PRINTED: 09/13/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _				C 1 16/2018
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	, 00,	10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	INITIAL COMMENTS		G	000			
	Recertification survey - 8/16/18. A complain	a Federal Home Health with survey dates of 8/7/18 at was investigated during ey was fully extended on					
	Survey dates: 8/7/18	- 8/16/18					
		5734: Complaint was al deficiencies related to the Unrelated deficiencies					
	Facility ID: 011556						
	Provider #: 15K070						
	Medicaid #: 2010221	00					
	year 16 active pat	ted skilled patients for past ients atients in past 6 months					
	own home health train evaluation for a period 8/17/18 - 8/17/2020 d compliance with the CCFR 484.50 Patient F Planning, Coordinatio Quality Assessment / 484.70 Infection prevents of the coordinate of the coordi	d of two years beginning ue to being found out of Conditions of Participation Rights; 484.60 Care in, Quality of Care; 484.65 performance improvement; ention and control; 484.75 dervices; 484.105 ininistration of Services; and					
G 406	Patient rights		G 4	406			

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

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						С	
		15K070	B. WING _			08/	16/2018
NAME OF PI	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
TMC HOM	E HEALTH CARE INC			224	W JEFFERSON BLVD STE 200		
I WIG HOW	IE HEALTH CARE INC			SC	OUTH BEND, IN 46601		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
G 406	6 Continued From page 1		G 4	406			
	CFR(s): 484.50						
	right to be informed of language and manne. The HHA must proted of these rights. This CONDITION is a Based on record reviagency failed to ensure presentatives received the Patient Bill of Right Agreement, and Acknotice of Privacy Right treatment (See G 410 patients / patient reproduced from the health agency abusiness address, an order to receive compensure written notice responsibilities was produced from the initial asset to ensure the patient the right to be informed transfer and discharge ensure the home health appropriate transwhen the needs of the HHA's capabilities (See G 46 complaint made by a representative (See G 46 complaint made patients).	owledgement Forms, and onts before the initiation of all; failed to ensure the esentatives received the administrator's name, d business phone number in plaints (see G 414); failed to of the patient's rights and rovided within 4 business essment (see G 422); failed and for the HHA's policy for esee G 452); failed to lith agency arranged a safe fer to another care entities espatient exceeded the ese G 454); failed to ensure and the legal formed in advance of a 44); failed to investigate the patient's legal 6 478); and failed to ce of a complaint made by resentative and the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				C 16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		1 001	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 406	resulted in the home ensure the provision safe environment for 42 CFR 484.50 Patie	of these systemic problems health agency's inability to of quality health care in a the condition of participation nt Rights.		406			
G 410	during the initial evaluation furnishing care to the This ELEMENT is not Based on record reviagency failed to ensure representatives was possible of the Patient Bill of Agreement, and Ackr Notice of Privacy Right treatment in 5 of 9 clin 2, 4, 5, 7) The findings include: 1. The policy titled "Final stated, "The patient or representative has the patient's rights throug communication. The protect and promote that as follows: The home provide the patient with patient's rights in advitation.	and the patient's legal b), the following information contaction visit, in advance of patient: but met as evidenced by: ew and interview, the re patient and/ or patient corovided an accurate notice clights, Authorization, cowledgement Forms, and contact records reviewed. (#1, Patient Rights" dated 7/12/18 or the patient's legal e right to be informed of the ch effective means of home health agency must the exercise of these rights	G	410			
		ce conference on 8/7/18 at of the agency indicated the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			0.5	C 3/16/2018		
	ROVIDER OR SUPPLIER			224 W JE	DDRESS, CITY, STATE, ZIP CODE FFERSON BLVD STE 200 BEND, IN 46601	1 00	710/2010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
