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	l í	UILDING	00	COMPL 03/22	LETED	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448					
(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 APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	-	ect certification period n 4-30 to 6-28-15.						
	of care date 1-11 billable visit), w The clinical reco physician's plan care of 1-11-17,	record of patient #8, start 1-17, (defined as the first as reviewed on 3-22-17. ord evidenced a of care with a start of and certification period with orders for SN and						
	a start of care co	of assessments evidenced omprehensive GIS was performed on 1-						
	evidenced the fir HHA on 1-23-1' care date should	of the visit notes rst billable visit was by a 7. The correct start of have been 1-23-17, and accident period should to 3-23-17.						
	of care date 3-13 billable visit), w The clinical reco physician's plan care of 3-13-17,	record of patient #9, start 3-17, (defined as the first as reviewed on 3-22-17. ord evidenced a of care with a start of and certification period with orders for HHA						
	A. Review o	of assessments evidenced						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE A. BUILDING B. WING	OO OO	COMP	E SURVEY LETED 2/2017	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	a start of care co was performed o	mprehensive assessment n 2-7-17.					
	evidenced the fir HHA on 3-14-17 care date should correct certificat been 3-14 to 5 12 8. The clinical start of care date reviewed on 3-2 evidenced a physical the certification 2-7-17, with an or serious constant of the certification 2-7-17, with an or serious care date and the certification 2-7-17, with an or serious care date and the certification 2-7-17, with an or serious care date and the certification 2-7-17, with an or serious care date and the certification 2-7-17.	record of patient #10, of 10-2-13, was 1-17. The clinical record sician's plan of care for period 12-10-16 to order for "SN: [skilled					
	4 days/week (1 h 2 days/week (1 h	#1; 0 visits, Weeks #2-9, nour per visit) Week #10, nour per visit) for essment, and to change al wound."					
	supervisor verificand stated the stated information to be plan of care. The stated the agency comprehensive at the start of care of visit had occurre stated not being	t 4:00 PM, the nursing ed the above findings art of care date and od dates are appropriate edocumented on the enursing supervisor had used the date of the ssessment to establish date, although no billable d. The administrator aware the use of a to was not an acceptable					

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	DF CORRECTION IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00	COMPLETED 03/22/2017			
	ROVIDER OR SUPPLIER RE MEDICAL SOLUTIONS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
G 0170 Bldg. 00	frequency of visits for plan of care orders. The administrator stated there was no further documentation to present for review. 484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on observation, record review, and interview, the agency failed to ensure the registered nurse dispensed medications in the patient's medication set up container in accordance with agency policy and according to the plan of care orders for 1 of 5 patients with home visit observations (Patient #4) of a sample of 10 patients whose clinical records were reviewed.	G 0170	The ADON reviewed the Medication Set-up Policy. No revisions were require The DON and ADON will conduct in-services with a nursing staff on 4/13/17, providing written and vertinstruction regarding the policy that medication be set-up in accordance with the Plan of Care and that	ed. all pal			
	The findings included:		each medication be				

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	OF CORRECTION	IDENTIFICATION NUMBER:	r í	ULTIPLE CO JILDING	00	(X3) DATE (
		15K066	B. W	ING		03/22/	
	PROVIDER OR SUPPLIER RE MEDICAL SOLU SUMMARY S		<u> </u>	25 ART	ADDRESS, CITY, STATE, ZIP CODE IST DRIVE ILLE, IN 47448 PROVIDER'S PLAN OF CORRECTION	•	(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
	last reviewed/reviewed and star medications will standards of practal last reviewed and star medications will standards of practal last reviewed the practal last red to the should then complete to the 485 MAR [medication before administer filling the med practal last red to the star last red to the sta	ecord of patient #4, start -15-15, was reviewed on inical record evidenced a of care with a start of and certification 10-14 h orders for skilled h home visit observation urse (RN) on 3-21-17 at			compared to the Plan of Care to confirm dose, ro and frequency. RNCMs have been instructed to review medications and Plan of Care at each supervisory visit, at time re-certification and when alerted to changes in medical or treatment regimen and make appropriate revisions to Plan of Care to ensure the each patient receives nursing care in accordar with the Plan of Care. The DON, ADON and design will review the clinical record during QA to mor for compliance.	the of the nat	
	medication order	of the plan of care rs evidenced Guaifenesin et, 1 tablet, two times a					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	JILDING	00	(X3) DATE S COMPL		
		15K066	B. W.	ING		03/22/	2017
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
G 0173 Bldg. 00	supervisor indicate failed to compare with the medicate agency policy, to dosage of the Gudispensed in patrices are up container. 484.30(a) DUTIES OF THE IT The registered nurcare and necessary care and necessary care to obtain or gastrostomy tube patient's tracheot patient home obsa a gastrostomy tube (Patient #5) revisions to the proxygen in use for whom home visit	ation, record review, and gistered nurse failed to revisions to the plan of ders to change a patient's	G 0	173	The ADON reviewed the procedure for initiating an revising the POC. No revisions were made. The DON and ADON will conduct in-services on 4/13/17 with all RNs on initiating and revising the Plan of Care. RNs were instructed to include complete orders for all medications, treatments, disciplines and equipment in the Plan of Care and the the plan of care be revised.	e t nat	04/13/2017

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	DER/SUPPLIER/CLIA (X2) MULTII		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		15K066	B. W	ING		03/22/2017	
		1		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	3			IST DRIVE		
LIFE CAF	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	clinical records	were reviewed.			accordingly when any		
					changes are made to the		
	The findings included:				patient's equipment,		
	<i>S</i> - 3- 3- 3- 3- 3- 3- 3- 3- 3- 3- 3- 3- 3-				disciplines, medical or		
	 1 During a hor	me visit observation of an			treatment regimen. The		
		25 on 3-21-17 at 12 noon,			DON and ADON will revie	ew	
	_	bserved to have a			all POCs to ensure that		
	_				they contain all required		
	tracheotomy and	l a gastrostomy tube.			elements and revisions.		
					cicinents and revisions.		
		of the plan of care for the					
		iod of 1-14 to 3-14-17,					
	failed to evidence	ce a physician order for					
	the tracheotomy	tube to be changed each					
	2 months, and fo	or the gastrostomy tube to					
	be changed each	2 months.					
	B. During i	nterview with employee					
		nurse in the home, on 3-					
	'	n, the employee indicated					
		the gastrostomy tube and					
		e 2 months after the start					
	of care date of 1						
	or care date of f	1-13-10.					
	C. On 3-22	-17 at 4:00 PM, the					
		sor stated the registered					
		ve initiated updating the					
		btain physician orders to					
	. •	eotomy tube and					
	_	•					
	gastrostomy tub	e periodically as directed.					
	2. The clinical r	ecord of natient #4 start					
	2. The clinical record of patient #4, start of care date of 9-15-15, was reviewed						
		plan of care for the					
		•					
	certification per	iod 2-5 to 4-5-17, with					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIP A. BUILDIN B. WING		NSTRUCTION 00	(X3) DATE : COMPL 03/22/	ETED
	PROVIDER OR SUPPLIER		25	ARTI	DDRESS, CITY, STATE, ZIP CODE IST DRIVE ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	orders for skilled health aide servi	I nursing and home ces.					
	of a registered not 10 AM, the patie	home visit observation arse (RN) on 3-21-17 at ent was observed to be 2 liters per minute by					
	to evidence the F revisions to the p	olan of care to obtain a For oxygen, to include					
	of care date of 1 and contained a certification peri	ecord of patient #5, start 1-15-16, was reviewed plan of care for the od of 1-14 to 3-14-17, killed nursing services.					
	of an RN for pat noon, patient #5	home visit observation ient #5 on 3-21-17 at 12 was observed to have via tracheotomy collar at te.					
	to evidence the F revisions to the p physician order f setting and meth	olan of care to obtain a For oxygen, to include					
	3.						

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		A. BUILDING 00 B. WING			COMPLETED 03/22/2017			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448					
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
G 0331 Bldg. 00	assessment visit to care and support of Medicare paties for Medicare paties for the Medicare including homebo. Based on record the agency failed nurse completed visit before agent furnished for 9 colinical record was 2, 3, 5, 6, 7, 8, 9. The findings inc. 1. The clinical start of care date reviewed. The evidence a regist performed an initial determine the paneeds and suppositions.	e must conduct an initial o determine the immediate needs of the patient; and, ants, to determine eligibility nome health benefit, and status. review and interview, at to ensure the registered an initial assessment cy services were of 10 patients whose as reviewed (Patients#1, and 10). Iluded: records of patient #1, of 2-1-17, was clinical record failed to the tend of the tender to the te	G 0.	331	The ADON reviewed the policy and procedure for Initial Assessments. The policy was revised to include that an Initial Assessment will be performed by an RN with 48 hours of referral, 48 hours of return home or the physician ordered stored are date. The Initial Assessment visit must be completed before service are Provided. The DON ADON will be notified of referrals and will ensure that an Initial Assessment completed within the required time frames.	hin on art ee and all	04/13/2017	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULT A. BUILD B. WING		NSTRUCTION 00	(X3) DATE (COMPL 03/22/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	evidence a regist performed an ini	tial assessment to tient's immediate care						
	start of care date reviewed. The evidence a regist performed an ini	clinical record failed to sered nurse had tial assessment to tient's immediate care						
	start of care date reviewed. The evidence a regist performed an ini	tial assessment to tient's immediate care						
	start of care date reviewed. The evidence a regist performed an ini	clinical record failed to tered nurse had tial assessment to tient's immediate care						
	start of care date	clinical record failed to						

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ í	ULTIPLE CO JILDING	NSTRUCTION 00	COMPL	
		15K066	B. W	ING		03/22/	2017
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE MEDICAL SOLU	ITIONS INC			ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	*	tial assessment to tient's immediate care rt.					
	start of care date reviewed. The cevidence a regist performed an ini	clinical record failed to ered nurse had tial assessment to tient's immediate care					
	start of care date reviewed. The cevidence a regist performed an ini	clinical record failed to ered nurse had tial assessment to tient's immediate care					
	start of care date reviewed. The cevidence a regist performed an ini	clinical record failed to ered nurse had tial assessment to tient's immediate care					
	supervisor indicates performed and described a reference of the supervisor indicates and the supervisor	at 4:00 PM, the nursing atted the agency had not ocumented an initial ach patients after having al, and prior to ibility of the patient for					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPLETED	
		15K066	B. WI	NG		03/22/	2017
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated the age initial assessmen comprehensive a OASIS/compreh start of care. The	The administrator ency did not conduct ts and only conducted ssessments and/or ensive assessments at the e administrator indicated ther documentation to iewed.					
G 0334 Bldg. 00	ASSESSMENT The comprehensive completed in a time with the patient's in later than 5 calend care. Based on record the agency failed comprehensive aperformed no mostart of care date whose clinical resulting (Patients #1, 4, 7) The findings included the properties of the patients whose clinical resulting the properties of the patients whose clinical resulting the patients w	ssessment was ore than 5 days after the for 5 of 10 patients were reviewed (, 8, and 9).	G 03	334	The ADON reviewed the policy for "Plan of Care." The policy was revised to include that Comprehens Assessments will be completed no more than five (5) days after the SO date. The ADON will conduct an in-service with all RNs on 04/13/1917. R will be instructed to ensur that Comprehensive Assessments are completed in a timely	ive C n Ns	04/13/2017

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. W	ING		03/22/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			IST DRIVE		
LIFE CAF	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
			1		, -		Q15)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	DATE
TAG				TAG			DATE
		physician shall be			manner, consistent with the		
	*	n patient receiving home			patient's immediate need	S,	
	health service	s. The Plan of Care shall			but no later than five (5)		
	be completed in	full to include: a. All			days after the SOC date.		
	pertinent diagno	sis(es), principle and			The DON and ADON will		
	I	ding date of onset. b.			review all SOCs and		
	l	e. Type, frequency, and			Re-certifications to ensure	e	
		isits/services t. Other			that the Comprehensive		
					Assessments are		
	appropriate item	5.			completed in required		
					timeframe.		
		ecord of patient #1, start			umename.		
	of care date of 2	-1-17, (defined as the					
	first billable visi	t), was reviewed on					
	3-20-17. The cli	inical record evidenced a					
	physician's plan	of care with a start of					
		nd certification period					
	· ·	ith orders for skilled					
	nursing (SN) ser	vices.					
		of assessments evidenced					
	a start of care co	mprehensive					
	assessment/OAS	SIS was performed on 2-1					
	-17.						
	B Review	of the visit notes					
		rst billable visit was by a					
		al nurse on 2-2-17. The					
	•						
		are date should have					
		e comprehensive					
		performed 1 day prior to					
	the correct date of	of establishment of a start					
	of care.						
	3. The clinical	record of patient #4, start					
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILE		00	(X3) DATE S COMPL			
		15K066	B. WING		<u>00</u>	03/22/		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	first billable visi 3-21-17. The cli physician's plan care of 9-15-15,	-15-15, (defined as the t), was reviewed on inical record evidenced a of care with a start of and certification period 5, with orders for SN						
	a start of care co	of assessments evidenced mprehensive IS was performed on 9-						
	evidenced the fir SN on 10-20-15 date should have comprehensive a performed appro	of the visit notes est billable visit was by a The correct start of care been 10-20-15. The assessment was eximately 35 days prior to of establishment of a start						
	start of care date first billable visi 3-22-17. The cli physician's plan care of 4-20-15,	al record of patient #7, 4-20-15(defined as the t), was reviewed on nical record evidenced a of care with a start of and certification period with orders for SN and						
	a start of care co	of assessments evidenced mprehensive IS was performed on 4-						

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Event ID:

EGYK11

Facility ID: 012412

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	OF CORRECTION IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00		LETED 2/2017
	PROVIDER OR SUPPLIER RE MEDICAL SOLUTIONS INC	STREET A 25 ART NASHV			
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	B. Review of the visit notes evidenced the first billable visit was by a registered nurse on 4-30-15. The correct start of care date should have been 4-30-15. The comprehensive assessment was performed 10 days prior to the correct date of the establishment of a start of care. 5. The clinical record of patient #8, start of care date 1-11-17, (defined as the first billable visit), was reviewed on 3-22-17. The clinical record evidenced a physician's plan of care with a start of care of 1-11-17, and certification period 1-11 to 3-11-17, with orders for SN and HHA services. A. Review of assessments evidenced a start of care comprehensive assessment/OASIS was performed on 1-11-17. B. Review of the visit notes evidenced the first billable visit was by a HHA on 1-23-17. The correct start of care date should have been 1-23-17. The comprehensive assessment was performed 12 days prior to the correct date of the establishment of a start of care.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		(X2) MULTIPI A. BUILDIN B. WING		TRUCTION 00	(X3) DATE : COMPL 03/22/	ETED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448						
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
TAG	6. The clinical rof care date 3-13 billable visit), we have the clinical recording physician's plan care of 3-13-17, 3-13 to 5-11-17, services. A. Review of a start of care converse was performed of the establishment of the establishment of the comprehensive and stated the agonal the comprehensive and stated the agonal the comprehensive and stated the start of billable visit is administrator start comprehensive and start of the establishment of the establishment of the comprehensive and start of the start of the comprehensive and start of the start of the establishment	ecord of patient #9, start -17, (defined as the first as reviewed on 3-22-17. rd evidenced a of care with a start of and certification period with orders for HHA f assessments evidenced mprehensive assessment in 2-7-17. of the visit notes st billable visit was by a f. The correct start of have been 3-14-17. The ssessment was ys prior to the correct lishment of a start of t 4:00 PM, the nursing ed the above findings ency had used the date of t of care date, although had occurred. The	TAG				DATE		
		dministrator stated there ocumentation to be							