G 410	organizations. 3. Review of the ag Bill of Rights" stated includes, but is not informed in advance provided, including care and the freque modifications to the information about the Medicare home head Participate in the derevision of the plan and to refuse care of consequences of refully presented. Be writing, in advance changes, including property and person consideration, and and individuality. Be members through person mistreatment, sexual, and physical unknown source informed of patient formulate advance determining the exist directives" Include to complain with conformed accrediting bodies: including a Spanish agency was not part This form was date records as received.	gency document titled "Patient d, "The patient bill of rights limited to, the right to be fully a about service / care to be the disciplines that furnish ency of visits as any service / care plan receive the services covered under the alth or hospice benefit. Evelopment and periodic of care. Informed consent for treatment after the effusing care or treatment are informed, both orally and in of care being provided, of the payment Have one's in treated with respect recognition of patient dignity the able to identify visiting staff proper identification. Be free neglect, or verbal, mental, all abuse, including injuries of voice grievances be rights under state law to care directives to include, stence of advance care died on this document was how that information to two Company A and Company B translation. The home health that of these accrediting bodies. diency document titled gency document titled	G 4	110					

[` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		15K070	B. WING			08/16/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	33.13.23.10		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
G 410	signing with each painformation for two a including how to corinformation including address, phone num translation of this in not part of these two (Company A and Coevidenced by the fold to be widenced by the fold to evidenced by the fold to evidenced by the fold to evidenced by the fold to evidence the privacy Rights" store the organization and the organization and the organization at the fold to evidence their privacy complaints should be the employee, Person A organization at the fold to evidence the proper organization at the fold to evidence the organization at the fold to evidence the organization at the fold the organization at the	form" (included dates of atient), included contact accrediting bodies' information inplain and the contact grax number, mailing aber, email information, and Spanish. The agency was accreditation bodies impany B). This was further lowing: ency document titled "Notice ated, "This notice describes ation about you may be you can get access to this adviduals may complain to at to the Secretary of the US and Human Services if they rights have been violated. The directed to [former and a directed to [former and a directed to [former als should contact [Person A] at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact in effect at the following number [out of a directed to [former als should contact	G 4					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		15K070	B. WING		08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	, 33.10.2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
G 410	12/4/17, failed to ev patient representative Patient Bill of Rights Acknowledgement, documents before the patient signed the documents signed the administrator / dapproximately 22 dacare with the agence 8. A review of clinic on 12/13/17, failed to received an accurate Notice of Privacy Risigned the document Employee A. 9. A review of clinical 11/16/17, failed to ereceived accurate P	cal record #2, start of care idence that the patient / //e received an accurate s, Authorization/ Agreement/ and Notice of Privacy Rights he initiation of treatment. The ocuments on 12/26/17 with irector of nursing, which was ays after the patient started y. all record #3, a start of care of evidence that the patient he patient hat son 12/13/17 with all record #4, a start of care of vidence that the patient atient Bill of Rights,	G 411	,		
	Authorization/ Agreement/ Acknowledgment, and Notice of Privacy Rights documents before the initiation of treatment. The patient signed the documents on 11/21/17 with Employee A, which was approximately 5 days after the patient started care with the agency. 10. A review of clinical record #5, a start of care of 12/15/17, failed to evidenced that the patient/ patient representative received accurate Patient Bill of Rights, Authorization/ Agreement/ Acknowledgement, and Notice of Privacy Rights document before the initiation of treatment. The patient's representative signed the documents on 12/19/17 with Employee A, which was approximately 4 days after the patient started care with the agency.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	CODE	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
G 410	of 1/18/18, failed to received accurate F Authorization, Agree documents. The part on 1/18/18 with Em 12. A review of clin of 2/23/18, failed to received accurate F before the initiation signed the document was 4 days after the agency. 13. A review of clin of 4/19/16, failed to received accurate F The patient's legal redocument on 4/19/11. A review of clin of 6/27/18, failed to patient representati Bill of Rights and Nedocuments. The patients of administrator directions of 15. During a phone the complaint line for 15. During a phone the complaint line for 15. During a phone the complaint line for 15.	ical record #6, a start of care evidence that the patient Patient Bill of Rights ement, and Acknowledgement attent signed the documents ployee A. ical record #7, a start of care evidenced that the patient Patient Bill of Rights document of treatment. The patient not on Paper on 2/27/18 with expatient started care with the Patient Bill of Rights document of the patient started care with the Patient Bill of Rights document. The patient Patient Bill of Rights document. The patient Bill of Rights document attent Bill of Rights document. The patient Bill of Rights document attent Bill of Rights document. The patient Bill of Rights document between the patient Patient Bill of Rights document attent Bill of Rights document. The patient Bill of Rights document between the patient between the patient Bill of Rights document accord #9, a start of care evidenced that the patient between the patient Bill of Rights document between the patient	G 4	110			