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMF	ESURVEY			
		15K066	B. WING		_	2/2017			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448						
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
N 0000 Bldg. 00	state re-licensure This was a partia Survey Dates: 3- and 3-22-2017 Facility Number: Medicaid Number Census Service T Unduplicated previous 12 mon 80 33 0 Pers	al survey on 3-17-2017. -16-17, 3-17, 3-20, 3-21, E IN 012412 er: 201013320 Type: d skilled admissions ths Skilled Home Health Aide Only conal Care Only Total	N 0000						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		l í	ILDING	00	COMPL 03/22/	ETED		
	ROVIDER OR SUPPLIER	TIONS INC	STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	visit	ord Review with home ord review without home						
N 0449 Bldg. 00	may also be the siregistered nurse reshall do the following (6) Ensure that the meets all rules and Based on record the administrator agency policy retesting to evaluate 2 of 6 direct care personnel file way A and B); based review and interval failed to ensure the conference notes of coordination of the shall be the same and the	cy nagement 6) The administrator, who upervising physician or equired by subsection (d),	N 04	149	[if gte mso 9] <xml> <o:officedocumentsettings> <o:allowpng></o:allowpng> </o:officedocumentsettings> </xml> [endif] [if gte ms 9] <xml> <w:worddocument> <w:view>Normal</w:view> <w:zoom>0</w:zoom> <w:trackmoves></w:trackmoves> <w:trackformatting></w:trackformatting> <w:validateagainstschemas. <w:savelfxmlinvalid="">false</w:validateagainstschemas.></w:worddocument></xml>	50	04/13/2017	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPLETED	
		15K066	B. W	ing		03/22/2017	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
1.155.041	DE MEDIOAL COLL	ITIONIC INC			IST DRIVE		
	RE MEDICAL SOLU	TIONS INC		NASHV	ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE	ON
1710		o received care from		1710		DATE	
		gency, of a total sample			<w:ignoremixedcontent>false</w:ignoremixedcontent>	<td></td>	
	l '	cords reviewed (Patient			:IgnoreMixedContent>		
		10); based on record			<u :="" chowdlacoholdor="" td="" to<="" λίνονο=""><td>.v4></td><td></td></u>	.v4>	
		view, the administrator			<w:alwaysshowplaceholdertefalse< p=""></w:alwaysshowplaceholdertefalse<>		
		ent its policy related to			Text>		
		nly when orders from the			<w:donotpromoteqf></w:donotpromoteqf>		
		ian had been obtained for			<w:lidthemeother>EN-US<td>ct i</td><td></td></w:lidthemeother>	ct i	
		whose clinical record			dThemeOther>	/.LI	
	_	atients #1-10); based on					
	` `	ord review and interview,			<w:lidthemeasian>X-NONE<</w:lidthemeasian>	/w:	
	· · · · · · · · · · · · · · · · · · ·	r failed to ensure the plan			LidThemeAsian> X-NON		
		d orders for oxygen			<w:compatibility></w:compatibility>		
		2 patients with home			<w:breakwrappedtables></w:breakwrappedtables>		
		s (Patients #4 and 5), of			<w:snaptogridincell></w:snaptogridincell>		
		e visit observations;			<w:wraptextwithpunct></w:wraptextwithpunct> <w:useasianbreakrules></w:useasianbreakrules>		
		ation, record review, and			<pre><w:oseasianbreakrules></w:oseasianbreakrules> <w:dontgrowautofit></w:dontgrowautofit></pre>		
		gency failed to ensure the					
		dispensed medications in			<w:splitpgbreakandparamark< td=""><td></td><td></td></w:splitpgbreakandparamark<>		
	_	lication set up container			<pre><w:enableopentypekerning <w:dontflipmirrorindents=""></w:enableopentypekerning></pre>	/>	
	_	ith agency policy and			<w:overridetablestylehps></w:overridetablestylehps>		
		plan of care orders for 1					
	_	h home visit observations			<m:mathpr></m:mathpr>		
	•	sample of 10 patients			<m:mathfont m:val="Cambr
Math"></m:mathfont>	a	
	` ′	ecords were reviewed;			<m:brkbin m:val="before"></m:brkbin>		
		ation, record review, and			<m:brkbinsub m:val="-</td><td>."></m:brkbinsub>		
		ministrator failed to			<m:smallfrac m:val="off"></m:smallfrac>		
		ered nurse failed to			<m:dispdef></m:dispdef> <m:lmargin m:val="0"></m:lmargin>		
	1	y revisions to the plan of			<m:rmargin m:val="0"></m:rmargin>		
		ders to change a patient's			<m:defjc< td=""><td></td><td></td></m:defjc<>		
		e and to change a			m:val="centerGroup"/>	1/5	
	•	tomy tube for 1 of 1			<pre><m:wrapindent <m:intlim="" m:val="subSup"></m:wrapindent></pre>	1>	
		servations of patient with			<m:narylim <="" m:val="undOvr" td=""><td>></td><td></td></m:narylim>	>	
		be and a tracheotomy			•		
		<u>-</u>					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. W	B. WING		03/22/	/2017
NAME OF A	DOLUBER OR GURRU IEE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF			25 ART	IST DRIVE		
LIFE CA	RE MEDICAL SOLU	JTIONS INC		NASHV	ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	<td>ont</td> <td>DATE</td>	ont	DATE
		o, of a total of 10 patients			> ////.///atili 12 <td>5111</td> <td></td>	5111	
		ecords were reviewed;			[endif] [if gte ms</td <td>0</td> <td></td>	0	
		review and interview, the			9]> <xml></xml>		
		ensure staff did not			<w:latentstyles< td=""><td></td><td></td></w:latentstyles<>		
		ocumentation from a			DefLockedState="false"		
		e of care in the active			DefUnhideWhenUsed="false" DefSemiHidden="false"		
		or 1 of 1 patients who had			DefQFormat="false"		
	been discharged	and then readmitted			DefPriority="99"		
	(Patients #3) in a	a total sample of 10			LatentStyleCount="374">		
	patients.				<pre><w:lsdexception 0"="" <="" locked="fa Priority=" pre="" qformat="true"></w:lsdexception></pre>	lse"	
					Name="Normal"/>		
	The findings inc	luded:			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
					Priority="9" QFormat="true"		
	1. Policy, "Hea	lth Screening,", last			Name="heading 1"/>		
		d 1-11-17, was reviewed			<w:lsdexception 9"="" locked="fa</p></td><td></td><td></td></tr><tr><td></td><td></td><td>h employee having direct</td><td></td><td></td><td>Priority=" semihidden="true
UnhideWhenUsed=" td="" true"<=""><td></td><td></td></w:lsdexception>		
	contact with pati	1 1			QFormat="true" Name="headi	ng	
	_	of baseline health			2"/>	Ü	
		o providing care to			<w:lsdexception 9"="" <="" locked="fa</p></td><td></td><td></td></tr><tr><td></td><td></td><td>ny employee or contract</td><td></td><td></td><td>Priority=" semihidden="true</td><td>" td=""><td></td></w:lsdexception>		
	-	ling direct patient care,			UnhideWhenUsed="true" QFormat="true" Name="headi	na	
	there shall be do	-			3"/>	''g	
					<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	_	tuberculin (TB) skin test,			Priority="9" SemiHidden="true	"	
		method using two-step			UnhideWhenUsed="true"	na	
	_	toux skin test will be			QFormat="true" Name="headi 4"/>	iig	
		e of hire and repeated			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
		eks of the first test TB			Priority="9" SemiHidden="true		
	skin tests shall b				UnhideWhenUsed="true"		
	Registered Nurs				QFormat="true" Name="headi 5"/>	ng	
		onal Nurse, within			<pre>5"/> <w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
		venty-two (48-72) hours			Priority="9" SemiHidden="true		
		as "non-significant"			UnhideWhenUsed="true"		
		gnificant" (positive) in			QFormat="true" Name="headi	ng	
	millimeters of in	duration."			6"/>		

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 41 of 129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	ETED
		15K066	B. W	ING		03/22/	2017
NAME OF I	DROVIDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		25 ART	IST DRIVE		
LIFE CAI	RE MEDICAL SOLU	JTIONS INC		NASHV	'ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	2 "0 :11: (<w:lsdexception 9"="" locked="fa
Priority=" semihidden="true</td><td></td><td></td></tr><tr><td></td><td></td><td>or Preventing the</td><td></td><td></td><td>UnhideWhenUsed=" td="" true"<=""><td></td><td></td></w:lsdexception>		
	Transmission of Mycobacterium				QFormat="true" Name="headi	ng	
	tuberculosis in F	Iealth -Care Settings",			7"/>		
	Volume 54, Pag	e 46, Recommendations			<pre><w:lsdexception 9"="" locked="fa</pre></td><td></td><td></td></tr><tr><td></td><td>and Reports-17,</td><td>2005, was reviewed and</td><td></td><td></td><td>Priority=" semihidden="true
UnhideWhenUsed=" td="" true"<=""><td></td><td></td></w:lsdexception></pre>		
	stated "The tube	erculin skin test should be			QFormat="true" Name="headi	na	
	read by a design	ated, trained health care			8"/>	· · J	
	worker 48-72 ho	ours after the tuberculin			<w:lsdexception 9"="" <="" locked="fa</td><td></td><td></td></tr><tr><td></td><td>skin test is place</td><td>d. If the tuberculin skin</td><td></td><td></td><td>Priority=" semihidden="true</td><td>" td=""><td></td></w:lsdexception>		
	test was not read	l between 48-72 hours,			UnhideWhenUsed="true"	n.a	
		tuberculin skin test			QFormat="true" Name="headi 9"/>	ng	
	_	l as soon as possible and			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	read within 48-7	•			SemiHidden="true"		
	read within 40 /	2 Hours.			UnhideWhenUsed="true"		
	2 The personne	el file of employee A, was			Name="index 1"/>		
	_	idenced employee A was			<pre><w:lsdexception locked="fa SemiHidden=" pre="" true"<=""></w:lsdexception></pre>	ise"	
		• •			UnhideWhenUsed="true"		
	_	ered nurse on 1-18-17,			Name="index 2"/>		
		patient contact of			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		onfidential health file of			SemiHidden="true"		
		tained a TB skin test			UnhideWhenUsed="true"		
	-	denced a TB skin test			Name="index 3"/> <w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		d on 1-3-17, at 10 AM,			SemiHidden="true"	. 	
		1-5-17, the time of			UnhideWhenUsed="true"		
	reading failed to	be documented, with a			Name="index 4"/>		
	result of 0 milling	neters, negative. The			<pre><w:lsdexception locked="fa SomiHiddon=" pre="" true"<=""></w:lsdexception></pre>	ise"	
	form evidenced	a second step TB skin			SemiHidden="true" UnhideWhenUsed="true"		
	test was adminis	tered on 1-11-17, the			Name="index 5"/>		
	time of administ	ration failed to be			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	documented, and	d was read on 1-13-17,			SemiHidden="true"		
	the time of readi	· ·			UnhideWhenUsed="true"		
		ult of 0 millimeters.			Name="index 6"/> <w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
					SemiHidden="true"	100	
	4. The personne	el file of employee B, was			UnhideWhenUsed="true"		
	I		1		l e e e e e e e e e e e e e e e e e e e		i

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED			
		15K066	B. WI	NG		03/22/	2017			
				STREET A	ADDRESS, CITY, STATE, ZIP CODE					
NAME OF I	PROVIDER OR SUPPLIEF	8			IST DRIVE					
LIFE CAI	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)			
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE	COMPLETION			
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE			
		idenced employee B was			Name="index 7"/> <w:lsdexception <="" locked="fa</td><td>lea" td=""><td></td></w:lsdexception>					
		ed practical nurse on			SemiHidden="true"	130				
		late of first patient			UnhideWhenUsed="true"					
	contact of 10-24	-16. The confidential			Name="index 8"/>					
	health file of em	ployee B contained a TB			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>					
	skin test report v	vhich evidenced a TB			SemiHidden="true"					
	skin test was adr	ninistered on 2-1-17, and			UnhideWhenUsed="true" Name="index 9"/>					
	was read on 2-3-	-17, the time of reading			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>					
		imented, with a result of			Priority="39" SemiHidden="tru					
		The form failed to			UnhideWhenUsed="true"					
		e of administration on			Name="toc 1"/>					
		ed to evidence the time of			<pre><w:lsdexception 20"="" <="" comit="" liddon="true" locked="fa Priority=" pre=""></w:lsdexception></pre>					
		7. The health file failed			Priority="39" SemiHidden="tru UnhideWhenUsed="true"	е				
	_				Name="toc 2"/>					
		cond step TB skin test			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>					
		stered and read three			Priority="39" SemiHidden="tru	e"				
		first step TB skin test, as			UnhideWhenUsed="true"					
		ncy policy. The TB skin			Name="toc 3"/>	la a "				
	test result of 2-3	-17 was obtained over 3			<w:lsdexception 39"="" locked="fa
Priority=" semihidden="tru</td><td></td><td></td></tr><tr><td></td><td>months after the</td><td>date of employee B's</td><td></td><td></td><td>UnhideWhenUsed=" td="" true"<=""><td>C</td><td></td></w:lsdexception>	C				
	first patient cont	act.			Name="toc 4"/>					
					<w:lsdexception 39"="" <="" locked="fa</td><td></td><td></td></tr><tr><td></td><td>5. On 3-22-17 a</td><td>t 4:00 PM, the</td><td></td><td></td><td>Priority=" semihidden="tru</td><td>e" td=""><td></td></w:lsdexception>					
		ated the above cited TB			UnhideWhenUsed="true"					
	skin test reports	were not documented in			Name="toc 5"/> <w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>					
	_	agency policy. The			Priority="39" SemiHidden="tru					
		ated there was no further			UnhideWhenUsed="true"					
	documentation to				Name="toc 6"/>					
		0.1011011.			<pre><w:lsdexception coordination="" locked="fa</pre></td><td></td><td></td></tr><tr><td></td><td>6 A policy title</td><td>d " of<="" td=""><td></td><td></td><td>Priority="39" SemiHidden="tru UnhideWhenUsed="true"</td><td>e"</td><td></td></w:lsdexception></pre>			Priority="39" SemiHidden="tru UnhideWhenUsed="true"	e"	
		d "Coordination of			Name="toc 7"/>					
	1	" last reviewed/revised			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>					
	· ·	"All personnel furnishing			Priority="39" SemiHidden="tru					
		aintain liaison to assure			UnhideWhenUsed="true"					
	that their efforts				Name="toc 8"/>					
	effectively and s	support the objectives			<w:lsdexception <="" locked="fa</td><td>ise" td=""><td></td></w:lsdexception>					

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 43 of 129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. Wl	ING		03/22/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	IST DRIVE		
LIFE CA	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORREC			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	outlined in the P	lan of Care. This may be			Priority="39" SemiHidden="tru	e"	
	done through for	rmal case conferences,			UnhideWhenUsed="true"		
		nplete, current Care			Name="toc 9"/>	1"	
	Plans, and writte	-			<w:lsdexception locked="fa
SemiHidden=" td="" true"<=""><td>ise"</td><td></td></w:lsdexception>	ise"	
	interaction."	on and versus			UnhideWhenUsed="true"		
	interaction.				Name="Normal Indent"/>		
	7 79	and affinations #1			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		record of patient #1, start			SemiHidden="true"		
		-1-17, was reviewed and			UnhideWhenUsed="true"		
		cian's written plan of			Name="footnote text"/>	loo"	
	care for the certi	fication period of 2-1 to			<w:lsdexception locked="fa
SemiHidden=" td="" true"<=""><td>ise"</td><td></td></w:lsdexception>	ise"	
	4-1-17.				UnhideWhenUsed="true"		
					Name="annotation text"/>		
	A. During l	nome visit observation of			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		cal nurse (LPN) on 3-20-			SemiHidden="true"		
	_	a registered nurse from			UnhideWhenUsed="true"		
	1	care agency, person H, a			Name="header"/>		
		, was observed in the			<w:lsdexception locked="fa
SemiHidden=" td="" true"<=""><td>ise"</td><td></td></w:lsdexception>	ise"	
	-				UnhideWhenUsed="true"		
		indicated making skilled			Name="footer"/>		
	_	r wound care, foley care,			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	_	t of anticoagulation			SemiHidden="true"		
	PT/INR (Prothro	ombin Time and			UnhideWhenUsed="true"		
	International No	rmalized Ratio) lab tests			Name="index heading"/>	loo"	
	[blood tests to m	neasure blood thinning].			<w:lsdexception 35"="" locked="fa
Priority=" semihidden="tru</td><td></td><td></td></tr><tr><td></td><td>Person A indicar</td><td>ted having made early</td><td></td><td></td><td>UnhideWhenUsed=" td="" true"<=""><td>~ </td><td></td></w:lsdexception>	~	
		nd occasionally having			QFormat="true"		
		ncy LPN, employee B, as			Name="caption"/>		
		eparting and employee B			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	was arriving.	parang and employee D			SemiHidden="true"		
	was alliving.				UnhideWhenUsed="true"		
	D D .	- Called a lam a Constant of the			Name="table of figures"/> <w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		of the plan of care, visit			SemiHidden="true"		
	· ·	nunication notes, failed to			UnhideWhenUsed="true"		
		entation of the results of			Name="envelope address"/>		
	coordination of	care activities between			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	the two agencies	s to include			SemiHidden="true"		

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 44 of 129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		(X2) MULT A. BUILD B. WING		NSTRUCTION 00	(X3) DATE : COMPL 03/22/	ETED	
NAME (DF PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE ST DRIVE		
LIFE (CARE MEDICAL SOLU	JTIONS INC			LLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRI	D EFIX 'AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	when person A a communicated. C. On 3-22 nursing supervisive record document documentation of care activities stated morning redocument specific activities for patronference had a second for the certification of the two agencies. B. On 3-22 nursing supervisive record document coordination of the coordin	at 4:00 PM, the cor stated the clinical tation failed to evidence of results of coordination at The administrator meeting notes did not fic coordination of care ient #1 and a 60 day case not yet been held. The administrator meeting notes did not fic coordination of care ient #1 and a 60 day case not yet been held. The administrator meeting notes did not fic coordination of care ient #4, start -15-15, was reviewed thysician's written plan of fication period of 2-5 to find the plan of care int #4 received attendant in an outside agency, visit notes, and inotes, failed to evidence of the results of care activities between			UnhideWhenUsed="true" Name="envelope return"/> <w:lsdexception <w:lsdexception="" locked="fasemiHidden=" name="annotation reference complete com</td><td>> lse" s="" td="" true"="" unhidewhenused="true" se"="" se"<=""><td></td></w:lsdexception>		

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 45 of 129

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. WI	ING		03/22/	2017
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			IST DRIVE		
LIFE CA	RE MEDICAL SOLU	JTIONS INC		NASHV	/ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		onference notes did not			<w:lsdexception locked="fa
SemiHidden=" td="" true"<=""><td>aise"</td><td></td></w:lsdexception>	aise"	
	document specif	ic coordination of care			UnhideWhenUsed="true"		
	activities for pat	ient #4.			Name="List Bullet"/>		
	9. The clinical record of patient #6, start of care date of 3-6-17, was reviewed and				<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	alse"	
					SemiHidden="true"		
					UnhideWhenUsed="true"		
		cian's written plan of			Name="List Number"/>		
		_			<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	alse"	
		fication period of 3-6 to			SemiHidden="true" UnhideWhenUsed="true"		
	5-4-17. A. Review of the plan of care				Name="List 2"/>		
					<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	alse"	
					SemiHidden="true"		
	evidenced patier	nt #6 received attendant			UnhideWhenUsed="true"		
	care services fro	m an outside agency.			Name="List 3"/>		
	The clinical reco	ord, communication			<w:lsdexception <="" locked="fa</td><td>alse" td=""><td></td></w:lsdexception>		
		conference notes, failed			SemiHidden="true"		
	· ·	umentation of the results			UnhideWhenUsed="true" Name="List 4"/>		
		of care activities between			<pre><w:lsdexception <="" locked="fa" pre=""></w:lsdexception></pre>	alse"	
					SemiHidden="true"	2.00	
	the two agencies	5.			UnhideWhenUsed="true"		
		45			Name="List 5"/>		
		17 at 4:00 PM, the			<w:lsdexception <="" locked="fa</p></td><td>alse" td=""><td></td></w:lsdexception>		
		or stated the clinical			SemiHidden="true"		
	record documen	tation failed to evidence			UnhideWhenUsed="true"		
	coordination of	care activities. The			Name="List Bullet 2"/> <w:lsdexception <="" locked="fa</td><td>alse" td=""><td></td></w:lsdexception>		
	administrator sta	ated morning meeting			SemiHidden="true"	1130	
		onference notes did not			UnhideWhenUsed="true"		
		ic coordination of care			Name="List Bullet 3"/>		
	activities for pat				<w:lsdexception <="" locked="fa</p></td><td>alse" td=""><td></td></w:lsdexception>		
	activities for par	iont mo.			SemiHidden="true"		
	10 The 15	1			UnhideWhenUsed="true"		
		l record of patient #7,			Name="List Bullet 4"/> <w:lsdexception <="" locked="fa</td><td>alse" td=""><td></td></w:lsdexception>		
		e of 4-20-15, was			SemiHidden="true"	ai3 C	
		2-17,and included a			UnhideWhenUsed="true"		
	physician's writt	en plan of care for the			Name="List Bullet 5"/>		
	certification peri	iod of 2-8 to 4-8-17.			<w:lsdexception <="" locked="fa</p></td><td>alse" td=""><td></td></w:lsdexception>		
					SemiHidden="true"		

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 46 of 129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. W	ING		03/22/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		25 ART	IST DRIVE		
LIFE CAI	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A. Review	of the plan of care			UnhideWhenUsed="true"		
	evidenced patien	nt #7 received services			Name="List Number 2"/>		
	from an outside	agency. The clinical			<pre><w:lsdexception locked="fa Comittieden=" pre="" true"<=""></w:lsdexception></pre>	ise"	
		cation notes, visit notes,			SemiHidden="true" UnhideWhenUsed="true"		
		ence notes, failed to			Name="List Number 3"/>		
		entation of the results of			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
					SemiHidden="true"		
		care activities between			UnhideWhenUsed="true"		
	the two agencies	5.			Name="List Number 4"/>		
					<pre><w:lsdexception fault";<="" locked="fa Compillide on = " pre=""></w:lsdexception></pre>	lse"	
	B. On 3-22-	17 at 4:00 PM, the			SemiHidden="true" UnhideWhenUsed="true"		
	nursing supervis	or stated the clinical			Name="List Number 5"/>		
	record document	tation failed to evidence			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	coordination of	care activities. The			Priority="10" QFormat="true"		
	administrator sta	ated morning meeting			Name="Title"/>		
		onference notes did not			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>		
		ic coordination of care			SemiHidden="true"		
	_				UnhideWhenUsed="true" Name="Closing"/>		
	activities for pat	ient #/.			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	l				SemiHidden="true"	100	
		record of patient #10,			UnhideWhenUsed="true"		
	start of care date	e of 10-2-13, was			Name="Signature"/>		
	reviewed and inc	cluded a physician's			<w:lsdexception 1"="" <="" locked="fa</p></td><td></td><td></td></tr><tr><td></td><td>written plan of c</td><td>are for the certification</td><td></td><td></td><td>Priority=" semihidden="true</td><td>" td=""><td></td></w:lsdexception>		
	period of 12-10-	16 to 2-7-17.			UnhideWhenUsed="true"		
					Name="Default Paragraph Font"/>		
	A. Review	of the plan of care			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
		nt #10 received attendant			SemiHidden="true"		
	_	m an outside agency.			UnhideWhenUsed="true"		
					Name="Body Text"/>		
		ord communication notes,			<pre><w:lsdexception fault";<="" locked="fa Compillide on = " pre=""></w:lsdexception></pre>	lse"	
	·	case conference notes,			SemiHidden="true" UnhideWhenUsed="true"		
		e documentation of the			Name="Body Text Indent"/>		
		nation of care activities			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>		
	between the two	agencies.			SemiHidden="true"		
					UnhideWhenUsed="true"		
	B. On 3-22-	17 at 4:00 PM, the			Name="List Continue"/>		
	i		1		İ		ı