	Company A. 16. During a phone the complaint line for	e call on 8/14/18 at 1:50 PM, or the accrediting organization, alled. This number was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			1	C 16/2018	
	ROVIDER OR SUPPLIER E HEALTH CARE INC			22	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601	1 00/	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
G 414	recording. 17. During an interviet the administrator / direction owner indicated not horganizations involved. 18. The number on the was called on 8/15/18 identified self as emplificated self as emplificated and indicated HHA administrator concerning to the contact information for including the administrator address, and business receive complaints. This ELEMENT is not a Based on record reving agency failed to ensure presentatives receive administrator's name, business phone number complaints for 8 of 9 of 17, #9). The findings include: 1. The agency policy 7/12/18 stated, "The presentative may experiented by law the permitted by law the second second interview of the permitted by law the second second interview of the permitted by law the second sec	ew on 8/14/18 at 3:39 PM, ector of nursing and the aving the accrediting d in the agency. The documents for Person A at 11:20 AM. Person B loyee of an agency in Person A was not available. Intact information (iii) The HHA administrator, trator's name, business sphone number in order to the trate as evidenced by: ew and interview, the re the patients / patient wed the home health agency business address, and		410				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _		,	C 08/16/2018		
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
G 414	investigate complain patient's legal repres or care that is [or fail regarding the lack of property by anyone flack of respect for the anyone furnishing set health agency and so of the complaint and complaint." This poladministrator's name 2. The agency policy Policy" revised 7/6/1 questions concerning a desire to file a complaint above please con RN / administrator In Blvd, Suite 200, Sout phone [574] 233 - 95 3. A review of the ur Packet failed to show contact information. agency patients at a consideration of nursing indicated to the patient's upon 4. A review of clinicated to the patient's upon 4. A review of clinicated to the patient's upon 5. A review of clinicated to the patient's upon 5. A review of clinicated to the patient's upon 5. A review of clinicated to the patient's upon 5. A review of clinicated to the patient's upon 5. A review of clinicated to the patient's upon 6. A review of clinicated to the patient's upon 6. A review of clinicated to the patient's upon 6. A review of clinicated to the patient's upon 6. A review of clinicated to the patient's upon 6. A review of clinicated to the patient's upon 6. A review of clinicated to the patient's upon 7. A review of clinicated to the patient's upon 7. A review of clinicated to the patient's upon 8. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon 9. A review of clinicated to the patient's upon	ts made to the patient or sentative regarding treatment is to be] furnished or respect for the patient's furnished or regarding the e patient's property by ervices on behalf of the home hall document both existence the resolution of the ficy did not evidence the error contact information. The patient of the first of the patient of the patient of the error contact information of the first of the patient of t	G 4	14				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3)	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	E	33/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
G 414	administrator's name business phone num complaints. 6. A review of clinica 12/13/17, failed to expatient representativadministrator's name business phone num complaints. 7. A review of clinica care 11/16/17, failed patient representativadministrator's name business phone num complaints. 8. A review of clinica care 12/15/17, failed patient representativadministrator's name business phone num complaints. 9. A review of clinical patient representativadministrator's name business phone num complaints.	e received the current be, business address, and liber in order to receive all record #3, start of care beindence that the patient / e received the current be, business address, and liber in order to receive all record #4, start of to evidence that the patient / e received the current be, business address, and liber in order to receive	G 4				
	10. A review of clinic 2/23/18, failed to evipatient representativ administrator's name	cal record #7, start of care of dence that the patient / e received the current e, business address, and ober in order to receive					

PRINTED: 09/13/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			l	C 16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			2	STREET ADDRESS, CITY, STATE, ZIP CODE 124 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
G 414	of 6/27/18, failed to expatient representative	al record #9, a start of care vidence that the patient / e received the current business address, and	G 4	414			
G 422	complaints. Written notice within 4 CFR(s): 484.50(a)(4)		G 4	422			
	Based on record reviensure written notice responsibilities was p days of the initial asserviewed (#1, #2, #4)	t met as evidenced by: ew, the agency failed to of the patient's rights and rovided within 4 business essment for 3 of 9 records					
	stated, "The patient or representative has the patient's rights throug communication. The protect and promote that as follows: The home provide the patient with patient's rights in advertine patient or during the patient of the patient or during the patient of	e right to be informed of the h effective means of home health agency must he exercise of these rights health agency shall the awritten notified of the ance of furnishing care to he initial evaluation visit treatment." clinical records reviewed patients/ patient ceived the rights within 4					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(c
		15K070	B. WING _			08/	16/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
TMG HOM	E HEALTH CARE INC			22	24 W JEFFERSON BLVD STE 200		
111101110111	E HEAEITI GARE ING			S	OUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 422	did not sign the Patien with Employee A, Regagency failed to ensureceived an accurate 4 day business days of 4. A review of clinical 12/4/17, evidenced the Patient Bill of Rights of document was not sign administrator / director The agency failed to an accurate Patient Bill of an accurate Patient Bill of 11/21/17 with Employensure the patient Bill of 11/21/17 with Employensure the patient received and person of CFR(s): 484.50(c)(1) Have his or her proper respect; This ELEMENT is not Based on record reving agency failed to ensure with dignity for 1 of 1 visits observed (paties LPN, who completed The findings include:	ne patient's representative nt Bill of Rights until 1/19/18 gistered Nurse (RN). The re the patient representative Patient Bill or Rights within of the initial evaluation visit. I record #2, start of care re patient did not sign the until 12/26/17 and the greed by the patient and the prof nursing until 12/26/17. The patient received fill or Rights within 4 day initial evaluation visit. Inical record #4 with a start of renced the patient did not for Rights document until received an accurate Patient day business days of the reated with respect retained with respect retained to be and interview, the retained practical nurse retained practical nurse retained with Employee B, a home health aide visit).		422			
	The agency policy	titled "Patient Rights" dated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		15K070	B. WING _		08	C 3/ 16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 428	exercise his / her right health agency as folloright to be treated: 2. During a home vist. 4:10 PM, Employee Ewas observed to give During the bath, Empwindow blinds and hat times during the bath other exposed parts and not covered with PM, the patient cover During the bath, the vapproximately 15 mir undressed. 3. During an interviet the administrator / dirthe blinds had been addited not provide privated Transfer and discharge CFR(s): 484.50(d) The patient and representation of the patient and representation of the patient of the pati	patient has the right to hts as a patient of the home ows The patient has the with dignity." Sit observation on 8/14/18 at B, Licensed Practical Nurse, a a bed bath to patient #2. Bloyee B did not close the ad the patient uncovered. At a, the patient's peri area and of the body were exposed a towel or blanket. At 4:15 red self with covering. Window blinds were open for nutes while the patient was W on 8/14/18 at 4:45 PM, rector of nursing indicated open during the bath and this by for the patient. ge essentative (if any), have a of the HHA's policies for ge. The HHA may only the patient from the HHA if: not met as evidenced by: iew, the agency failed to patient representative had the of the HHA's policy for ge for 9 of 9 records patients who received care.	G 4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		35/16/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 452	1. A review of the ag Discharge / Transfer "The agency will main ongoing assessment care and discharge p 2. A review of record patient had received policy. 3. A review of record patient had received policy. 4. A review of record patient had received policy. 