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. W	ING		03/22/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			IST DRIVE		
LIFE CA	RE MEDICAL SOLU	ITIONS INC			ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)	_	TAG			DATE
		or stated the clinical			<w:lsdexception locked="fa
SemiHidden=" td="" true"<=""><td>ise"</td><td></td></w:lsdexception>	ise"	
	record documen	tation failed to evidence			UnhideWhenUsed="true"		
	coordination of	care activities. The			Name="List Continue 2"/>		
	administrator sta	ated morning meeting			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
		onference notes did not			SemiHidden="true"		
		ic coordination of care			UnhideWhenUsed="true"		
	_				Name="List Continue 3"/>		
	activities for pat	lent #10.			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		2.5			SemiHidden="true"		
	12. Policy, "Plar	·			UnhideWhenUsed="true"		
	reviewed/revised	d 1-11-17, was reviewed			Name="List Continue 4"/> <w:lsdexception <="" locked="fa</td><td>leo" td=""><td></td></w:lsdexception>		
	and stated, "Hon	ne care services are			SemiHidden="true"	150	
	furnished under	the supervision and			UnhideWhenUsed="true"		
		patient's physician."			Name="List Continue 5"/>		
		F January			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	12 Policy Phy	rsician Orders," last			SemiHidden="true"		
		•			UnhideWhenUsed="true"		
		d 1-11-17, was reviewed			Name="Message Header"/>		
	•	medications, treatments,			<pre><w:lsdexception 11"="" <="" locked="fa Priority=" pre="" qformat="true"></w:lsdexception></pre>	ise"	
	•	vided to patients must be			Name="Subtitle"/>		
	ordered by a phy	vsician. The orders may			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	be initiated via t	elephone or in writing			SemiHidden="true"		
	and must be cou	ntersigned by the			UnhideWhenUsed="true"		
	physician in a tir	melv manner."			Name="Salutation"/>		
		3			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	14 The clinical	l record of patient #1 was			SemiHidden="true"		
		of care date of 2-1-17, and			UnhideWhenUsed="true" Name="Date"/>		
	· ·				<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	-	of care with orders for			SemiHidden="true"	100	
	respite skilled nu	arsing services.			UnhideWhenUsed="true"		
					Name="Body Text First		
	A. Review	of the start of care			Indent"/>		
	comprehensive a	assessment/OASIS dated			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	•	ed care was coordinated			SemiHidden="true"		
	•	ng physician. On 3-20-17			UnhideWhenUsed="true"	nt	
		nursing supervisor stated			Name="Body Text First Inde 2"/>	TIL	
					<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	ine comprehensi	ve assessment was not			-W.EddException Locked- ia		

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 48 of 129

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00		COMPLI	ETED
		15K066	B. W	ING		03/22/2	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹		25 ART	IST DRIVE		
LIFE CA	RE MEDICAL SOLU	JTIONS INC	NASHVILLE, IN 47448				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sent to the attend	ding physician and did			SemiHidden="true"		
	not evidence phy	ysician orders for the care			UnhideWhenUsed="true"		
	of patient #1.				Name="Note Heading"/>	"	
					<pre><w:lsdexception locked="fa SemiHidden=" pre="" true"<=""></w:lsdexception></pre>	ise	
	B Pavian	of physician's orders			UnhideWhenUsed="true"		
					Name="Body Text 2"/>		
		ce a physician's verbal			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		disciplines, frequency of			SemiHidden="true"		
	•	fic physician orders for			UnhideWhenUsed="true"		
	the care of paties	nt #1.			Name="Body Text 3"/>		
					<pre><w:lsdexception locked="fa Comit lidden=" pre="" true"<=""></w:lsdexception></pre>	ise"	
	C. Review	of visit notes evidenced			SemiHidden="true" UnhideWhenUsed="true"		
	skilled nursing of	eare was furnished on 2-2			Name="Body Text Indent 2"	/>	
	and 2-7-17.				<w:lsdexception locked="fa</p></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td>SemiHidden=" td="" true"<=""><td></td><td></td></w:lsdexception>		
	D. Pavious	of the decument history			UnhideWhenUsed="true"		
		of the document history			Name="Body Text Indent 3"		
		medical record system			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	_	an of care was created on			SemiHidden="true" UnhideWhenUsed="true"		
	•	and faxed to the			Name="Block Text"/>		
	attending physic	ian on 2-9-17, and signed			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>		
	by the attending	physician on 2-9-17.			SemiHidden="true"		
					UnhideWhenUsed="true"		
	15. The clinical	record of patient #2,			Name="Hyperlink"/>		
		e of 1-24-13, was			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>		
		ntained a plan of care for			SemiHidden="true" UnhideWhenUsed="true"		
		period 3-4 to 5-2-17,			Name="FollowedHyperlink"/	,	
		killed nursing and home			<w:lsdexception 22"="" <="" locked="fa</p></td><td></td><td></td></tr><tr><td></td><td></td><td>•</td><td></td><td></td><td>Priority=" qformat="true" td=""><td></td><td></td></w:lsdexception>		
	health aide servi	ces.			Name="Strong"/>		
					<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		of the recertification			Priority="20" QFormat="true"		
	comprehensive a	assessment/OASIS dated			Name="Emphasis"/>		
	3-1-17, evidence	ed care was coordinated			<pre><w:lsdexception locked="fa SemiHidden=" pre="" true"<=""></w:lsdexception></pre>	ise	
	with the attendir	ng physician. On 3-20-17			UnhideWhenUsed="true"		
		nursing supervisor stated			Name="Document Map"/>		
		ive assessment was not			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>		
	l are comprehensi	ive assessment was not					

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 49 of 129

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPL	ETED
		15K066	B. W	ING		03/22/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			IST DRIVE		
LIFE CA	RE MEDICAL SOLU	ITIONS INC			ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	SemiHidden="true"		DATE
		ding physician and did			UnhideWhenUsed="true"		
		ysician orders for the care			Name="Plain Text"/>		
	of patient #2.				<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>		
					SemiHidden="true"		
	B. Review	of physician's orders			UnhideWhenUsed="true"		
		ce physician verbal orders			Name="E-mail Signature"/>		
		lines, frequency of visits,			<pre><w:lsdexception <="" locked="fa Compilities of the compile of the</td><td>lse" td=""><td></td></w:lsdexception></pre>		
	-	e orders based on the			SemiHidden="true" UnhideWhenUsed="true"		
	_	ssessment of patient #2,			Name="HTML Top of Form"	/>	
		_			<w:lsdexception locked="fa</p></td><td></td><td></td></tr><tr><td></td><td>after expiration</td><td></td><td></td><td></td><td>SemiHidden=" td="" true"<=""><td></td><td></td></w:lsdexception>		
	certification peri	iod orders on 3-3-17.			UnhideWhenUsed="true"		
					Name="HTML Bottom of		
		of visit notes evidenced			Form"/>		
	skilled nursing f	furnished care on 3-6-17.			<pre><w:lsdexception locked="fa Comit lidden=" pre="" true"<=""></w:lsdexception></pre>	lse"	
					SemiHidden="true" UnhideWhenUsed="true"		
	D. Review	of the plan of care			Name="Normal (Web)"/>		
		an of care orders were			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	_	ending physician on 3-7-			SemiHidden="true"		
	17.	chang physician on 5 7			UnhideWhenUsed="true"		
	17.				Name="HTML Acronym"/>		
	16 771 11 1	1 6 4 40			<pre><w:lsdexception fm.o"<="" locked="fa Com:!!iddon=" pre=""></w:lsdexception></pre>	lse"	
		record of patient #3,			SemiHidden="true" UnhideWhenUsed="true"		
		e of 3-13-17, was			Name="HTML Address"/>		
		ntained a plan of care			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	with orders for s	killed nursing and home			SemiHidden="true"		
	health aide servi	ces.			UnhideWhenUsed="true"		
					Name="HTML Cite"/>		
	A. Review	of the start of care			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		assessment/OASIS dated			SemiHidden="true"		
	•	ced evidenced care was			UnhideWhenUsed="true" Name="HTML Code"/>		
	1				<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
		the attending physician.			SemiHidden="true"		
		30 PM, the nursing			UnhideWhenUsed="true"		
	_	d the comprehensive			Name="HTML Definition"/>		
		not sent to the attending			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	physician and di	d not evidence physician			SemiHidden="true"		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPL	ETED
		15K066	B. W	ING		03/22/	2017
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t		1	IST DRIVE		
LIEE CAI	RE MEDICAL SOLU	ITIONS INC			/ILLE, IN 47448		
					TEEE, IN 47440		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	orders for the ca	re of patient #3.			UnhideWhenUsed="true"		
					Name="HTML Keyboard"/>	laa"	
	B. Review	of physician's orders			<pre><w:lsdexception locked="fa SemiHidden=" pre="" true"<=""></w:lsdexception></pre>	ise	
		e physician verbal orders			UnhideWhenUsed="true"		
		lines, frequency of visits,			Name="HTML Preformatted"	"/>	
	_				<w:lsdexception locked="fa</p></td><td></td><td></td></tr><tr><td></td><td>_</td><td>e orders based on the</td><td></td><td></td><td>SemiHidden=" td="" true"<=""><td></td><td></td></w:lsdexception>		
	assessment of pa	itient #3.			UnhideWhenUsed="true"		
					Name="HTML Sample"/>		
	C. Review	of visit notes evidenced			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>		
	skilled nursing f	furnished care on 3-13-17,			SemiHidden="true"		
	and a home heal	th aide visit was			UnhideWhenUsed="true"		
	furnished on 3-1				Name="HTML Typewriter"/> <w:lsdexception locked="fa</td><td></td><td></td></tr><tr><td></td><td>Turinsned on 3 1</td><td>3 17.</td><td></td><td></td><td>SemiHidden=" td="" true"<=""><td>ise</td><td></td></w:lsdexception>	ise	
	D D .	C.1 1 C			UnhideWhenUsed="true"		
		of the plan of care			Name="HTML Variable"/>		
		y in the agency electronic			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	medical record s	ystem evidenced the plan			SemiHidden="true"		
	of care was crea	ted on 3-17-17, and was			UnhideWhenUsed="true"		
	finalized and fax	ted to the attending			Name="Normal Table"/>		
	physician on 3-2	0-17. At time of exit of			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	1 ^ -	17, the plan of care had			SemiHidden="true"		
	1	ned by the attending			UnhideWhenUsed="true" Name="annotation subject"/:		
	1	led by the attending			<w:lsdexception locked="fa</p></td><td></td><td></td></tr><tr><td></td><td>physician.</td><td></td><td></td><td></td><td>SemiHidden=" td="" true"<=""><td></td><td></td></w:lsdexception>		
					UnhideWhenUsed="true"		
	17. The clinical	record of patient #4,			Name="No List"/>		
	start of care date	of 9-15-15, was			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>		
	reviewed and co	ntained a plan of care for			SemiHidden="true"		
	the certification	period 2-5 to 4-5-17,			UnhideWhenUsed="true"		
	· ·	killed nursing and home			Name="Outline List 1"/> <w:lsdexception <="" locked="fa</td><td>lco" td=""><td></td></w:lsdexception>		
	health aide servi	_			SemiHidden="true"	io c	
	incarin and servi	CC 5.			UnhideWhenUsed="true"		
		6.4			Name="Outline List 2"/>		
		of the recertification			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		assessment/OASIS dated			SemiHidden="true"		
	2-2-17, evidence	ed care was coordinated			UnhideWhenUsed="true"		
	with the attendir	ng physician. On 3-20-17			Name="Outline List 3"/>		
	I		1		I		i

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPI	
		15K066	B. W	ING		03/22	/2017
NAME OF I	DROVIDED OD GUDDI IEI		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	PROVIDER OR SUPPLIEF			25 ART	IST DRIVE		
LIFE CA	RE MEDICAL SOLU	JTIONS INC		NASHV	/ILLE, IN 47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	at 3:30 PM, the	nursing supervisor stated			<w:lsdexception <="" locked="fa</td><td>alse" td=""><td></td></w:lsdexception>		
	the follow-up co	emprehensive assessment			SemiHidden="true"		
	was not sent to t	he attending physician.			UnhideWhenUsed="true"		
					Name="Table Simple 1"/> <w:lsdexception <="" locked="fate: </td><td>alco" td=""><td></td></w:lsdexception>		
	D Paviany	of physician's orders			SemiHidden="true"	aise	
					UnhideWhenUsed="true"		
		ce physician verbal orders			Name="Table Simple 2"/>		
	•	lines, frequency of visits,			<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	alse"	
	_	e orders based on the			SemiHidden="true"		
	recertification as	ssessment of patient #4			UnhideWhenUsed="true"		
	after expiration	of the previous			Name="Table Simple 3"/>	oloo"	
	certification peri	iod orders on 2-4-17.			<w:lsdexception locked="fallowed: SemiHidden=" p="" true"<=""></w:lsdexception>	aise	
					UnhideWhenUsed="true"		
	C Review	of visit notes evidenced a			Name="Table Classic 1"/>		
		e furnished care on 2-6-			<w:lsdexception <="" locked="fa</td><td>alse" td=""><td></td></w:lsdexception>		
	17.	c furnished care on 2-0-			SemiHidden="true"		
	1/.				UnhideWhenUsed="true"		
					Name="Table Classic 2"/>		
		of the plan of care			<w:lsdexception <="" fallow="fal</td><td>alse" locked="fallow=" td=""><td></td></w:lsdexception>		
	document histor	y in the agency electronic			SemiHidden="true" UnhideWhenUsed="true"		
	medical record s	system evidenced the plan			Name="Table Classic 3"/>		
	of care was crea	ted on 2-6-17, was			<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	alse"	
	finalized and fax	xed to the attending			SemiHidden="true"		
		8-17, and was signed by			UnhideWhenUsed="true"		
		ysician on 2-9-17.			Name="Table Classic 4"/>		
	the attending pin	ysician on 2 > 17.			<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	alse"	
	10 The eliminal	record of nations #5			SemiHidden="true" UnhideWhenUsed="true"		
		record of patient #5,			Name="Table Colorful 1"/>		
		e of 11-15-16, was			<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	alse"	
		ntained a plan of care for			SemiHidden="true"	= =	
		period of 1-14 to			UnhideWhenUsed="true"		
	3-14-17, with or	ders for skilled nursing			Name="Table Colorful 2"/>		
	services.				<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	alse"	
					SemiHidden="true"		
	A. Review	of the recertification			UnhideWhenUsed="true" Name="Table Colorful 3"/>		
		assessment/OASIS, dated			<pre><w:lsdexception <="" locked="fa" pre=""></w:lsdexception></pre>	alse"	
	•	ced care was coordinated			SemiHidden="true"		
	1-13-1/, evidence	teu care was coordinated					1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. WI	NG		03/22/	/2017
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			IST DRIVE		
LIEE CAI		ITIONS INC					
LIFE CAI	RE MEDICAL SOLU	TIONS INC		NASHV	ILLE, IN 47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	with the attending	ng physician. On 3-20-17			UnhideWhenUsed="true"		
		nursing supervisor stated			Name="Table Columns 1"/>		
		-			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	_	ve assessment was not			SemiHidden="true"		
	sent to the attend	ling physician.			UnhideWhenUsed="true"		
					Name="Table Columns 2"/>		
	B. Review	of physician's orders			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		ee physician verbal orders			SemiHidden="true"		
		lines, frequency of visits,			UnhideWhenUsed="true"		
	_				Name="Table Columns 3"/>	loo"	
		e orders based on the			<pre><w:lsdexception locked="fa SamiHiddon=" pre="" true"<=""></w:lsdexception></pre>	ise	
	recertification as	ssessment of patient #5			SemiHidden="true" UnhideWhenUsed="true"		
	after expiration of	of the previous			Name="Table Columns 4"/>		
	certification peri	od orders on 1-13-17.			- w:LsdException Locked="fa	leo"	
	Continuation peri	iod orders on 1 15 17.			SemiHidden="true"	130	
	C.D.	6 : :			UnhideWhenUsed="true"		
		of visit notes evidenced			Name="Table Columns 5"/>		
	skilled nursing f	furnished care on 1-14, 1-			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	15, 1-16, and 1-1	17-17, prior to return of			SemiHidden="true"		
		with physician signature			UnhideWhenUsed="true"		
	dated 1-18-17.				Name="Table Grid 1"/>		
	dated 1-16-17.				<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
					SemiHidden="true"		
	19. The clinical	record of patient #6,			UnhideWhenUsed="true"		
	start of care date	e of 3-6-17, was			Name="Table Grid 2"/>		
	reviewed and co	ntained a plan of care			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		killed nursing and home			SemiHidden="true"		
	health aide servi				UnhideWhenUsed="true"		
	lieaitii aide seivi	ces.			Name="Table Grid 3"/>		
					<pre><w:lsdexception <="" locked="fa</pre></td><td>ise" td=""><td></td></w:lsdexception></pre>		
	A. Review	of the start of care			SemiHidden="true"		
	comprehensive a	assessment/OASIS dated			UnhideWhenUsed="true"		
		ced care was coordinated			Name="Table Grid 4"/> <w:lsdexception <="" locked="fa</td><td>lco" td=""><td></td></w:lsdexception>		
		ng physician. On 3-20-17			SemiHidden="true"	io c	
					UnhideWhenUsed="true"		
		nursing supervisor stated			Name="Table Grid 5"/>		
	the comprehensi	ve assessment was not			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	sent to the attend	ding physician and did			SemiHidden="true"		
	not evidence phy	ysician orders for the care			UnhideWhenUsed="true"		
	of patient #6.	,			Name="Table Grid 6"/>		
	or patient $\pi 0$.						