5. A review of record patient had received policy. 6. A review of record patient had received policy. 7. A review of record patient had received policy. 8. A review of record patient had received policy in it. This does the caregiver or patient had received policy. 8. A review of record patient had received policy. 9. A review of record patient had received policy.	ency policy titled "2/17 Policy" dated 2015 stated, ntain a process for the of each patient's continuing lanning process" #1 failed to evidence the the transfer and discharge #2 failed to evidence the the transfer and discharge #3 failed to evidence the the transfer and discharge #4 failed to evidence the the transfer and discharge #5 failed to evidence the the transfer and discharge #5 failed to evidence the the transfer and discharge #6 evidenced the record tharge / transfer of patient cument was not signed by	G 4!	52			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				C 16/2018
	ROVIDER OR SUPPLIER		1	2:	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 452	patient had received to policy.	d #9 failed to evidence the the transfer and discharge		452			
G 454	HHA can no longer m CFR(s): 484.50(d)(1) The transfer or discharpatient's welfare becarphysician who is respondent of care agree that meet the patient's neacuity. The HHA must appropriate transfer to the needs of the patient capabilities; This ELEMENT is not Based on record reviagency failed to ensurarranged a safe and a another care entities patient exceeded the closed records review. The findings included 1. The policy titled "2 Policy" dated 2015 st shall begin at the time being advised as to the treatment. Re- evaluadditional planning we through out the course the documentation of date of discharge 1 discharge, the patient notified of discharge.	consible for the home health at the HHA can no longer eds, based on the patient's tarrange a safe and cother care entities when ent exceed the HHA's with met as evidenced by: we and interview, the re the home health agency appropriate transfer to when the needs of the HHA's capabilities for 2 of 3 and (#6 and #8).	G	454			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 8/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 454	patient was discharge transfer 4/17/18. The other home care on 4 summary on this Disc document dated 4/17 had received home he day X 5 days a week of Daily Living and In Living, housekeeping safety. Skilled nurse hours a day X 5 days catheterization of bla medication and healt record evidenced the another home care we care in the record. To by the following: During an interview of administrator / director patient #6 requested cooperate with the act documentation of this the request to be transferred / discharge was written out of for caregiver. A copy of for the clinical record home health aide visit director of nursing indiagency providing hor to relinquish the prior health aide visits. The home health aide	e of 4/17/18 evidenced the ed due to patient's request / e patient was transferred to 4/17/18. The discharge charge assessment //18 evidenced the patient ealth aide services 8 hours a for assistance with Activities strumental Activities of Daily I, meal preparation, and services included services 3 e / week for straight dder, bowel program, and h monitoring. The clinical e patient transferred to 1/2 ithout the name of the home in this was further evidenced a transfer and refused to gency staff. There was no serfusal of care except for 1/2 ithough a fer and the patient after the patient the patient after the patient the patient and the new 1/2 ith document was not kept and 1/2 ith document was not kept and 1/2 ith document was not kept and 1/2 ith document health and e visits refused another home health and e authorization for the home its agency did not complete	G 4	54			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	1 33.10.20.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 454	and so the agency cany longer. The adminursing had lined up indicated this did not the nurse's family. To informal caregiver error information informatio	Patient #6 indicated and employment elsewhere build not meet his / her needs an inistrator / director of a nurse for the patient but work out due to conflict with the patient indicated anded up taking over the care. In 8/16/18 at 11 AM with the Practical Nurse, indicated and due to needing more care by. In a record #8, start of care of physical abuse complicating and epilepsy and attention flisorder, failed to evidenced a prestigated by the agency for staff. Review of the closed ence that the agency failed to egal representative in the error intentions to disharge the error with finding another errors so that there be no evidenced by the following:	G 45	54			
	visits completed on 8	d evidenced home health 8/18/17, 8/19/17, 8/21/17, 8/17, 8/25/17, 8/26/17,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		15K070	B. WING		08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETIC
G 454	8/28/17, 8/29/17, 8/3 9/5/17, 9/6/17, 9/7/17 9/12/17, 9/13/17, 9/1 9/19/17, 9/20/17, 9/2 nurse visit was comp A review of the reconaide visit with no task. The note was signed Health Aide. A note is signature stated, "Po [illegible words after signed by Employee Review of the clinical communication about was dated 9/28/17 frostated, "Please computo use that note to dis 923/17." This review. The only communication the notes was dated RN, which stated, "P 8/14/17. Need to use patient as of 9/23/17. 8/14/18 - 8/16/18. During an interview cowner of the agency representative for pavisit notes. The patie of the records that he sign without receiving grabbing aides inapprestated, "[Patient #8] is sign without receiving grabbing aides inappresentation.	0/17, 8/31/17, 9/1/17, 9/2/17, 7, 9/8/17, 9/9/17, 9/11/17, 9/15/17, 9/18/17, 1/17, 9/15/17, 9/18/17, 1/17, 9/22/17. A supervisory eleted on 8/18/17. d evidenced a home health as completed on 10/2/17. by Employee K, Home on this note under patient's ever of attorney verbalized this.]" This was electronically K on 10/19/17. I record, the only the discharge in the notes on Employee L, RN, which elete note on 8/14/17. Need scharge patient as of a occurred 8/14/18 - 8/18/18. Ition about the discharge in 9/28/17 from Employee L, lease complete note on ethat note to discharge." This review occurred	G 45	54	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 454	she would not sign the During an interview of administrator/ director discharge oasis and the record. During an interview of patient representative refusing to sign the attention and the agency refused to complaining to the agency dischof her / his refusal to patient representative to the agency when to called in sick. A new was assigned after the representative recalled and administrator due and the smell of the subject of the case of indicated there was a administrator and own aware of the complainance of the confirm that [Patien from our agency as of to noncompliance of of changes of [patient]	told [the patient ould not service [him / her] if the visit notes." on 8/14/18 at 3:45 PM, the per of nursing indicated the summary were not found in on 8/15/18 at 9:40 AM, the per of patient #8 indicated the gency visit notes because to give him / her copies and gency and case manager that are also indicated complaining the aide did not show up or a aide, Employee K, HHA, the complaint. The patient the ded complaining to the owner that the design of the told the service in the home. on 8/15/18 at 10:18 AM, the service in the home. on 8/15/18 at 10:18 AM, the service in the agency. She are complaint filed and the the service in the service	G 4	54			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	DE	1 33/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	DATE
G 454	further questions or c matter please contact [past administrator, d administrator."	e services. If you have any oncerns regarding this tour office. Thank you. irector of nursing] RN BSN,	G 4			
G 464	physician(s) issuing of plan of care, and the practitioner or other had will be responsible for to the patient after disany) that a discharge considered; This ELEMENT is not agency failed to ensurand the legal represe advance of a discharge reviewed in a sample Findings include: A review of a clinical 4/25/16, diagnosis of pregnancy, generalized ficit hyperactivity domplaint that was in administrator or other record, failed to evide inform the patient's prepresentative in advision to the representative in advision of the prepresentative in advision to the record.	presentative (if any), the orders for the home health patient's primary care realth care professional who reproviding care and services scharge from the HHA (if for cause is being of the metas evidenced by: sew and interview, the rethe patient's physician intative was informed in ge for 1 of 3 closed records of 9. (#8) record #8, start of care physical abuse complicating ed epilepsy and attention - isorder, failed to evidenced a vestigated by the agency in staff. Review of the closed ence that the agency failed to hysician and legal ance notice of their in the patient as evidenced by	G 4	464		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 224 W JEFFERSON BLVD S SOUTH BEND, IN 46601	STE 200	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)	
G 464	"Comprehensive Adul 8/14/17, with time in or PM. This note evider by Employee H, RN, Under discharge plan "other" and stated, "Vneeded or can be provisits completed on 8/22/17, 8/23/18, 8/24/8/28/17, 8/29/17, 8/30/9/5/17, 9/6/17, 9/7/17/9/12/17, 9/13/17, 9/12/17, 9/13/17, 9/20/17,	It Assessment" dated of 3:42 PM and time out of 5 inced a visit was completed and signed on this date. It is, Employee H checked box when services are no longer vided by another source." If evidenced home health (18/17, 8/19/17, 8/21/17, 8/25/17, 8/26/17, 8/17, 8/25/17, 8/26/17, 8/17, 8/25/17, 8/26/17, 8/17, 9/15/17, 9/11/17, 9/15/17, 9/18/17, 9/15/17, 9/18/17, 9/15/17, 9/18/17, 9/15/17, 9/18/17, 9/15/17, 9/18/17, 9/15/17, 9/18/17, 9/15/17, 9/18/17, 9/15/17, 9/18/17, 9/15/17, 9/18/17, 9/15/17, 9/18/17, 9/18/17. If evidenced a home health is completed on 10/2/17. It is was electronically on this note under patient's	G	164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	DE	33/13/2313