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 53 of 129

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETI	ED
		15K066	B. W	ING		03/22/20	17
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	S.		1	IST DRIVE		
LIFE CAI	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
					I	<u> </u>	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) OMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA'	TE C	DATE
TAG	REGULATORY OR	LSC IDENTIFTING INFORMATION)	-	TAG	<pre><w:lsdexception <="" locked="fa</pre></td><td>loo" td=""><td>DATE</td></w:lsdexception></pre>	DATE	
					SemiHidden="true"	136	
		of physician's orders			UnhideWhenUsed="true"		
	failed to evidence	e physician verbal			Name="Table Grid 7"/>		
	orders related to	disciplines, frequency of			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	visits, and specif	ic care orders based on			SemiHidden="true"		
	the assessment o				UnhideWhenUsed="true"		
		- parient ii o.			Name="Table Grid 8"/>		
	C. Daniem	- C: .: t			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>		
		of visit notes evidenced			SemiHidden="true"		
		es had furnished care on			UnhideWhenUsed="true" Name="Table List 1"/>		
	3-14, 3-15, 3-17	, 3-18, 3-20, 3-21, and 3-			<pre><w:lsdexception locked="fa</pre></td><td>اموا</td><td></td></tr><tr><td></td><td>22-17, and a skil</td><td>led nursing visit was</td><td></td><td></td><td>SemiHidden=" td="" true"<=""><td></td><td></td></w:lsdexception></pre>		
	made on 3-14-17	7.			UnhideWhenUsed="true"		
					Name="Table List 2"/>		
	D Review	of the plan of care			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		y in the agency electronic			SemiHidden="true"		
	·				UnhideWhenUsed="true"		
		ystem evidenced the plan			Name="Table List 3"/>		
		ted on 3-20-17, and was			<pre><w:lsdexception faux"<="" locked="fa Considiration=" pre=""></w:lsdexception></pre>	ise"	
	finalized and fax	ted to the attending			SemiHidden="true" UnhideWhenUsed="true"		
	physician on 3-2	2-17.			Name="Table List 4"/>		
					<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	20. The clinical	record of patient #7,			SemiHidden="true"		
	start of care date	•			UnhideWhenUsed="true"		
		ntained a plan of care for			Name="Table List 5"/>		
		period of 2-8 to 4-8-17.			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	life certification	period of 2-8 to 4-8-17.			SemiHidden="true"		
					UnhideWhenUsed="true" Name="Table List 6"/>		
		of the recertification			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	comprehensive a	assessment dated 2-7-17,			SemiHidden="true"		
	evidenced care v	vas coordinated with the			UnhideWhenUsed="true"		
	attending physic	ian. On 3-20-17 at 3:30			Name="Table List 7"/>		
		supervisor stated the			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	'	rehensive assessment was			SemiHidden="true"		
		tending physician.			UnhideWhenUsed="true"		
	not sent to the at	chang physician.			Name="Table List 8"/>	loo"	
					<pre><w:lsdexception locked="fa SomiHiddon=" pre="" true"<=""></w:lsdexception></pre>	ise	
	B. Review of	of physician's orders			SemiHidden="true"		

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 54 of 129

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPL	ETED
		15K066	B. W	ING		03/22/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			IST DRIVE		
LIFE CAI	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	failed to evidence	e physician verbal orders			UnhideWhenUsed="true"		
	related to discip	lines, frequency of visits,			Name="Table 3D effects 1"/		
	and specific care	e orders based on the			<w:lsdexception locked="fa
SemiHidden=" td="" true"<=""><td>ise"</td><td></td></w:lsdexception>	ise"	
	-	sment of patient #7 after			UnhideWhenUsed="true"		
		f the physician orders on			Name="Table 3D effects 2"/	>	
	_				<w:lsdexception locked="fa</td><td></td><td></td></tr><tr><td></td><td>1 *</td><td>tification period which</td><td></td><td></td><td>SemiHidden=" td="" true"<=""><td></td><td></td></w:lsdexception>		
	expired on 2-7-1	. / .			UnhideWhenUsed="true"		
					Name="Table 3D effects 3"/3		
		of visit notes evidenced			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	care was furnish	ed on 2-8 and 2-9-17.			SemiHidden="true" UnhideWhenUsed="true"		
					Name="Table Contemporary	/"/>	
	D. Review	of the plan of care			<w:lsdexception locked="fa</p></td><td></td><td></td></tr><tr><td></td><td></td><td>tending physician signed</td><td></td><td></td><td>SemiHidden=" td="" true"<=""><td></td><td></td></w:lsdexception>		
		orders on 2-14-17.			UnhideWhenUsed="true"		
	line plan of care	014015 011 2 1 1 17.			Name="Table Elegant"/>		
	O1 The diminal				<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
		record of patient #8,			SemiHidden="true"		
		e of 1-11-17, was			UnhideWhenUsed="true" Name="Table Professional"/	_	
		ntained a plan of care			<pre><w:lsdexception locked="fa</pre></td><td></td><td></td></tr><tr><td></td><td>with orders for s</td><td>killed nursing and home</td><td></td><td></td><td>SemiHidden=" td="" true"<=""><td>.00</td><td></td></w:lsdexception></pre>	.00	
	health aide servi	ces.			UnhideWhenUsed="true"		
					Name="Table Subtle 1"/>		
	A. Review	of the start of care			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	comprehensive a	assessment/OASIS dated			SemiHidden="true"		
		ced care was coordinated			UnhideWhenUsed="true"		
	· ·	ng physician. On 3-20-17			Name="Table Subtle 2"/> <w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
					SemiHidden="true"	.50	
	1	nursing supervisor stated			UnhideWhenUsed="true"		
	_	ve assessment was not			Name="Table Web 1"/>		
		ding physician and did			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		ysician orders for the care			SemiHidden="true"		
	of patient #8.				UnhideWhenUsed="true"		
					Name="Table Web 2"/> <w:lsdexception <="" locked="fa</td><td>leo" td=""><td></td></w:lsdexception>		
	B. Review	of physician's orders			SemiHidden="true"	io c	
		ee physician verbal orders			UnhideWhenUsed="true"		
		lines, frequency of visits,			Name="Table Web 3"/>		
	related to discipi	inies, frequency of visits,	1				

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 55 of 129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. WI	NG		03/22/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			IST DRIVE		
LIFE CAI	RE MEDICAL SOLU	ITIONS INC			ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·		DATE
		e orders based on the			<pre><w:lsdexception locked="fa SemiHidden=" pre="" true"<=""></w:lsdexception></pre>	ise"	
	assessment of pa	itient #8.			UnhideWhenUsed="true"		
					Name="Balloon Text"/>		
	C. Review	of visit notes evidenced			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	home health aide	e visits were furnished on			Priority="39" Name="Table		
		, 1-26, 1-27, 1-28, 1-29,			Grid"/>		
		2-2, 2-3, 2-4, and 2-5-17,			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
					SemiHidden="true"		
		ng care was furnished on			UnhideWhenUsed="true"		
	1-14-17 and 1-30	0-1 /.			Name="Table Theme"/> <w:lsdexception <="" locked="fa</td><td>lco" td=""><td></td></w:lsdexception>		
					SemiHidden="true"	150	
	D. Review o	of the plan of care			Name="Placeholder Text"/>		
	evidenced the at	tending physician signed			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	the plan of care	orders on 2-6-17.			Priority="1" QFormat="true"		
	1				Name="No Spacing"/>		
	22 The clinical	record of patient #9,			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
		•			Priority="60" Name="Light		
		e of 3-13-17, was			Shading"/>	laa"	
		ntained a plan of care			<w:lsdexception 61"="" fa<="" locked="fa
Priority=" name="Light List</td><td></td><td></td></tr><tr><td></td><td>with orders for h</td><td>nome health aide services.</td><td></td><td></td><td><pre><w:LsdException Locked=" pre=""></w:lsdexception>		
					Priority="62" Name="Light Grid		
	A. Review	of the start of care			<w:lsdexception 63"="" locked="fa</p></td><td></td><td></td></tr><tr><td></td><td>comprehensive a</td><td>assessment dated 2-7-17,</td><td></td><td></td><td>Priority=" name="Medium</td><td></td><td></td></tr><tr><td></td><td>evidenced care v</td><td>vas coordinated with the</td><td></td><td></td><td>Shading 1"></w:lsdexception>		
		ian. On 3-20-17 at 3:30			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
		supervisor stated the			Priority="64" Name="Medium		
	'	assessment was not sent			Shading 2"/> <w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
					Priority="65" Name="Medium I		
		physician and did not			1"/>		
	1 1	ian orders for the care of			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	patient #9.				Priority="66" Name="Medium I		
					2"/>		
	B. Review	of physician's orders			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
		e physician verbal			Priority="67" Name="Medium		
		disciplines, frequency of			Grid 1"/> <w:lsdexception <="" locked="fa</td><td>leo" td=""><td></td></w:lsdexception>		
		fic care orders based on			Priority="68" Name="Medium	io c	
	_				Grid 2"/>		
	the assessment of	or patient #9.					

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 56 of 129

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. W	ING		03/22/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				IST DRIVE		
	RE MEDICAL SOLU	ITIONS INC			ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					<pre><w:lsdexception <="" locked="fa</pre></td><td>ilse" td=""><td></td></w:lsdexception></pre>		
	C. Review o	f visit notes evidenced			Priority="69" Name="Medium Grid 3"/>		
	home health aide	e visits were furnished on			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	3-14, 3-15, and 3	3-16-17.			Priority="70" Name="Dark List		
					<w:lsdexception 71"="" locked="fa</td><td></td><td></td></tr><tr><td></td><td>D Review (</td><td>of the plan of care</td><td></td><td></td><td>Priority=" name="Colorful</td><td></td><td></td></tr><tr><td></td><td></td><td>tending physician signed</td><td></td><td></td><td>Shading"></w:lsdexception>		
					<pre><w:lsdexception <="" locked="fa Priority 70 Norman 10 70 </td><td>ilse" td=""><td></td></w:lsdexception></pre>		
	uie pian of cafe (orders on 3-22-17.			Priority="72" Name="Colorful List"/>		
	23. The clinical	record of patient #10,			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	start of care date	* *			Priority="73" Name="Colorful		
		ntained a plan of care for			Grid"/>	lee"	
		period of 12-10-16 to			<pre><w:lsdexception 60"="" locked="fa Priority=" name="Light</pre></td><td>iise</td><td></td></tr><tr><td></td><td>·</td><td></td><td></td><td></td><td>Shading Accent 1"></w:lsdexception></pre>		
	•	ers for skilled nursing			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	and home health	aide services.			Priority="61" Name="Light List		
					Accent 1"/>		
	A. Review	of the recertification			<pre><w:lsdexception 62"="" locked="fa</pre></td><td></td><td></td></tr><tr><td></td><td>comprehensive a</td><td>ssessment/OASIS dated</td><td></td><td></td><td>Priority=" name="Light Grid</td><td>d</td><td></td></tr><tr><td></td><td>12-9-16, evidenc</td><td>ed care was coordinated</td><td></td><td></td><td>Accent 1"></w:lsdexception> <w:lsdexception <="" locked="fa</td><td>lso" td=""><td></td></w:lsdexception></pre>		
	with the attendin	g physician. On 3-20-17			Priority="63" Name="Medium	1130	
		nursing supervisor stated			Shading 1 Accent 1"/>		
		ve assessment was not			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	sent to the attend				Priority="64" Name="Medium		
	Som to the attent	mig pirysician.			Shading 2 Accent 1"/>		
	p paris	of physician's and an			<pre><w:lsdexception 65"="" locked="fa Priority=" name="Medium 1 Accent 1"></w:lsdexception></pre>	LiSt	
		e physician verbal orders			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	_	ines, frequency of visits,			SemiHidden="true"		
	and specific care	orders based on the			Name="Revision"/>		
	follow-up assess	ment of patient #10 after			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>		
	the expiration of	the physician orders on			Priority="34" QFormat="true"		
	the previous plan	of care certification			Name="List Paragraph"/>	leo"	
		h expired on 12-9-16.			<w:lsdexception 29"="" <="" locked="fa
Priority=" qformat="true" td=""><td>ii5C</td><td></td></w:lsdexception>	ii5 C	
		•			Name="Quote"/>		
	C. Review	of visit notes evidenced			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED				
		15K066	B. Wl	ING		03/22/	2017				
				STREET A	ADDRESS, CITY, STATE, ZIP CODE						
NAME OF I	PROVIDER OR SUPPLIEF	8			IST DRIVE						
LIFE CA	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448						
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)				
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION				
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE				
	care was furnish	ed by a home health aide			Priority="30" QFormat="true"						
	on 12-11-16, by	a home health aide and			Name="Intense Quote"/>	1"					
	skilled nurse on	12-12-16, and care was			<w:lsdexception 66"="" locked="fa
Priority=" name="Medium</td><td></td><td></td></tr><tr><td></td><td>furnished by a h</td><td>ome health aide and</td><td></td><td></td><td>2 Accent 1"></w:lsdexception>	LIST					
	skilled nurse on				<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>						
		12 13 10.			Priority="67" Name="Medium						
	D. Daviere	of the plan of care			Grid 1 Accent 1"/>						
		of the plan of care			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>						
		tending physician had			Priority="68" Name="Medium Grid 2 Accent 1"/>						
	signed the plan of	of care orders on			<pre><w:lsdexception <="" locked="fa</pre></td><td>lco" td=""><td></td></w:lsdexception></pre>						
	12-14-16.				Priority="69" Name="Medium	130					
					Grid 3 Accent 1"/>						
	24. On 3-22-17	at 4:00 PM, the nursing			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>						
	supervisor stated	the agency staff had			Priority="70" Name="Dark List						
	furnished care to	the above patients			Accent 1"/>						
		aining specific physician			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>						
		sciplines, frequency of			Priority="71" Name="Colorful Shading Accent 1"/>						
		fic care orders by verbal			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>						
	-	order at the time of the			Priority="72" Name="Colorful I						
					Accent 1"/>						
		prior to the return of a			<w:lsdexception 73"="" locked="fa</td><td></td><td></td></tr><tr><td></td><td></td><td>l plan of care with written</td><td></td><td></td><td>Priority=" name="Colorful (</td><td>Grid</td><td></td></tr><tr><td></td><td>orders for care.</td><td></td><td></td><td></td><td>Accent 1"></w:lsdexception>	loo"					
					<w:lsdexception 60"="" locked="fa
Priority=" name="Light</td><td>ise</td><td></td></tr><tr><td></td><td>25. Policy, " pla<="" td=""><td>n of Care," last</td><td></td><td></td><td>Shading Accent 2"/></td><td></td><td></td></w:lsdexception>	n of Care," last			Shading Accent 2"/>		
	reviewed/revised	d 1-11-17, was reviewed			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>						
	and stated, "An	individualized Plan of			Priority="61" Name="Light List						
	Care signed by a	a physician shall be			Accent 2"/>						
		h patient receiving home			<pre><w:lsdexception 62"="" fa<="" locked="fa</pre></td><td></td><td></td></tr><tr><td></td><td>_</td><td>s. The Plan of Care shall</td><td></td><td></td><td>Priority=" name="Light Grid</td><td>ם</td><td></td></tr><tr><td></td><td></td><td>full to include: a. All</td><td></td><td></td><td><pre><w:LsdException Locked=" pre=""></w:lsdexception></pre>	lse"					
	_	sis(es), principle and			Priority="63" Name="Medium	.50					
	1 .	* / *			Shading 1 Accent 2"/>						
		ding date of onset. b.			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>						
		e. Type, frequency, and			Priority="64" Name="Medium						
		isits/services 1.			Shading 2 Accent 2"/>						
	Medications, tre	atments, and procedures			<w:lsdexception <="" locked="fa</td><td>ise" td=""><td></td></w:lsdexception>						

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 58 of 129

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		15K066	B. W	ING	_	03/22/2	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		25 ART	IST DRIVE		
LIFE CA	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWING DE ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	t. Other appr	opriate items."			Priority="65" Name="Medium	List	
		1			1 Accent 2"/>		
	26 During a ho	me visit observation of a			<w:lsdexception 66"="" locked="fa</td><td></td><td></td></tr><tr><td></td><td>_</td><td></td><td></td><td></td><td>Priority=" name="Medium</td><td>List</td><td></td></tr><tr><td></td><td>_</td><td>(RN) for patient #4 on</td><td></td><td></td><td>2 Accent 2"></w:lsdexception>	laa"	
		M, patient #4 was			<w:lsdexception 67"="" locked="fa
Priority=" name="Medium</td><td>ise</td><td></td></tr><tr><td></td><td></td><td>sing oxygen at 2 liters</td><td></td><td></td><td>Grid 1 Accent 2"></w:lsdexception>		
	per minute by na	asal cannula. Review of			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	the plan of care	failed to evidence a			Priority="68" Name="Medium		
	physician order	for oxygen, to include			Grid 2 Accent 2"/>		
	setting and meth	od of delivery.			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>		
		•			Priority="69" Name="Medium		
	27 During a ho	me visit observation of			Grid 3 Accent 2"/>	loo"	
	1				<w:lsdexception 70"="" locked="fa
Priority=" name="Dark List</td><td></td><td></td></tr><tr><td></td><td>_</td><td>nt #5 on 3-21-17 at 12</td><td></td><td></td><td>Accent 2"></w:lsdexception>		
		was observed to have			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	1	via tracheotomy collar at			Priority="71" Name="Colorful		
	2 liters per minu	te. Review of the plan of			Shading Accent 2"/>		
	care for the certi	fication period of 1-14 to			<w:lsdexception 72"="" locked="fa</p></td><td></td><td></td></tr><tr><td></td><td>3-14-17, failed t</td><td>o evidence a physician</td><td></td><td></td><td>Priority=" name="Colorful I</td><td>₋ist</td><td></td></tr><tr><td></td><td>order for oxyger</td><td>n, to include setting and</td><td></td><td></td><td>Accent 2"></w:lsdexception>	laa"	
	method of delive	•			<w:lsdexception 73"="" locked="fa
Priority=" name="Colorful (</td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td>Accent 2"></w:lsdexception>	Jilu	
	20 0 2 22 17	at 4:00 DM the numering			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
		at 4:00 PM, the nursing			Priority="60" Name="Light		
		ed the above findings			Shading Accent 3"/>		
	_	ans of care for patients			<w:lsdexception 61"="" locked="fa</td><td></td><td></td></tr><tr><td></td><td>#4 and 5 should</td><td>have contained complete</td><td></td><td></td><td>Priority=" name="Light List</td><td></td><td></td></tr><tr><td></td><td>oxygen therapy</td><td>orders. The</td><td></td><td></td><td>Accent 3"></w:lsdexception>	"	
	administrator sta	ated there was no further			<w:lsdexception 62"="" locked="fa
Priority=" name="Light Grid</td><td></td><td></td></tr><tr><td></td><td>documentation t</td><td>o be reviewed.</td><td></td><td></td><td>Accent 3"></w:lsdexception>	u	
					<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>		
	29 The clinical	record of patient #4,			Priority="63" Name="Medium		
		e of 9-15-15, was			Shading 1 Accent 3"/>		
		1-17. The clinical record			<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	lse"	
					Priority="64" Name="Medium		
		sician's plan of care with			Shading 2 Accent 3"/>	loo"	
	a start of care of	9-15-15, and care period					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED				
		15K066	B. W	ING		03/22/2017				
				STREET A	ADDRESS, CITY, STATE, ZIP CODE					
NAME OF I	PROVIDER OR SUPPLIEF	₹			IST DRIVE					
LIFE CAI	RE MEDICAL SOLU	ITIONS INC			ILLE, IN 47448					
					1222, 114 17 110					
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)				
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·	DATE				
		15, with orders for skilled			Priority="65" Name="Medium I 1 Accent 3"/>	-ISI				
	nursing services	-			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""></w:lsdexception></pre>					
					Priority="66" Name="Medium					
	A. During a	home visit observation			2 Accent 3"/>					
	of a registered n	urse (RN) on 3-21-17 at			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""></w:lsdexception>					
	10 AM, the regis				Priority="67" Name="Medium					
	, ,	ense 400 mg Guaifenesin			Grid 1 Accent 3"/>					
	_	ratient #4' medication set			<w:lsdexception 68"="" <="" locked="fa
Priority=" name="Medium</td><td>ise" td=""></w:lsdexception>					
	up container.	attent #4 incarcation set			Grid 2 Accent 3"/>					
	up container.				<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""></w:lsdexception></pre>					
	D D .				Priority="69" Name="Medium					
		of the plan of care			Grid 3 Accent 3"/>					
	medication orde	rs evidenced Guaifenesin			<w:lsdexception 70"="" locked="fa</td><td></td></tr><tr><td></td><td>600 mg oral tabl</td><td>et, 1 tablet, two times a</td><td></td><td></td><td>Priority=" name="Dark List</td><td></td></tr><tr><td></td><td>day, orally.</td><td></td><td></td><td></td><td>Accent 3"></w:lsdexception>	la a "				
					<w:lsdexception 71"="" locked="fa
Priority=" me<="" name="Colorful</td><td>ise</td></tr><tr><td></td><td>30. Policy, " td=""><td>dication Set Up Policy,"</td><td></td><td></td><td>Shading Accent 3"/></td><td></td></w:lsdexception>	dication Set Up Policy,"			Shading Accent 3"/>	
		vised 1-11-17, was			<w:lsdexception <="" locked="fa</td><td>lse" td=""></w:lsdexception>					
		ated, "staff setting up			Priority="72" Name="Colorful I					
		I follow accepted			Accent 3"/>					
		-			<w:lsdexception 73"="" locked="fa</td><td></td></tr><tr><td></td><td>_</td><td>ctice the nurse must</td><td></td><td></td><td>Priority=" name="Colorful (</td><td>Grid</td></tr><tr><td></td><td></td><td>pharmacy labels carefully</td><td></td><td></td><td>Accent 3"></w:lsdexception> <w:lsdexception <="" locked="fa</td><td>loo" td=""></w:lsdexception>					
		s filling a med planner or			Priority="60" Name="Light	ise				
		e medication. The nurse			Shading Accent 4"/>					
	should then com	pare the medication			<w:lsdexception <="" locked="fa</p></td><td>lse" td=""></w:lsdexception>					
	labels to the 485	, medication list, and/or			Priority="61" Name="Light List					
	MAR [medication	on administration record]			Accent 4"/>					
	_	ering the medication or			<w:lsdexception 62"="" locked="fa</p></td><td></td></tr><tr><td></td><td>filling the med p</td><td></td><td></td><td></td><td>Priority=" name="Light Grid</td><td>1</td></tr><tr><td></td><td>l med b</td><td></td><td></td><td></td><td>Accent 4"></w:lsdexception> <w:lsdexception <="" locked="fa</td><td>lse" td=""></w:lsdexception>					
	31 On 2 21 17	at 2:00 DM the nursing			Priority="63" Name="Medium					
		at 2:00 PM, the nursing			Shading 1 Accent 4"/>					
		ated the registered nurse			<w:lsdexception <="" locked="fa</td><td>lse" td=""></w:lsdexception>					
	_	re the medication label			Priority="64" Name="Medium					
		tion order, as required by			Shading 2 Accent 4"/>					
	agency policy, to	o ensure the correct			<w:lsdexception <="" locked="fa</p></td><td>ise" td=""></w:lsdexception>					