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 464	owner of the agency representative for particular visit notes. The paties of the records that he sign without receiving grabbing aides inappostated, "[Patient #8] was in aides." The owner administrator and tole the patient representative] we was she would not sign the During an interview of administrator directed discharge oasis and the record. During an interview of administrator directed discharge oasis and the agency refused to complaining to the agency refused to complaining to the agency when the ag	on 8/14/18 at 3:20 PM, the indicated the patient tient #8 refused to sign the ent representative wanted all e / she signed and would not g copies. The patient was propriately. The owner was abusive and would grab indicated talking to the past ad the past administrator that ative needed to sign the visit told [the patient ould not service [him / her] if the visit notes." on 8/14/18 at 3:45 PM, the part of nursing indicated the summary were not found in the patient #8 indicated the gency visit notes because to give him / her copies and gency and case manager marging the patient because sign the visit notes. The ge also indicated complaining the aide did not show up or raide, Employee K, HHA, the complaint. The patient the complaint grants at 10:18 AM, manager for patient #8,	G 4	464		
		erns with the agency. She a complaint filed and the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 50.25.			(c
		15K070	B. WING			08/	16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC	ATEMENT OF DEFICIENCIES	ID	2	ETREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
G 464	aware of the complain A letter dated Septem Patient #8] Date of 11/24/17, To Whom It to confirm that [Patien from our agency as of to noncompliance of of changes of [patient caregiver's refusal to with home health aide further questions or comatter please contact	ner of the agency were nt. aber 26, 2017 stated, "[Service: 5/26/17 - May Concern: This letter is nt #8] has been discharged f September 23, 2017 due caregiver to inform [agency]	G	464			
G 478	patient's representative caregivers and family the following topics: This ELEMENT is not Based on observation interview, the agency complaint made by a representative for 1 or (#8). The findings include: A policy titled "Patient stated, "The patient or representative has the patient's right through communication. The	s made by a patient, the ve (if any), and the patient's , including, but not limited to, t met as evidenced by: n, record review, and failed to investigate the patient's legal f 3 closed records reviewed t Rights" revised 7/12/18 r the patient's legal e right to be informed of the	G	478			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 478	his / her rights as a pagency as follows voice grievances reg is or fails to be furnis right to be informed a furnished as follows: shall advise the patied disciplines that will fur of visits proposed to health agency shall into the patient or the pregarding treatment of furnished and shall the complaint and the complaint." During the entrance of 10:55 AM, in regargs complaints, the owner "Mostly they are not complaint log available investigated complaint investigated complaint this time, the administ and the owner indical missing. The owner may have been taken coordinator, Employed A review of a clinical 4/25/16, failed to evic investigated by the a staff. The only commit discharge in the note	ient has the right to exercise atient of the home health the patient has the right to arding treatment or care that hed the patient has the about the care to be a. The home health agency and in advance of the arnish care and the frequency be furnished the home hovestigate complaints made patient's representative or care that is or fails to be I document both existence of the aresolution of the agency stated, documented but [the he personnel files." Was observed there was no ble at the agency and no note for 2016 - 2018. During strator/ director of nursing the the complaint log was indicated the complaint log was indicated the complaint log by the past office the J. Trecord #8, start of care denced a complaint that was gency administrator or other nunication about the s was dated 9/28/17 from ich stated, "Please complete	G 4	.78		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 478	During an interview of owner of the agency representative for parvisit notes. The paties of the records that he sign without receiving grabbing aides inappostated, "[Patient #8] would not sign the patient representative] we wishe would not sign the During a phone call to on 8/15/18 at 9:40 All complaint had been for was not present in the no evidence that this investigated or resolver refused to give him/ in representative indicates the agency visit notes.	of 923/17." This review 18/18. on 8/14/18 at 3:20 PM, the indicated the patient tient #8 refused to sign the ent representative wanted all electric services. The patient was ropriately. The owner was abusive and would grab indicated talking to the past administrator that ative needed to sign the visit told [the patient ould not service [him/ her] if the visit notes." o patient #8's representative M, it was found that a filed in September 2017, that the complaint log. There was complaint had been wed. The patient's ted he/ she refused to sign is because the agency her copies. The patient ted he complained to the se manager. The patient	G 4	<u> </u>			