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 60 of 129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		l í	JILDING	ONSTRUCTION 00	(X3) DATE S COMPLE 03/22/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u>.</u>			ADDRESS, CITY, STATE, ZIP CODE		
	RE MEDICAL SOLU				TIST DRIVE YILLE, IN 47448		
					TLLE, IN 47440		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		uaifenesin had been			Priority="65" Name="Medium	List	
		ient #4's the medication			1 Accent 4"/>		
	set up container.				<w:lsdexception <="" locked="fa" p=""></w:lsdexception>		
					Priority="66" Name="Medium 2 Accent 4"/>	LIST	
	32. During a ho	ome visit observation of			<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	alse"	
	_	nt #5 on 3-21-17 at 12			Priority="67" Name="Medium		
	-	was observed to have a			Grid 1 Accent 4"/> <w:lsdexception <="" locked="fa</td><td>ulso" td=""><td></td></w:lsdexception>		
	tracheotomy and	l a gastrostomy tube.			Priority="68" Name="Medium	1136	
		•			Grid 2 Accent 4"/>		
A. Review of the plan of care for the				<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	ilse"		
certification period of 1-14 to 3-14-17,				Priority="69" Name="Medium Grid 3 Accent 4"/>			
failed to evidence a physician order for			<w:lsdexception <="" locked="false" td=""><td></td></w:lsdexception>				
	the tracheotomy	tube to be changed each		Priority="70" Name="Dark List			
	2 months, and fo	or the gastrostomy tube to			Accent 4"/>	ulaa"	
	be changed each	2 months.			<w:lsdexception <br="" locked="fa">Priority="71" Name="Colorful</w:lsdexception>	lise	
					Shading Accent 4"/>		
	B. During i	nterview with employee			<w:lsdexception <="" locked="fa" p=""></w:lsdexception>		
		nurse in the home, on 3-			Priority="72" Name="Colorful Accent 4"/>	List	
		n, the employee indicated			<pre><w:lsdexception <="" locked="fa</pre></td><td>alse" td=""><td></td></w:lsdexception></pre>		
		the gastrostomy tube and			Priority="73" Name="Colorful		
	1	e 2 months after the start			Accent 4"/>	.1"	
	of care date of 1	1-15-16.			<pre><w:lsdexception 60"="" locked="fa Priority=" name="Light</pre></td><td>lise</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td>Shading Accent 5"></w:lsdexception></pre>		
		at 4:00 PM, the nursing			<w:lsdexception <="" locked="fa" p=""></w:lsdexception>		
	_	I the registered nurse			Priority="61" Name="Light Lis Accent 5"/>	t	
		iated updating the plan of			<pre><w:lsdexception <="" locked="fa</pre></td><td>alse" td=""><td></td></w:lsdexception></pre>		
	_	nysician orders to change			Priority="62" Name="Light Gri		
	1	tube and gastrostomy			Accent 5"/>		
	tube periodically	as directed.			<w:lsdexception <br="" locked="fa">Priority="63" Name="Medium</w:lsdexception>	use"	
	24 Donie 1841	ha aliminal managel a C			Shading 1 Accent 5"/>		
		he clinical record of			<w:lsdexception <="" locked="fa" p=""></w:lsdexception>	alse"	
		nced a start of care date			Priority="64" Name="Medium		
		riew of the paper portion			Shading 2 Accent 5"/> <w:lsdexception <="" locked="fa</td><td>alse" td=""><td></td></w:lsdexception>		
	of the clinical re	cord evidenced clinical			.w.LouLxcoption Locked- 18		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 B. WING			COMPL	ETED	
		15K066	B. W	ING	03/22/2017			
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF	8			IST DRIVE			
LIFE CAF	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	record documentation to include a home				Priority="65" Name="Medium I	_ist		
	health aide care	plan created on			1 Accent 5"/>			
		rral form dated 10-2-15;			<pre><w:lsdexception 66"="" locked="fa</pre></td><td></td><td></td></tr><tr><td></td><td>•</td><td>ayer verification dated</td><td></td><td></td><td>Priority=" name="Medium I</td><td>_ist</td><td></td></tr><tr><td></td><td></td><td>-</td><td></td><td></td><td>2 Accent 5"></w:lsdexception> <w:lsdexception <="" locked="fa</td><td>leo" td=""><td></td></w:lsdexception></pre>			
	•	e environment safety			Priority="67" Name="Medium	13 C		
		11-11-15; a patient			Grid 1 Accent 5"/>			
	information guio	le dated 11-11-15; an			<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>			
	admission service	e agreement dated			Priority="68" Name="Medium			
	11-11-15; a hom	ne health advance			Grid 2 Accent 5"/>			
	· ·	ce dated 11-11-15; an			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>			
					Priority="69" Name="Medium			
	abuse and neglect vulnerability assessment dated 11-11-15; and a notice				Grid 3 Accent 5"/>			
				<pre><w:lsdexception locked="false" name="Dark List</pre></td><td></td></tr><tr><td></td><td>of privacy rights</td><td>dated 11-11-15.</td><td></td><td></td><td>Accent 5" priority="70"></w:lsdexception></pre>				
					<pre><w:lsdexception <="" locked="fa</pre></td><td>leo" td=""><td></td></w:lsdexception></pre>			
	35. On 3-21-17,	, the nursing supervisor			Priority="71" Name="Colorful	130		
	and the case man	nager registered nurse,			Shading Accent 5"/>			
		ted patient #3 had been			<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>			
		4-17,9 days prior to the			Priority="72" Name="Colorful L			
	_				Accent 5"/>			
		are date of on the plan of			<w:lsdexception 73"="" locked="fa</td><td></td><td></td></tr><tr><td></td><td>· ·</td><td>and the above noted</td><td></td><td></td><td>Priority=" name="Colorful (</td><td>Grid</td><td></td></tr><tr><td></td><td></td><td>e active clinical record</td><td></td><td></td><td>Accent 5"></w:lsdexception>			
	were from a pre-	vious episode of care,			<pre><w:lsdexception 60"="" <="" locked="fa Driggity=" name="Light</pre></td><td>ise" td=""><td></td></w:lsdexception></pre>			
	now closed.				Priority="60" Name="Light Shading Accent 6"/>			
					<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>			
					Priority="61" Name="Light List			
					Accent 6"/>			
					<w:lsdexception <="" locked="fa</td><td>lse" td=""><td></td></w:lsdexception>			
					Priority="62" Name="Light Grid	t		
					Accent 6"/>			
					<w:lsdexception <="" locked="fa</p></td><td>lse" td=""><td></td></w:lsdexception>			
					Priority="63" Name="Medium			
					Shading 1 Accent 6"/>	l = = "		
					<pre><w:lsdexception 64"="" <="" locked="fa Priority=" name="Medium</pre></td><td>ise" td=""><td></td></w:lsdexception></pre>			
					Priority="64" Name="Medium Shading 2 Accent 6"/>			
					<pre><w:lsdexception <="" locked="fa</pre></td><td>lse" td=""><td></td></w:lsdexception></pre>			
						.50		

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 62 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00	COMPLETED 03/22/2017
NAME OF P	ROVIDER OR SUPPLIEF	· :		ADDRESS, CITY, STATE, ZIP CODE	•
LIFE CAF	RE MEDICAL SOLU	JTIONS INC		TIST DRIVE VILLE, IN 47448	
(X4) ID		TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO)N
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				Priority="65" Name="Medium 1 Accent 6"/>	ım List
				<pre><w:lsdexception locked="</pre"></w:lsdexception></pre>	="false"
				Priority="66" Name="Mediu	
				2 Accent 6"/>	116-111
				<w:lsdexception locked="<br">Priority="67" Name="Medium of the color by /w:lsdexception>	
				Grid 1 Accent 6"/>	
				<w:lsdexception locked<="" td=""><td></td></w:lsdexception>	
				Priority="68" Name="Medium Grid 2 Accent 6"/>	ım
				<pre><w:lsdexception locked="</pre"></w:lsdexception></pre>	="false"
				Priority="69" Name="Mediu	
			Grid 3 Accent 6"/>		
				<w:lsdexception locked="</p"></w:lsdexception>	
				Priority="70" Name="Dark Accent 6"/>	LISI
				<pre><w:lsdexception locked="</pre"></w:lsdexception></pre>	="false"
				Priority="71" Name="Color	ful
				Shading Accent 6"/>	-114-111
				<w:lsdexception locked="<br">Priority="72" Name="Color</w:lsdexception>	
				Accent 6"/>	TOT LIST
				<w:lsdexception locked="</td"><td></td></w:lsdexception>	
				Priority="73" Name="Color	ful Grid
				Accent 6"/> <w:lsdexception locked="</td"><td>="false"</td></w:lsdexception>	="false"
				Priority="19" QFormat="tru	
				Name="Subtle Emphasis	"/>
				<pre><w:lsdexception locked="</pre"></w:lsdexception></pre>	
				Priority="21" QFormat="tru Name="Intense Emphasi	
				<w:lsdexception locked="</p"></w:lsdexception>	
				Priority="31" QFormat="tru	
				Name="Subtle Reference	
				<w:lsdexception locked="<br">Priority="32" QFormat="tru</w:lsdexception>	
				Name="Intense Reference	
				<w:lsdexception locked="</td"><td></td></w:lsdexception>	
				Priority="33" QFormat="tru	e"
				Name="Book Title"/> <w:lsdexception locked="</td"><td>="false"</td></w:lsdexception>	="false"
			1	-w.LouLxooption Locked-	idioc

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 63 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15K066	A. BUILDING 00 B. WING		COMPLETED 03/22/2017		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE				
LIFE CAF	RE MEDICAL SOLU	TIONS INC		ILLE, IN 47448			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
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State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 64 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15K066	A. BUILDING 00 B. WING		COMPLETED 03/22/2017	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE MEDICAL SOLU	TIONS INC		/ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Priority="51" Name="Grid Tab Colorful"/>	DATE	
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				Accent 2"/>		

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 65 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00	- I	ESURVEY LETED 2/2017
	PROVIDER OR SUPPLIER		25 ART	ADDRESS, CITY, STATE, ZIP CO TIST DRIVE VILLE, IN 47448	DDE	
(X4) ID PREFIX TAG	SUMMARY S' (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)	ECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
				<pre><w:lsdexception lock="" name="G Dark Accent 2" priority="50"></w:lsdexception> <w:lsdexception lock="" name="Grid Table 6 Accent 2" priority="51"></w:lsdexception> <w:lsdexception lock="" name="Grid Table 7 Accent 2" priority="52"></w:lsdexception> <w:lsdexception lock="" name="Grid Table 1 Accent 3" priority="46"></w:lsdexception> <w:lsdexception lock="" name="G Accent 3" priority="47"></w:lsdexception> <w:lsdexception lock="" name="G Accent 3" priority="48"></w:lsdexception> <w:lsdexception lock="" name="G Accent 3" priority="49"></w:lsdexception> <w:lsdexception lock="" name="G Accent 3" priority="50"></w:lsdexception> <w:lsdexception lock="" name="G Dark Accent 3" priority="50"></w:lsdexception> <w:lsdexception lock="" name="Grid Table 6 Accent 3" priority="51"></w:lsdexception> <w:lsdexception lock="" name="Grid Table 7 Accent 3" priority="52"></w:lsdexception> <w:lsdexception lock="" name="Grid Table 1 Accent 4" priority="46"></w:lsdexception> <w:lsdexception lock="" name="Grid Table 1 Accent 4" priority="46"></w:lsdexception> <w:lsdexception lock="" name="G Accent 4" priority="47"></w:lsdexception> <w:lsdexception lock="" name="G Accent 4" priority="47"></w:lsdexception> </pre>	rid Table 5 ked="false" Colorful ked="false" Colorful ked="false" Light ked="false" rid Table 2 ked="false" rid Table 3 ked="false" rid Table 4 ked="false" rid Table 5 ked="false" Colorful ked="false" Colorful ked="false" Light ked="false"	

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 66 of 129

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	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BUILDING 00 B. WING		COMPLETED 03/22/2017		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE				
LIFE CAF	RE MEDICAL SOLU	TIONS INC		/ILLE, IN 47448			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
				<pre><w:lsdexception 48"="" locked="fa Priority=" name="Grid Tab Accent 4"></w:lsdexception></pre>	alse" le 3 alse" le 4 alse" le 5 alse" ll alse" ll alse" le 2 alse" le 3 alse" le 4 alse" le 5 alse" le 4 alse" le 5 alse" le 1		

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 67 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15K066	A. BUILDING 00 B. WING		COMPLETED 03/22/2017		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE				
LIFE CAF	RE MEDICAL SOLU	TIONS INC		IST DRIVE ILLE, IN 47448			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Priority="46" Name="Grid Table 1 Light Accent 6"/> <w:lsdexception 47"="" locked="fa Priority=" name="Grid Tabl Accent 6"></w:lsdexception> <w:lsdexception 48"="" locked="fa Priority=" name="Grid Tabl Accent 6"></w:lsdexception> <w:lsdexception 49"="" locked="fa Priority=" name="Grid Tabl Accent 6"></w:lsdexception> <w:lsdexception 50"="" locked="fa Priority=" name="Grid Tabl Dark Accent 6"></w:lsdexception> <w:lsdexception 51"="" locked="fa Priority=" name="Grid Table 6 Colorfu Accent 6"></w:lsdexception> <w:lsdexception 52"="" locked="fa Priority=" name="Grid Table 7 Colorfu Accent 6"></w:lsdexception> <w:lsdexception 46"="" locked="fa Priority=" name="List Table Light"></w:lsdexception> <w:lsdexception 47"="" locked="fa Priority=" name="List Table 2"></w:lsdexception> <w:lsdexception 48"="" locked="fa Priority=" name="List Table 3"></w:lsdexception> <w:lsdexception 48"="" locked="fa Priority=" name="List Table 3"></w:lsdexception> <w:lsdexception 49"="" locked="fa Priority=" name="List Table 4"></w:lsdexception> <w:lsdexception 50"="" locked="fa Priority=" name="List Table Dark"></w:lsdexception> <w:lsdexception 51"="" locked="fa Priority=" name="List Table Colorful"></w:lsdexception> <w:lsdexception 1="" 2="" 3="" 4="" 5="" 6<="" alse"="" e="" le="" ll="" locked="fa</td><td>alse" td=""></w:lsdexception>			

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 68 of 129

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2017
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	JTIONS INC		VILLE, IN 47448	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				Priority="52" Name="List Table Colorful"/>	false"

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 03/22/2017
		TORUOU			03/22/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	ITIONS INC		TIST DRIVE /ILLE, IN 47448	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION
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				Priority="51" Name="List Table 6 Colorf Accent 2"/> <w:lsdexception 52"<="" locked=" Priority=" td=""><td></td></w:lsdexception>	
				Name="List Table 7 Colorf Accent 2"/>	
				<pre><w:lsdexception 46"="" <="" locked=" Priority=" name="!! ist Table 1 Light." pre=""></w:lsdexception></pre>	false"
				Name="List Table 1 Light Accent 3"/>	
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			Accent 3"/> <w:lsdexception <="" locked="</td><td>false" td=""></w:lsdexception>		
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				Accent 3"/>	
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	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BUILDING 00 B. WING		COMPLETED 03/22/2017		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE				
LIFE CAF	RE MEDICAL SOLU	TIONS INC		/ILLE, IN 47448			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
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State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 71 of 129

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
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		101.000	_	ADDRESS CITY STATE SIN CORE	00/22/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	JTIONS INC		/ILLE, IN 47448	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		
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				<w:lsdexception locked="</td"><td></td></w:lsdexception>	
				Priority="48" Name="List Ta	able 3
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			Name="List Table 6 Color	ful	
				Accent 6"/>	uc
				<pre><w:lsdexception locked='Priority="52"</pre'></w:lsdexception></pre>	"false"
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				Accent 6"/>	
				<w:lsdexception locked="</p"></w:lsdexception>	"false"
				SemiHidden="true"	
				UnhideWhenUsed="true" Name="Mention"/>	
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				10]> <style></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td>/* Style Definitions */</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td>table.MsoNormalTable</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td>{mso-style-name:"Table</td><td>e </td></tr><tr><td></td><td></td><td></td><td></td><td>Normal"; mso-tstyle-rowband-siz</td><td>·e·0·</td></tr><tr><td></td><td></td><td></td><td></td><td>mso-tstyle-colband-size</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></tbody></table></style>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED	
ANDILAN	OI CORRECTION	15K066	B. WING	00	03/22/2017
		101.000		ADDRESS CITY STATE ZID CORE	00,22,2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	ITIONS INC		/ILLE, IN 47448	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) mso-style-noshow:yes; mso-style-priority:99; mso-style-parent:""; mso-padding-alt:0in 5.4pt 5.4pt; mso-para-margin-top:0in mso-para-margin-left:0in mso-para-margin-left:0in line-height:107%; mso-pagination:widow-on; font-size:11.0pt; font-family:"Calibri",sans; mso-ascii-font-family:Cal mso-ascii-theme-font:miatin; mso-hansi-font-family:"Tim New Roman"; mso-bidi-font-family:"Tim New Roman"; mso-bidi-theme-font:mindi;} [endif] [if gte mso 9] <xml> <0:OfficeDocumentSettings: <</xml>	ate COMPLETION DATE of Oin d; in; ins, i:8.0 ; rpha -serif libri; nor-l alibri; inor-l als or-bi
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State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 73 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED	
		15K066	B. WING		03/22/2017	
	.no.unnn	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	K		TIST DRIVE		
	RE MEDICAL SOL			VILLE, IN 47448		
(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 APPROPR DEFICIENCY)	COMPLETION DATE	
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				<pre><w:splitpgbreakandparama <w:dontflipmirrorindents="" <w:enableopentypekernii=""></w:splitpgbreakandparama> <w:overridetablestylehps <="" w:compatibility=""> <m:mathpr> <m:mathfont m:val="Cambath"></m:mathfont> <m:brkbin m:val="before"></m:brkbin> <m:brkbinsub m:val="- <m:smallFrac m:val=" off"=""></m:brkbinsub> <m:dispdef></m:dispdef> <m:lmargin m:val="0"></m:lmargin> <m:rmargin m:val="0"></m:rmargin> <m:defjc m:val="centerGroup"></m:defjc> <m:wrapindent <="" m:val="144 <m:intLim m:val=" pre="" subsup"=""></m:wrapindent></m:mathpr></w:overridetablestylehps></pre>	ng/> //> pria 5;-"/>	

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 74 of 129

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	LAN OF CORRECTION IDENTIFICATION NUMBER: 15K066 A. BUILDING B. WING		COMPLETED 03/22/2017		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	TIONS INC		/ILLE, IN 47448	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	DATE
				<m:narylim <="" m:mathpr="" m:val="undOvr"> <!--[endif]--><!--[if gte ms 9]--><xml> <w:latentstyles deflockedstate="false" defpriority="99" defsemihidden="false" defunhidewhenused="false" latentstylecount="374"> <w:lsdexception defpriority="0" locked="false" name="Normal" qformat="true"></w:lsdexception> <w:lsdexception locked="false" name="hormal" priority="0" qformat="true"></w:lsdexception> <w:lsdexception locked="false" name="heading 1" priority="9" qformat="true"></w:lsdexception> <w:lsdexception locked="false" name="heading 1" priority="9" qformat="true" semihidden="true"></w:lsdexception> <w:lsdexception <="" locked="false" priority="9" qformat="true" semihidden="true" td=""><td>ent SO alse" alse" ng alse" ng alse" ng alse" ng alse" ng alse" ng alse"</td></w:lsdexception></w:latentstyles></xml></m:narylim>	ent SO alse" alse" ng alse" ng alse" ng alse" ng alse" ng alse" ng alse"

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY COMPLETED	
THE LEAD	o. condenion	15K066	B. WING	00	03/22/2017
			STREET	ADDRESS, CITY, STATE, ZIP CODE	1
NAME OF P	ROVIDER OR SUPPLIER			TIST DRIVE	
LIFE CAF	RE MEDICAL SOLU	ITIONS INC		/ILLE, IN 47448	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	BE COMPLETION
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				Name="index 2"/> <w:lsdexception locked="</td"><td>"false"</td></w:lsdexception>	"false"
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				Name="index 3"/> <w:lsdexception locked="</td"><td>"falso"</td></w:lsdexception>	"falso"
				<pre><w:lsaexception locked='SemiHidden="true"</pre'></w:lsaexception></pre>	Idioc
				UnhideWhenUsed="true"	
				Name="index 4"/>	"foloo"
				<pre><w:lsdexception locked='SemiHidden="true"</pre'></w:lsdexception></pre>	raise"
				UnhideWhenUsed="true"	
				Name="index 5"/>	
				<pre><w:lsdexception locked='SomiHiddon="true"</pre'></w:lsdexception></pre>	"false"
				SemiHidden="true" UnhideWhenUsed="true"	
				Name="index 6"/>	
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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
		15K066	B. WING		03/22/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	JTIONS INC		ΓIST DRIVE /ILLE, IN 47448	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	<u> </u>	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	N
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
				SemiHidden="true" UnhideWhenUsed="true" Name="index 7"/> <w:lsdexception locked='SemiHidden="true"' name="index 8" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked='SemiHidden="true"' name="index 9" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked='Priority="39"' name="toc 2" semihidden='UnhideWhenUsed="true" Name="toc 1"/> <w:LsdException Locked=Priority="39" SemiHidden=' unhidewhenused="true"></w:lsdexception> <w:lsdexception locked='Priority="39"' name="toc 4" semihidden='UnhideWhenUsed="true" Name="toc 3"/> <w:LsdException Locked=Priority="39" SemiHidden=' unhidewhenused="true"></w:lsdexception> <w:lsdexception locked='Priority="39"' name="toc 6" semihidden='UnhideWhenUsed="true" Name="toc 5"/> <w:LsdException Locked=Priority="39" SemiHidden=' unhidewhenused="true"></w:lsdexception> <w:lsdexception locked='Priority="39"' name="toc 7" semihidden='UnhideWhenUsed="true" Name="toc 6"/> <w:LsdException Locked=Priority="39" SemiHidden=' unhidewhenused="true"></w:lsdexception> <w:lsdexception locked='Priority="39"' name="toc 7" semihidden='UnhideWhenUsed="true" Name="toc 7"/> <w:LsdException Locked=Priority="39" SemiHidden=' unhidewhenused="true"></w:lsdexception> <w:lsdexception locked='Priority="39"' name="toc 7" semihidden='UnhideWhenUsed="true" Name="toc 7"/> <w:LsdException Locked=Priority="39" SemiHidden=' unhidewhenused="true"></w:lsdexception>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED	
		15K066	B. WING		03/22/2017	
			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		TIST DRIVE		
	RE MEDICAL SOL	LITIONS INC		VILLE, IN 47448		
LIFE CAP	RE MEDICAL SOL	OTIONS INC	IVASIT	VILLE, IN 47440		
(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 ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
				Name="toc 8"/>		
				<pre><w:lsdexception <="" locked="" pre=""></w:lsdexception></pre>		
				Priority="39" SemiHidden="tr	ue"	
				UnhideWhenUsed="true"		
				Name="toc 9"/>	falso"	
				<pre><w:lsdexception locked=" SemiHidden=" pre="" true"<=""></w:lsdexception></pre>	aisc	
				UnhideWhenUsed="true"		
				Name="Normal Indent"/>		
				<pre><w:lsdexception <="" locked="" pre=""></w:lsdexception></pre>	false"	
				SemiHidden="true"		
				UnhideWhenUsed="true"		
				Name="footnote text"/>		
				<pre><w:lsdexception <="" locked="</pre></td><td>false" td=""></w:lsdexception></pre>		
				SemiHidden="true"		
				UnhideWhenUsed="true"		
				Name="annotation text"/> <w:lsdexception <="" locked="</td><td>foloo" td=""></w:lsdexception>		
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				UnhideWhenUsed="true"		
				Name="header"/>		
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				SemiHidden="true"		
				UnhideWhenUsed="true"		
				Name="footer"/>		
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				SemiHidden="true"		
				UnhideWhenUsed="true"		
				Name="index heading"/> <w:lsdexception <="" locked="</td><td>false" td=""></w:lsdexception>		
				Priority="35" SemiHidden="tr		
				UnhideWhenUsed="true"		
				QFormat="true"		
				Name="caption"/>		
				<pre><w:lsdexception <="" locked="" pre=""></w:lsdexception></pre>	false"	
				SemiHidden="true"		
				UnhideWhenUsed="true"		
				Name="table of figures"/>		
				<pre><w:lsdexception <="" locked="</pre></td><td>false" td=""></w:lsdexception></pre>		
				SemiHidden="true"		
				UnhideWhenUsed="true"	,	
				Name="envelope address"	17	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING 00 COMPLETED B. WING 03/22/201		LETED		
		15K066				/201/
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	Е	
LIFE CAF	RE MEDICAL SOLU	ITIONS INC		TIST DRIVE /ILLE, IN 47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE ROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG			DATE
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				SemiHidden="true"		

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 79 of 129

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	COMPLETED
		15K066	B. WING		03/22/2017
	PROVIDER OR SUPPLIER		25 ART	ADDRESS, CITY, STATE, ZIP CODE FIST DRIVE VILLE, IN 47448	
LIFE CA	RE MEDICAL SOLO		NASHV	TILLE, IN 47446	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				UnhideWhenUsed="true" Name="List"/> <w:lsdexception locked="fi SemiHidden=" name="List Bullet" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fi SemiHidden=" name="List Number" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fi SemiHidden=" name="List 2" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fi SemiHidden=" name="List 3" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fi SemiHidden=" name="List 4" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fi SemiHidden=" name="List 5" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fi SemiHidden=" name="List Bullet 2" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fi SemiHidden=" name="List Bullet 3" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fi SemiHidden=" name="List Bullet 4" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fi SemiHidden=" name="List Bullet 5" true"="" unhidewhenused="true"></w:lsdexception> <m:lsdexception locked="fi SemiHidden=" name="List Bullet 5" true"="" unhidewhenused="true"></m:lsdexception>	false" false" false" false" false" false"

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 80 of 129

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED	
		15K066	B. WING		03/22/2017	
		1	STREET	T ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	CR.		TIST DRIVE		
LIFE CAI	RE MEDICAL SOL	UTIONS INC		VILLE, IN 47448		
(X4) ID		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 APPROPRI	ATE COMP ELITOR	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
				<pre><w:lsdexception locked="f SemiHidden=" name="List Number 2" true"="" unhidewhenused="true"></w:lsdexception></pre>		
				<w:lsdexception <="" locked="f</td><td>alse" td=""></w:lsdexception>		
				SemiHidden="true"		
				UnhideWhenUsed="true"		
				Name="List Number 3"/>		
				<pre><w:lsdexception <="" locked="f</pre></td><td>alse" td=""></w:lsdexception></pre>		
				SemiHidden="true" UnhideWhenUsed="true"		
				Name="List Number 4"/>		
				<pre><w:lsdexception <="" locked="i</pre></td><td>alse" td=""></w:lsdexception></pre>		
				SemiHidden="true"		
				UnhideWhenUsed="true"		
				Name="List Number 5"/>		
				<w:lsdexception 10"="" <="" locked="f</td><td></td></tr><tr><td></td><td></td><td></td><td></td><td>Priority=" qformat="true" td=""><td></td></w:lsdexception>		
				Name="Title"/>	ialco"	
				<pre><w:lsdexception locked="f SemiHidden=" pre="" true"<=""></w:lsdexception></pre>	aisc	
				UnhideWhenUsed="true"		
				Name="Closing"/>		
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				SemiHidden="true"		
				UnhideWhenUsed="true"		
				Name="Signature"/>		
				<pre><w:lsdexception 1"="" locked="1</pre></td><td></td></tr><tr><td></td><td></td><td></td><td></td><td>Priority=" semihidden="tru UnhideWhenUsed=" td="" true"<=""><td>e</td></w:lsdexception></pre>	e	
				Name="Default Paragraph		
				Font"/>		
				<pre><w:lsdexception <="" locked="1</pre></td><td>alse" td=""></w:lsdexception></pre>		
				SemiHidden="true"		
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				Name="Body Text"/>		
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				SemiHidden="true"		
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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066 A. BUILDING 00 B. WING		00	COMPLETED 03/22/2017	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	TIONS INC		/ILLE, IN 47448	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				UnhideWhenUsed="true" Name="List Continue"/> <w:lsdexception locked="fasemiHidden=" name="List Continue 2" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fasemiHidden=" name="List Continue 3" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fasemiHidden=" name="List Continue 4" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fasemiHidden=" name="List Continue 5" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fasemiHidden=" name="Message Header" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fasemiHidden=" name="Message Header" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fasemiHidden=" name="Subtitle" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fasemiHidden=" name="Salutation" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fasemiHidden=" name="Date" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fasemiHidden=" name="Body Text First Indent" true"="" unhidewhenused="true"></w:lsdexception>	alse" alse" alse" alse" alse" alse" alse"

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PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BUILDIN B. WING	NG 00	COME	PLETED 2/2017
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STAT	TE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	ITIONS INC		ARTIST DRIVE SHVILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
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PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER UPS ARTIST DRIVE NASHVILLE, IN 47448 D	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED	
NAME OF PROVIDER OR SUPPLIER LIFE CARE MEDICAL SOLUTIONS INC LIFE CARE MEDICAL SULTIONS INC SUMMASY STATEMENT OF DETICIENCIES PREFIX TAG SUMMASY STATEMENT OF DETICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG NEGULATORY OR LSC IDENTITYING INFORMATION) NAME—CONCERNEEMENT OF CONCERNMENT OF COMPLETION TAG NAME—CONCERNMENT OF CONCERNMENT OF COMPLETION TAG NAME—PROCEDURE OF CONCERNMENT OF COMPLETION TO ACCUMENT OF COMPLETION			15K066	-		03/22/2017
LIFE CARE MEDICAL SOLUTIONS INC (XS) ID SIMMARY STATEMENT OF DEFICIENCIES (ICACH DEFICIENCY MINS THE PRECEDED BY FILL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Name="Document Map"> Name="Plain Text"> Name="HTML Toy of Form"/> Name="HTML Toy of Form"/> Name="HTML Toy of Form"/> Name="HTML Bottom of Form"/> Name="HTML Bottom of Form"/> Name="HTML Bottom of Form"/> Name="HTML Acronym"/> Name="HTML Address"/> Name="HTML Code"/> Name="HTML	NAME OF P	ROVIDER OR SUPPLIER	1			
PRETX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Name="Document Map"/> *w*LsdException Locked="false" Semil-lidden="true" UnhideWhenUsed="true" Name="False" Semil-lidden="true" UnhideWhenUsed="true" Name="HTML Top of Form"/> *w*LsdException Locked="false" Semil-lidden="true" UnhideWhenUsed="true" Name="HTML Top of Form"/> *w*LsdException Locked="false" Semil-lidden="true" UnhideWhenUsed="true" UnhideWhenUsed="true" Name="HTML Top of Form"/> *w*LsdException Locked="false" Semil-lidden="true" UnhideWhenUsed="true" Name="HTML Bottom of Form"/> *w*LsdException Locked="false" Semil-lidden="true" UnhideWhenUsed="true" Name="Normal (Web)"/> *w*LsdException Locked="false" Semil-lidden="true" UnhideWhenUsed="true" Name="Normal (Web)"/> *w*LsdException Locked="false" Semil-lidden="true" UnhideWhenUsed="true" Name="HTML Coronym"/> *w*LsdException Locked="false" Semil-lidden="true" UnhideWhenUsed="true" UnhideWhenUsed="true" Name="HTML Coronym"/> *w*LsdException Locked="false" Semil-lidden="true" UnhideWhenUsed="true" UnhideWhenUs	LIFE CAF	RE MEDICAL SOLU	JTIONS INC			
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					SemiHidden="true" UnhideWhenUsed="true"	

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		IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00	COMPLETED 03/22/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	TIONS INC		IST DRIVE ILLE, IN 47448	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				<pre><w:lsdexception locked="fa" name="HTML Keyboard" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception fa"="" locked="fa" name="HTML Sample" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa" name="HTML Typewriter" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa" name="HTML Variable" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa" name="Normal Table" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa" name="Normal Table" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa" name="annotation subject" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa" name="No List" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa" name="Outline List 1" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa" name="Outline List 1" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa" name="Outline List 2" semihidden="true" unhidewhenused="true"></w:lsdexception> <w:lsdexception <="" locked="fa" p="" semihidden="true"></w:lsdexception></pre>	ulse" "/> ulse" ulse" ulse" slse" slse" slse" slse" slse"

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		IDENTIFICATION NUMBER: 15K066	r i		COMPLETED 03/22/2017	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE MEDICAL SOLU	TIONS INC		IST DRIVE ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				UnhideWhenUsed="true" Name="Outline List 3"/> <w:lsdexception locked="fate SemiHidden=" name="Table Simple 1" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table Simple 2" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table Simple 3" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table Classic 1" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table Classic 2" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table Classic 3" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table Classic 4" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table Colorful 1" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table Colorful 2" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table Colorful 3" true"="" unhidewhenused="true"></w:lsdexception>	ulse" ulse" ulse" ulse" ulse" ulse" ulse"	

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 86 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00	COMPLETED 03/22/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	TIONS INC		/ILLE, IN 47448	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				<pre><w:lsdexception locked="fa SemiHidden=" name="Table Columns 1" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Columns 2" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Columns 3" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Columns 4" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Columns 5" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Grid 1" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Grid 2" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Grid 3" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Grid 3" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Grid 4" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Grid 5" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" p="" true"<=""> SemiHidden="true" UnhideWhenUsed="true" Name="Table Grid 5"/> <w:lsdexception locked="fa SemiHidden=" p="" true"<=""></w:lsdexception></w:lsdexception></pre>	alse" alse" alse" alse" alse" alse" alse"

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 87 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00	COMPLETED 03/22/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	TIONS INC		IST DRIVE ILLE, IN 47448	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				UnhideWhenUsed="true" Name="Table Grid 6"/> <w:lsdexception locked="fate SemiHidden=" name="Table Grid 7" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table Grid 8" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table List 1" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table List 2" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table List 3" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table List 4" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table List 5" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table List 5" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table List 6" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fate SemiHidden=" name="Table List 7" true"="" unhidewhenused="true"></w:lsdexception>	llse" llse" llse" llse" llse" llse" llse"

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 88 of 129

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPI	LETED
		15K066	B. WING			/2017
NAME OF P	ROVIDER OR SUPPLIER	-		ADDRESS, CITY, STATE, ZIP COD	Ē	
LIFE CAF	RE MEDICAL SOLU	ITIONS INC		TIST DRIVE /ILLE, IN 47448		
						0/5
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	IION LD BE	(X5) COMPLETION
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		IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00	COMPLETED 03/22/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	TIONS INC		IST DRIVE ILLE, IN 47448	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				UnhideWhenUsed="true" Name="Table Web 3"/> <w:lsdexception locked="fa SemiHidden=" name="Balloon Text" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception 39"="" locked="fa Priority=" name="Table Grid"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Table Theme" true"="" unhidewhenused="true"></w:lsdexception> <w:lsdexception locked="fa SemiHidden=" name="Placeholder Text" true"=""></w:lsdexception> <w:lsdexception 1"="" locked="fa Priority=" name="No Spacing" qformat="true"></w:lsdexception> <w:lsdexception 60"="" locked="fa Priority=" name="Light Shading"></w:lsdexception> <w:lsdexception 61"="" fa="" locked="fa Priority=" name="Medium Shading 1" priority="63"></w:lsdexception> <w:lsdexception 64"="" locked="fa Priority=" name="Medium Shading 2"></w:lsdexception> <w:lsdexception 65"="" locked="fa Priority=" name="Medium Shading 2"></w:lsdexception> <w:lsdexception 65"="" locked="fa Priority=" name="Medium 1"></w:lsdexception> <w:lsdexception 65"="" locked="fa Priority=" name="Medium Grid 1"></w:lsdexception> <w:lsdexception 67"="" locked="fa Priority=" name="Medium Grid 1"></w:lsdexception> <w:lsdexception al<="" alse"="" locked="fa</td><td>alse" td=""></w:lsdexception>	

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PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00	COMPLETED 03/22/2017
	ROVIDER OR SUPPLIER		25 ART	ADDRESS, CITY, STATE, ZIP CODE FIST DRIVE /ILLE, IN 47448	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Priority="68" Name="Medium Grid 2"/> <w:lsdexception 69"="" locked="fa Priority=" name="Medium Grid 3"></w:lsdexception> <w:lsdexception 70"="" fa="" locked="fa Priority=" name="Colorful Shading" priority="71"></w:lsdexception>	alse" t"/>
				Shading"/>	alse" alse" t alse" id
				<w:lsdexception <="" locked="fa" p=""> Priority="63" Name="Medium Shading 1 Accent 1"/> <w:lsdexception <="" locked="fa" p=""> Priority="64" Name="Medium Shading 2 Accent 1"/> <w:lsdexception <="" locked="fa" p=""> Priority="65" Name="Medium 1 Accent 1"/> <w:lsdexception <="" locked="fa" p=""> SemiHidden="true" Name="Revision"/> <w:lsdexception <="" locked="fa" p=""> Priority="34" QFormat="true" Name="List Paragraph"/> <w:lsdexception <="" locked="fa" p=""> Priority="29" QFormat="true" Priority="29" QFormat="true"</w:lsdexception></w:lsdexception></w:lsdexception></w:lsdexception></w:lsdexception></w:lsdexception>	alse" alse" List alse"

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 91 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15K066	B. WING		03/22/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	•
LIFE CAF	RE MEDICAL SOLU	ITIONS INC		/ILLE, IN 47448	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
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State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 92 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BUILDING B. WING	00	COMPLETED 03/22/2017	
NAME OF P	ROVIDER OR SUPPLIER			TADDRESS, CITY, STATE, ZIP CO	DE	
LIFE CAF	RE MEDICAL SOLU	JTIONS INC		TIST DRIVE VILLE, IN 47448		
(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 CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION (X5 JLD BE COMPLE ROPRIATE DATE	TION
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State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 93 of 129

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	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		15K066	B. WING		03/22/2017
NAME OF P	ROVIDER OR SUPPLIER	<u>. </u>		ADDRESS, CITY, STATE, ZIP CODE	•
	RE MEDICAL SOLU			TIST DRIVE /ILLE, IN 47448	
				T	(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE
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State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 94 of 129

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Shading 2 Accent 4"/>	17
NAME OF PROVIDER OR SUPPLIER LIFE CARE MEDICAL SOLUTIONS INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Shading 2 Accent 4"/>	
LIFE CARE MEDICAL SOLUTIONS INC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 25 ARTIST DRIVE NASHVILLE, IN 47448 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Shading 2 Accent 4"/>	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Shading 2 Accent 4"/>	
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Shading 2 Accent 4"/>	OMPLETION DATE
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State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 95 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		15K066	B. WING		03/22/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	1
				TIST DRIVE	
	RE MEDICAL SOLU			/ILLE, IN 47448	T
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	ON (X5) BE COMPLETION
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State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 96 of 129

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	D PLAN OF CORRECTION DENTIFICATION NUMBER: 15K066 A. BUILDING 00 B. WING		00	COMPLETED 03/22/2017				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
LIFE CAF	RE MEDICAL SOLU	TIONS INC	25 ARTIST DRIVE NASHVILLE, IN 47448					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
				Shading 2 Accent 6"/>	List Ise" List Ise"			

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 97 of 129

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
		15K066	B. WING		03/22/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAF	RE MEDICAL SOLU	ITIONS INC		TIST DRIVE /ILLE, IN 47448	
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(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE	(X5) COMPLETION
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State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 98 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 15K066 A. BUILDING 00 B. WING		COMPLETED 03/22/2017					
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
LIFE CAF	RE MEDICAL SOLU	TIONS INC	25 ARTIST DRIVE NASHVILLE, IN 47448					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
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State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 99 of 129

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				COMPLETED 03/22/2017				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
LIFE CAF	RE MEDICAL SOLU	TIONS INC	25 ARTIST DRIVE NASHVILLE, IN 47448					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				Priority="49" Name="Grid Tab Accent 2"/>	alse" alse alse" alse alse alse alse alse alse alse alse			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED	
		15K066	B. WING		03/22/2017	
			STREET	T ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R		TIST DRIVE		
LIFE CAI	RE MEDICAL SOL	UTIONS INC		VILLE, IN 47448		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
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				Name="Grid Table 7 Colorfe	ul	
				Accent 4"/>		
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				Priority="46"		
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Diag. 00		The home health agency				
		all employees, staff				
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	patient contact a					
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		vith a negative history of				
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			LETED	
		15K066	B. WING 03/22/2017				/2017
			'	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8	25 ARTIST DRIVE				
LIFE CAF	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		tep of a two-step tuberculin					
	•	Mantoux method must be					
		(1) to three (3) weeks after					
	the first tuberculin	skin test was					
	administered.	ith:					
	(3) Any person wi						
	(i) history of tuber						
	(ii) previously posi						
	tuberculosis; or						
	(iii)completion of to	reatment for tuberculosis;					
	(B) newly positive	e results to the tuberculin					
	skin test;						
		chest rediograph to					
	exclude a diagnos	testing, tuberculosis					
	screening must:	testing, tuberculosis					
	(A) be completed	annually: and					
		ninimum, a tuberculin skin					
	test using the Mar						
		say unless the individual					
	was subject to sub	` '					
		aving a positive finding on					
	a tuberculosis eva	-					
		ome health agency; or					
	(B) provide direct						
		by a physician to work. Alth agency must maintain					
		tuberculosis evaluations					
	showing that any						
		e home health agency; or					
	(B) having direct						
	has had a negativ	e finding on a tuberculosis					
	examination withir	n the previous twelve (12)					
	months.						
			N 04	64	The form for recording the	Latina	03/23/2017
	Based on record	review and interview,			placement and results of TB skin		
	the agency failed	to implement its policy			testing has been revised	ta	
		ulosis (TB) skin testing			(3/23/2017) to provide separate spaces for the date and time. It is		
	1314104 10 140010				spaces for the date and time.	11.13	

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 102 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	ONSTRUCTION	(X3) DATE COMPL		
ANDILAN	or connection	15K066	B. W		00	03/22/	
		1511000			A DDDEGG CITY CTATE ZID CODE	OOIZZI	2017
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE IST DRIVE		
LIFE CAI	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·	+	TAG		ill	DATE
	to evaluate tuberculosis status for 2 of 6 direct care providers whose personnel file				result in complete filling of the	anticipated that this change will result in complete filling of the	
	_	-			form. Forms will be audited by	the	
	`	Employees A and B) of a			Manager of Human Resource		
	total of 77 direct	care provider			her designee at the end of each placement and each reading to		
	employees.				ensure that this deficiency is	J	
	The findings inc	luded:			corrected and will not recur.		
	1. Policy, "Healt	th Screening,", last					
	reviewed/revised	d 1-11-17, was reviewed					
	and stated, "Eacl	h employee having direct					
	contact with pati	ients must have					
	documentation of	of baseline health					
	screening prior t	o providing care to					
	patients On ar	ny employee or contract					
	personnel provid	ling direct patient care,					
	there shall be do	cumentation of					
	completion of a	tuberculin (TB) skin test,					
	via the Mantoux	method using two-step					
	testing a Man	toux skin test will be					
	given at the time	e of hire and repeated					
	within three wee	eks of the first test TB					
	skin tests shall b	•					
	Registered Nurse	e or Licensed					
		onal Nurse, within					
		venty-two (48-72) hours					
	and documented	as "non-significant"					
		gnificant" (positive) in					
	millimeters of in	duration."					
		or Preventing the					
	Transmission of	-					
		Health -Care Settings",					
	Volume 54, Page	e 46, Recommendations					

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PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUIL		NSTRUCTION	(X3) DATE : COMPL		
ANDILAN	OF CORRECTION	15K066	B. WING		00	03/22/	
		1511000				03/22/	2017
NAME OF I	PROVIDER OR SUPPLIEF	8			DDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE MEDICAL SOLU	JTIONS INC	25 ARTIST DRIVE NASHVILLE, IN 47448				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		2005, was reviewed and					
		erculin skin test should be					
		ated, trained health care					
		ours after the tuberculin					
	_	d. If the tuberculin skin					
		between 48-72 hours,					
		tuberculin skin test					
	_	l as soon as possible and					
	read within 48-7	2 hours."					
	3. The personne	el file of employee A, was					
	•	idenced employee A was					
		ered nurse on 1-18-17,					
	_	patient contact of					
	1-18-17. The co	onfidential health file of					
	employee A con	tained a TB skin test					
	report which evi	denced a TB skin test					
	was administere	d on 1-3-17, at 10 AM,					
	and was read on	1-5-17, the time of					
	reading failed to	be documented, with a					
	result of 0 millin	neters, negative. The					
	form evidenced	a second step TB skin					
	test was adminis	tered on 1-11-17, the					
	time of administ	ration failed to be					
	documented, and	d was read on 1-13-17,					
	the time of readi	ng failed to be					
	documented, res	ult of 0 millimeters.					
	4. The personne	el file of employee B, was					
	_	idenced employee B was					
		ed practical nurse on					
		late of first patient					
	contact of 10-24	-16. The confidential					
	health file of em	ployee B contained a TB					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED			
ANDIEAN	or connection	15K066	B. WING	00	03/22/2017		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448				
,			ID	T	(V5)		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE		
	skin test report was administrated to be docu of millimeters. The evidence the time 2-1-17, and failed reading on 2-3-1 to evidence a second been administrated by agent test result of 2-3-1 months after the first patient contact.	which evidenced a TB ministered on 2-1-17, and 17, the time of reading mented, with a result of the form failed to e of administration on d to evidence the time of The health file failed cond step TB skin test stered and read three first step TB skin test, as tecy policy. The TB skin the table to the time of the failed to the ti					
	skin test reports accordance with	ted the above cited TB were not documented in agency policy. The ted there was no further o review.					
N 0486 Bldg. 00	shall coordinate its						
	Based on observinterview, the ag	ation, record review and ency failed to ensure the rease conference notes	N 0486	The DON and ADON will inservice the LCMS nursing st on 04/13/17 regarding the necessity of documenting coordination of care between	04/13/2017		

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PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLI		ETED		
		15K066	B. W	ING		03/22/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	₹		25 ART	IST DRIVE		
	RE MEDICAL SOLU	JTIONS INC		NASHV	ILLE, IN 47448		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	themselves and other health c	oro	DATE
		results of coordination of			providers in Communication	ale	
		etween the agency and an			notes and Recertification		
	_	for 5 of 6 patients who			documentation at least once p	er	
		om more than one agency,			episode (to include frequency		
	_	e of 10 clinical records			discipline where indicated). Te		
	reviewed (Patier	nt #1, 4, 6, 7, and 10).			percent of the clinical records be audited for compliance each		
	The findings inc	luded:			be audited for compliance each quarter. The DON and ADON will be responsible for monitoring the corrective actions during		
	1. A policy title	d "Coordination of			QA/clinical record review to		
		," last reviewed/revised			ensure this deficiency is correct and will not recur.	cted	
	1-11-17, stated, "All personnel furnishing				and will not recur.		
		aintain liaison to assure					
	that their efforts						
		support the objectives					
	1	lan of Care. This may be					
		rmal case conferences,					
		iplete, current Care					
	Plans, and writte	-					
	interaction."	on and verbar					
	interaction.						
	2 The clinical :	record of patient #1, start					
		-1-17, was reviewed and					
		cian's written plan of					
		fication period of 2-1 to					
	4-1-17.						
		nome visit observation of					
	_	cal nurse (LPN) on 3-20-					
		a registered nurse from					
		care agency, person H, a					
	_	, was observed in the					
	home. Person A	indicated making skilled					
	nursing visits fo	r wound care, foley care,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COMPL	(X3) DATE SURVEY COMPLETED 03/22/2017	
	F PROVIDER OR SUPPLIEI		25 AR	ADDRESS, CITY, STATE, ZIP CODE TIST DRIVE VILLE, IN 47448	•	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
TAU	and managemen PT/INR (Prothro International No [blood tests to m Person A indica morning visits a spoken with age person A was de was arriving. B. Review notes, and comm evidence docum coordination of the two agencies documentation of when person A a communicated. C. On 3-22 nursing supervis record documen documentation of care activities stated morning i document specifi activities for pat conference had i 3. The clinical i of care date of 9 and included a p	t of anticoagulation ombin Time and ormalized Ratio) lab tests leasure blood thinning]. Ited having made early and occasionally having leaving the plan of care, wisit munication notes, failed to leaving the results of leare activities between to to include of the information shared				DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		A. BU	A. BUILDING 00 B. WING			COMPLETED 03/22/2017	
NAME OF F	PROVIDER OR SUPPLIER	-			DDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	evidenced patient care services from The plan of care communication of documentation of coordination of the two agencies. B. On 3-22-nursing supervisity record document coordination of cadministrator standers and case of document specific activities for patients. 4. The clinical roof care date of 3-included a physician care for the certification. A. Review of evidenced patient care services from The clinical reconders, and case of to evidence documents.	notes, failed to evidence of the results of care activities between and the control of the care activities. The care activities. The care activities. The care activities and the coordination of care care activities are notes did not coordination of care care activities are notes did not care care activities are notes and care care activities are notes are notes are notes are notes, failed amentation of the results of care activities between					

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 108 of 129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15K066	B. W	ING		03/22/	2017
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	· ·		25 ART	IST DRIVE		
	RE MEDICAL SOLU			<u> </u>	ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		17 at 4:00 PM, the					
		sor stated the clinical					
	record documentation failed to evidence						
	coordination of care activities. The						
	administrator stated morning meeting						
	notes and case conference notes did not						
	document specific coordination of care						
	activities for pat	ient #6.					
	•						
	5. The clinical	record of patient #7, start					
		-20-15, was reviewed on					
		luded a physician's					
		eare for the certification					
	period of 2-8 to						
	period of 2-6 to	4-0-17.					
	Δ Review	of the plan of care					
		nt #7 received services					
	_	agency. The clinical					
		• •					
		ication notes, visit notes,					
		ence notes, failed to					
		entation of the results of					
		care activities between					
	the two agencies	S.					
	B On 3-22-	17 at 4:00 PM, the					
		sor stated the clinical					
		tation failed to evidence					
		care activities. The					
		ated morning meeting					
		onference notes did not					
	_	fic coordination of care					
	activities for pat	ient #7.					
	6 The clinical r	record of patient #10,					
	o. The chineal f	ccord or patient #10,	1				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/22/2017
	ROVIDER OR SUPPLIER		25 ART	ADDRESS, CITY, STATE, ZIP CODE IST DRIVE /ILLE, IN 47448	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		cluded a physician's are for the certification			
	evidenced patient care services from The clinical reco- visit notes, and co- failed to evidence	of the plan of care at #10 received attendant an an outside agency. rd communication notes, ase conference notes, e documentation of the nation of care activities agencies.			
	nursing supervisorecord document coordination of cadministrator standard case co	17 at 4:00 PM, the or stated the clinical ration failed to evidence eare activities. The ted morning meeting onference notes did not ic coordination of care tent #10.			
N 0522 Bldg. 00	a written medical p	Medical care shall follow blan of care established eviewed by the physician, or, optometrist or	N 0522	The procedures for SOC, ROC	04/13/2017

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	TED
		15K066	B. W	ING		03/22/2	017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			IST DRIVE		
LIFE CAI	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		review and interview,			and Re-Certification have been	n	
	the agency failed	d to implement its policy			reviewed by the ADON. The procedures have been revised	to	
	related to provid	ling care only when			include obtaining verbal orders		
	orders from the	attending physician had			prior to providing care. Verbal		
	been obtained for	or 10 of 10 patients whose			orders will include the SOC/RO		
	clinical record w	vas reviewed (Patients			date, disciplines, frequencies		
	#1-10).	`			specific orders for care. Verba orders will be documented in t		
	,				clinical record, signed and date		
	The findings inc	luded:			by the RN and faxed to the		
					ordering physician for		
	1 Policy "Plan	of Care " last			countersignature. The DON ar		
	1. Policy, "Plan of Care," last reviewed/revised 1-11-17, was reviewed				ADON will conduct in-services		
					and provided written instructio		
	· ·	me care services are			RNCMs regarding the revision (4/13/17). The DON, ADON are		
		the supervision and			designee will review all SOCs,		
	direction of the p	patient's physician."			ROCs and Re-Certifications to		
					ensure compliance as part of t	he	
	2. Policy, Phys	ician Orders," last			regular QA process.		
	reviewed/revised	d 1-11-17, was reviewed					
	and stated, "All:	medications, treatments,					
	and services pro	vided to patients must be					
	_	vsician. The orders may					
		elephone or in writing					
		ntersigned by the					
	physician in a til	• •					
	physician in a th	mery manner.					
	3 The clinical	record of patient #1 was					
		•					
		of care date of 2-1-17, and					
	•	of care with orders for					
	respite skilled nu	ursing services.					
	Δ Ρονίου	of the start of care					
		assessment/OASIS dated					
	_						
	· ·	ed care was coordinated					
	with the attendir	ng physician. On 3-20-17					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: X2) MULTIPLE CONSTRUCTION A. BUILDING 00	(X3) DATE SURVEY COMPLETED
15K066 B. WING	03/22/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	00/22/2011
LIFE CARE MEDICAL SOLUTIONS INC 25 ARTIST DRIVE NASHVILLE, IN 47448	
	ave)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATION TAG DEFICIENCY)	DATE
at 3:30 PM, the nursing supervisor stated	
the comprehensive assessment was not	
sent to the attending physician and did	
not evidence physician orders for the care	
of patient #1.	
B. Review of physician's orders	
failed to evidence a physician's verbal	
orders related to disciplines, frequency of	
visits, and specific physician orders for	
the care of patient #1.	
C. Review of visit notes evidenced	
skilled nursing care was furnished on 2-2	
and 2-7-17.	
D. Review of the document history	
of the electronic medical record system	
evidenced the plan of care was created on	
2-3-17, finalized and faxed to the	
attending physician on 2-9-17, and signed	
by the attending physician on 2-9-17.	
4. The clinical record of patient #2, start	
of care date of 1-24-13, was reviewed	
and contained a plan of care for the	
certification period 3-4 to 5-2-17, with	
orders for skilled nursing and home health aide services.	
ileatui aide sei vices.	
A. Review of the recertification	
comprehensive assessment/OASIS dated	
3-1-17, evidenced care was coordinated	
with the attending physician. On 3-20-17	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		ľ í	UILDING	00	COMPL 03/22/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF		•		DDRESS, CITY, STATE, ZIP CODE	•	
LIFE CA	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
	the comprehensi	nursing supervisor stated ve assessment was not ling physician and did vsician orders for the care					
	failed to evidence related to disciple and specific care recertification as after expiration of	of physician's orders the physician verbal orders tines, frequency of visits, to orders based on the tisessment of patient #2, to f the previous od orders on 3-3-17.					
	b. Review evidenced the pl signed by the att	of visit notes evidenced turnished care on 3-6-17. of the plan of care an of care orders were ending physician on 3-7-					
	of care date of 3 and contained a	record of patient #3, start -13-17, was reviewed plan of care with orders ng and home health aide					
	comprehensive a 3-13-17, evidence coordinated with On 3-20-17 at 3:	of the start of care assessment/OASIS dated and evidenced care was a the attending physician. 30 PM, the nursing I the comprehensive					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BUILDING 00 B. WING			COMPLETED 03/22/2017	
NAME OF I	PROVIDER OR SUPPLIER		•	1	DDRESS, CITY, STATE, ZIP CODE		
LIFE CAI	RE MEDICAL SOLU	ITIONS INC			ST DRIVE ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		not sent to the attending d not evidence physician re of patient #3.					
	failed to evidence related to disciple	of physician's orders e physician verbal orders ines, frequency of visits, corders based on the tient #3.					
	document history medical record s of care was creat finalized and fax physician on 3-2 survey on 3-22-1	of the plan of care y in the agency electronic ystem evidenced the plan ted on 3-17-17, and was ted to the attending 0-17. At time of exit of 17, the plan of care had ted by the attending					
	of care date of 9- and contained a certification peri	ecord of patient #4, start -15-15, was reviewed plan of care for the od 2-5 to 4-5-17, with I nursing and home ces.					
		of the recertification assessment/OASIS dated					

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	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BU	A. BUILDING 00 B. WING		COMPLETED 03/22/2017	
NAME OF	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LIFE CA	RE MEDICAL SOLU	JTIONS INC			ST DRIVE ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	with the attendin at 3:30 PM, the i the follow-up co	ed care was coordinated ag physician. On 3-20-17 nursing supervisor stated mprehensive assessment he attending physician.					
	failed to evidence related to disciple and specific care recertification as after expiration of	of physician's orders the physician verbal orders tines, frequency of visits, to orders based on the the sessment of patient #4 of the previous od orders on 2-4-17.					
		of visit notes evidenced a e furnished care on 2-6-					
	document history medical record s of care was creat finalized and fax physician on 2-8	of the plan of care y in the agency electronic ystem evidenced the plan ted on 2-6-17, was ted to the attending -17, and was signed by ysician on 2-9-17.					
	of care date of 1 and contained a certification period with orders for s A. Review	record of patient #5, start 1-15-16, was reviewed plan of care for the od of 1-14 to 3-14-17, killed nursing services. of the recertification assessment/OASIS, dated					

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PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BUILDING 00 B. WING			COMPLETED 03/22/2017	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
LIFE CAI	RE MEDICAL SOLU	ITIONS INC			IST DRIVE ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	with the attendin at 3:30 PM, the 1	red care was coordinated g physician. On 3-20-17 nursing supervisor stated we assessment was not ling physician.					
	failed to evidence related to disciple and specific care recertification as after expiration of	of physician's orders e physician verbal orders ines, frequency of visits, orders based on the sessment of patient #5 of the previous od orders on 1-13-17.					
	skilled nursing for 15, 1-16, and 1-1	of visit notes evidenced arnished care on 1-14, 1- 7-17, prior to return of with physician signature					
	of care date of 3- contained a plan	record of patient #6, start -6-17, was reviewed and of care with orders for nd home health aide					
	comprehensive a 3-14-17, evidence with the attendin at 3:30 PM, the rather comprehensions sent to the attendary.	of the start of care assessment/OASIS dated and care was coordinated ag physician. On 3-20-17 aursing supervisor stated assessment was not aling physician and did assician orders for the care					

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 116 of 129

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE (A. BUILDING B. WING	OONSTRUCTION OO	(X3) DATE S COMPL 03/22/	ETED
NAME OF I	PROVIDER OR SUPPLIEF	·		T ADDRESS, CITY, STATE, ZIP CODE	•	
LIFE CAI	RE MEDICAL SOLU	JTIONS INC	NASH	VILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	of patient #6.					
	failed to evidend orders related to	of physician's orders the physician verbal disciplines, frequency of fic care orders based on of patient #6.				
	home health aid 3-14, 3-15, 3-17	of visit notes evidenced es had furnished care on , 3-18, 3-20, 3-21, and 3- lled nursing visit was 7.				
	document histor medical record s of care was crea	of the plan of care y in the agency electronic system evidenced the plan ted on 3-20-17, and was ted to the attending 12-17.				
	of care date of 4 and contained a	record of patient #7, start -20-15, was reviewed plan of care for the od of 2-8 to 4-8-17.				
	comprehensive a evidenced care v attending physic PM, the nursing follow-up compre	of the recertification assessment dated 2-7-17, was coordinated with the ian. On 3-20-17 at 3:30 supervisor stated the rehensive assessment was stending physician.				

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 117 of 129

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15K066	B. W	ING		03/22/	2017
NAME OF I	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				25 ART	IST DRIVE		
	RE MEDICAL SOLU	JTIONS INC		NASHV	ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
		of physician's orders					
		ce physician verbal orders					
	related to disciplines, frequency of visits,						
	and specific care orders based on the						
	follow-up assessment of patient #7 after						
	the expiration of	the physician orders on					
	the previous cert	tification period which					
	expired on 2-7-1	7.					
	C. Review	of visit notes evidenced					
	care was furnish	ed on 2-8 and 2-9-17.					
	D. Review of the plan of care						
		tending physician signed					
		orders on 2-14-17.					
	life plan of care	014015 011 2 11 17.					
	9. The clinical r	record of patient #8, start					
		-11-17, was reviewed					
		plan of care with orders					
		ng and home health aide					
	services.	ing and nome nearth arec					
	Scr vices.						
	Λ Ρουίουν	of the start of care					
		assessment/OASIS dated					
	_						
		ced care was coordinated					
		ng physician. On 3-20-17					
		nursing supervisor stated					
	_	ve assessment was not					
		ding physician and did					
		ysician orders for the care					
	of patient #8.						
		of physician's orders					
	failed to evidence	ce physician verbal orders					

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 118 of 129

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT		NSTRUCTION 00	(X3) DATE COMPL		
		15K066	B. WING		<u>00</u>	03/22/	
	PROVIDER OR SUPPLIER		2	25 ARTI	DDRESS, CITY, STATE, ZIP CODE ST DRIVE LLE, IN 47448		
	1						(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	related to discipl	lines, frequency of visits,					
	and specific care	e orders based on the					
	assessment of pa	tient #8.					
	C. Davison	-C:-:4					
		of visit notes evidenced e visits were furnished on					
		, 1-26, 1-27, 1-28, 1-29,					
		2-2, 2-3, 2-4, and 2-5-17,					
		ng care was furnished on					
	1-14-17 and 1-30	· ·					
		of the plan of care					
		tending physician signed					
	the plan of care	orders on 2-6-17.					
	10 The clinical	record of patient #9,					
		of 3-13-17, was					
		ntained a plan of care					
	with orders for h	ome health aide services.					
		of the start of care					
		assessment dated 2-7-17,					
		vas coordinated with the					
		ian. On 3-20-17 at 3:30 supervisor stated the					
	_	assessment was not sent					
	_	physician and did not					
		ian orders for the care of					
	patient #9.						
	B. Review of	of physician's orders					
		e physician verbal					
		disciplines, frequency of					
		fic care orders based on					

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 119 of 129

PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15K066	A. BUILDING 00 B. WING			COMPLETED 03/22/2017	
NAME OF P	ROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
LIFE CAF	RE MEDICAL SOLU	ITIONS INC			IST DRIVE ILLE, IN 47448		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	C. Review of home health aided 3-14, 3-15, and 3 D. Review of evidenced the attemption of care of the plan of care date reviewed and control the certification of 2-7-17, with order and home health. A. Review of comprehensive at 12-9-16, evidence with the attending at 3:30 PM, the properties of the certification of the previous plant of the previous	f patient #9. f visit notes evidenced e visits were furnished on 3-16-17. of the plan of care tending physician signed orders on 3-22-17. record of patient #10, of 10-2-13, was ntained a plan of care for period of 12-10-16 to ers for skilled nursing aide services. of the recertification assessment/OASIS dated eed care was coordinated g physician. On 3-20-17 nursing supervisor stated we assessment was not		IAU			DATE

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PRINTED: 04/17/2017 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K066	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY PLETED 22/2017		
NAME OF PROVIDER OR SUPPLIER LIFE CARE MEDICAL SOLUTIONS INC			STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448					
(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 CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	care was furnish on 12-11-16, by skilled nurse on furnished by a his skilled nurse on D. Review evidenced the at signed the plan of 12-14-16. 12. On 3-22-17 supervisor stated furnished care to without first obtatorders for the disvisits, and specific order or written assessment, and	of the plan of care tending physician had						
N 0524 Bldg. 00	plan of care shall: (A) Be developed home health agen	(1) As follows, the medical in consultation with the acy staff. rvices to be provided if a being provided. inent diagnoses.						

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 121 of 129

STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	SURVEY	
AND PLAN OF CORRECTION IDI		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED	
		15K066	B. WING 03/22/2017			/2017	
NAME OF F	DROVIDED OD GUDDUIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				25 ART	IST DRIVE		
	RE MEDICAL SOLU				'ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		rvices and equipment					
		and duration of visits.					
	(iv) Prognosis.						
	(v) Rehabilitation	-					
	(vi) Functional li						
	(vii) Activities pe (viii) Nutritional re						
	1	s and treatments.					
	` '	measures to protect					
	against injury.						
		for timely discharge or					
	referral.	dalities specifying length of					
	treatment.	danties specifying length of					
	(xiii) Any other ap	ppropriate items.	N 0524				
					The DON will inservice all RN		04/13/2017
	Based on observ	ration, record review and			case managers (04/13/17) on the		
		gency failed to ensure the			development and completion of the POC, ensuring that all	of	
	_	tained orders for oxygen			treatments, equipment,		
	1 ^	2 patients with home			medications and disciplines are		
		s who were receiving			documented on the POC and		
		(Patients #4 and 5), of a			followed. The DON and ADON		
	1	visit observations.			will ensure that the plan of car		
	total of 5 Home	viole observations.			contains all required elements including but not limited to ord		
	The findings included:				for O2 with correct dosage, frequency and route of		
	1. Policy, "Plan	of Care," last			administration. Each patient w be checked for O2 (with lpm,	III	
		d 1-11-17, was reviewed			frequency and route) on their r	med	
		individualized Plan of			list by the DON and ADON du		
	,				QA/quality review of recertifica	ition	
	Care signed by a physician shall be required for each patient receiving home				documentation.		
	_	s. The Plan of Care shall					
	_	full to include: a. All					
		sis(es), principle and					
	secondary, inclu	ding date of onset. b.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 0		(X3) DATE SURVEY COMPLETED
	15K066	B. WING	<u> </u>	03/22/2017
NAME OF PROVIDER OR SU		STREET ADDR 25 ARTIST NASHVILLE		
PREFIX (EACH DE	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Mental Star duration of Medication t. Other 2. During a registered registered registered to per minute the plan of physician of setting and 3. During RN for pating patient #5 with the the cert 3-14-17, far order for order for order method of 6. 4. On 3-22 supervisor and stated to	us. c. Type, frequency, and all visits/services 1. s, treatments, and procedures appropriate items." Thome visit observation of a turse (RN) for patient #4 on 0 AM, patient #4 was be using oxygen at 2 liters by nasal cannula. Review of care failed to evidence a reder for oxygen, to include method of delivery. The home visit observation of an ent #5 on 3-21-17 at 12 noon, was observed to have oxygen tracheotomy collar at 2 liters. Review of the plan of care fication period of 1-14 to led to evidence a physician ygen, to include setting and	CF CF	ROSS-REFERENCED TO THE APPROPRIA	AIE
oxygen the administrat	apy orders. The or stated there was no further ion to be reviewed.			

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 123 of 129

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	NSTRUCTION	(X3) DATE S	(3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPL			ETED		
15K066		15K066	B. WING 03/22/2017			2017		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIER				IST DRIVE			
LIEE CAE	DE MEDICAL SOLL	ITIONS INC			ILLE, IN 47448			
LIFE CARE MEDICAL SOLUTIONS INC				INACIIV	ILLE, IN 47440			
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
N 0537 Bldg. 00	shall provide nursi registered nurse on nurse in accordance care as follows: Based on observer interview, the agaregistered nurse the patient's med in accordance with according to the of 5 patients with (Patient #4) of a whose clinical results. The findings includes the reviewed and start medications will	The home health agency ng services by a r a licensed practical ce with the medical plan of ation, record review, and ency failed to ensure the dispensed medications in ication set up container th agency policy and plan of care orders for 1 in home visit observations sample of 10 patients becords were reviewed. It dided: It dided: It dided: It was ted, "staff setting up	N 0	537	The DON will inservice all RN case managers (04/13/17) on development and completion of the POC, ensuring that all treatments, equipment, medications and disciplines and documented on the POC and followed. The DON and ADON will ensure that the plan of carcontains all required elements including but not limited to all medications (including OTC) worrect dosage and route of administration. During placement of medication sets, all nurses where the medication before placement in the organizer. The is already a component of the LCMS procedure (C-701). Nurwere instructed on the proceduto use if there is a discrepancy between the dosage of a	of e e vith ent vill e of is ses ure	04/13/2017	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> COMPLETED			ED
15K066		B. WING 03/22/2017)17	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L			IST DRIVE		
	RE MEDICAL SOLU	JTIONS INC			ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	re C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		pharmacy labels carefully			medication on the med list and the dosage of the medication		
		s filling a med planner or			available in the home (e.g. call		
		e medication. The nurse			MD for recommendation and/o		
	should then com	pare the medication			verbal order). This teaching wi	II .	
	labels to the 485	, medication list, and/or			be done on an annual basis to		
	MAR [medication	on administration record]			ensure continued compliance.		
	-	ring the medication or					
	filling the med p						
	<i>S p</i>						
	2 The clinical r	ecord of patient #4, start					
		-15-15, was reviewed on					
		inical record evidenced a					
		of care with a start of					
		and certification 10-14					
	· ·	h orders for skilled					
	nursing services.						
	A. During a	home visit observation					
	of a registered n	urse (RN) on 3-21-17 at					
	10 AM, the regis	stered nurse was					
	_	ense 400 mg Guaifenesin					
	_	atient #4' medication set					
	up container.						
	ap comunion.						
	B. Review	of the plan of care					
	medication order	rs evidenced Guaifenesin					
	600 mg oral tabl	et, 1 tablet, two times a					
	day, orally.	•					
		t 2:00 PM, the nursing					
		ated the registered nurse					
	failed to compar	e the medication label					
	with the medicat	ion order, as required by					
		ensure the correct					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15K066		A. BUILDING B. WING	00	COMPLETED 03/22/2017			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 25 ARTIST DRIVE NASHVILLE, IN 47448				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
N 0542 Bldg. 00	dosage of the Gudispensed in patiset up container. 410 IAC 17-14-1(a Scope of Services Rule 14 Sec. 1(a) services are limite purposes of practisetting, the register following: (C) Initiate the plarevisions. Based on observinterview, the reginitiate necessary care to obtain or gastrostomy tube patient's tracheot patient home obsate a gastrostomy tutuse (Patient #5)	aifenesin had been ent #4's the medication	N 0542	On 04/13/17, the DON will inservice all RN case manage on the development and completion of the POC, ensur that all treatments, equipment medications and disciplines a documented on the POC and followed. The DON and ADOI will ensure that the plan of car contains all required elements including but not limited change tracheostomy and gastrostom tube dressings. Each patient be checked for change of	o4/13/2017 ers ring t, re N re s ging ny		
	The findings inc	luded:		tracheostomy and/or gastrost dressings orders by the DON ADON during QA of the recertification process.			

State Form Event ID: EGYK11 Facility ID: 012412 If continuation sheet Page 126 of 129

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE				
15K066		B. W	ING		03/22/2	2017	
NAME OF B	DOWNER OF CHIRD IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			25 ART	IST DRIVE		
	RE MEDICAL SOLU				ILLE, IN 47448		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	_	ne visit observation of an			Note that there was an appare		
		5 on 3-21-17 at 12 noon,		misunderstanding between one of our nurses and the surveyor. The			
	_	bserved to have a			surveyor believed that the nurs		
	tracheotomy and	a gastrostomy tube.			told her that she changed the		
	certification peri failed to evidence the tracheotomy	of the plan of care for the od of 1-14 to 3-14-17, e a physician order for tube to be changed each or the gastrostomy tube to 2 months.		told her that she changed the gastrostomy tube. Our nurses NOT change gastrostomy tube believe that the nurse was tryir to convey that she changes the gastrostomy tube dressing.			
	E, the registered 21-17 at 12 noon having changed tracheotomy tube of care date of 122. On 3-22-17 at	nterview with employee nurse in the home, on 3- n, the employee indicated the gastrostomy tube and e 2 months after the start 1-15-16.					
	_	ated updating the plan of					
		ysician orders to change					
	•	tube and gastrostomy					
	tube periodically						
N 0614	410 IAC 17-15-1(d	c)					
Bldg. 00	loss or unauthorize procedures shall g	e safeguarded against					

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		X1) PROVIDER/SUPPLIER/CLIA			INSTRUCTION	(X3) DATE	
		IDENTIFICATION NUMBER:	A. B. B. W	JILDING INC	00	COMPL	
		15K066	B. W	ing		03/22	/2017
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
					IST DRIVE		
LIFE CA	RE MEDICAL SOLU	JHONS INC		NASHV	ILLE, IN 47448		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nt's written consent shall					
	•	ease of information not . Current service files shall					
	_	the parent or branch office					
		rvices are provided until					
	•	harged from service.					
		be stored away from the					
		office provided they can be ice within seventy-two (72)					
		s do not become current					
	service files if the	patient is readmitted to					
	service.						
			N 0	614			04/13/2017
		review and interview,					
		d to ensure staff did not					
	retain clinical do	ocumentation from a					
	previous episode	e of care in the active					
	clinical record for	or 1 of 1 patients who had					
	been discharged	and then readmitted					
	(Patients #3) in a	a total sample of 10					
	patients.						
	The findings inc	luded:					
	1. Review of the	e clinical record of					
	patient #3 evide	nced a start of care date					
	•	riew of the paper portion					
		cord evidenced clinical					
		tation to include a home					
	health aide care						
		rral form dated 10-2-15;					
		ayer verification dated					
		ne environment safety					
	-	11-11-15; a patient					
		, *					
	_	le dated 11-11-15; an					
	aumission servic	ee agreement dated					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
15K066			B. WING		03/22/2017
NAME OF I	PROVIDER OR SUPPLIE	ER.	STREET	ADDRESS, CITY, STATE, ZIP CODE	
				TIST DRIVE	
LIFE CARE MEDICAL SOLUTIONS INC			NASH\	/ILLE, IN 47448	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	RIATE
TAG	•	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ne health advance			
	1	ice dated 11-11-15; an			
	_	ect vulnerability			
	assessment date	ed 11-11-15; and a notice			
	of privacy right	ts dated 11-11-15.			
	2. On 3-21-17,	the nursing supervisor			
	and the case ma	anager registered nurse,			
	employee G, st	ated patient #3 had been			
		3-4-17,9 days prior to the			
	_	care date of on the plan of			
		and the above noted			
	· · · · · · · · · · · · · · · · · · ·	ne active clinical record			
	were from a previous episode of care,				
	now closed.				

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