	discharging the patie to sign the visit notes also indicated he/ showhen the aide did no new aide, Employee the complaint. The precalled complaining	nt because of his/ her refusal b. The patient representative e complained to the agency t show up or called in sick. A K, HHA, was assigned after eatient representative also to the owner and Employee K's smoking and					

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	<u>I</u>	00/16/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 478	Continued From pag	e 25	G 4	78		
	Person C, a former of indicated there was agency. Person C in complaint filed and to of the agency were at A letter dated Septer Patient #8] Date of 11/24/17, To Whom to confirm that [Patien from our agency as to noncompliance of of changes of [patier caregiver's refusal to with home health aid further questions or matter please contact	the administrator and owner aware of the complaint. In the mber 26, 2017 stated, "[If Service: 5/26/17 - It May Concern: This letter is the many of				
	C, to the department to the past administr concerning care to be 10/23/17. The letter 224 W. Jefferson Bly To Whom It May Cor Service from 5/26/17 Concern: This letter received. I never ret paper work. You are paper work to reseverything had to be also said when you would give copies of your tablet. You new	7, was presented by Person This letter was addressed ator of the agency e received from 5/26/17 - stated, "[Past Administrator], d, Ste #200, South Bend ncern: Re [patient #8] 7 - 10/23/17 To Whom It May is in reply to your letter I fused to sign state regulated d [the owner] refused to give ad and sign. You said that done electronically. You visited on 5/26/17 that you the paperwork I signed on yer did. You said that [the yeas between [agency] and the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_			
		15K070	B. WING			08/	16/2018
	ROVIDER OR SUPPLIER			22	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 478	phone was shut off be to pay the bill on it. [I punch in and out ever time that I would not sallowed to read first. tablet would not work get me the paperwork far as the [patient #8's just recently changed [Employee K] knew it, appointment with us. you since we changed Signed by the Guardin Person C, Case Mana Document complaint CFR(s): 484.50(e)(1)(1) Document both the exand the resolution of the ELEMENT is not Based on observation interview, the agency existence of a complategal representative aclosed records review. The findings include: A policy titled "Patient or representative has the patient's right through communication. The protect and promote thas follows The patient of the rights as a patient's right as a patient's right as a patient's rights	HHA] said that [his/ her] ecause she could not afford He/ she] used my land line to ry day I told you at that sign any thing that I was not You also said that your in my house. I repeated, to read and I will sign it. As s] physician is concerned, I doctors for [patient #8]. I, [he/ she] went to [his/ her] I have not seen or talk to d doctors." Thank you. an for patient #8. Cc. ager. and resolution (ii) existence of the complaint the complaint; and of met as evidenced by: n, record review, and failed to document the sint made by the patient's and the resolution for 1 of 3 ared (#8). It Rights" revised 7/12/18 It Rights revised 7/12/18 It Rights revised of the		478			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION IG	· '	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 8/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		0/10/2010	
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 484	is or fails to be furnished right to be informed a furnished as follows: shall advise the patied disciplines that will fur of visits proposed to be health agency shall into the patient or the pregarding treatment of furnished and shall the complaint and the complaint." During the entrance of 10:55 AM, in regargs complaints, the owner "Mostly they are not of complaints] get into the complaint log available investigated complaint this time, the administiand the owner indicar missing. The owner may have been taken coordinator, Employed A review of a clinical 4/25/16, failed to evic investigated by the agent as a staff. The only committed discharge in the note Employee L, RN, whin note on 8/14/17. Needs to shall advise the patient of the staff. The only committed the constant of the staff	arding treatment or care that hed the patient has the bout the care to be a. The home health agency int in advance of the rnish care and the frequency be furnished the home hyestigate complaints made ratient's representative or care that is or fails to be a document both existence of the resolution of the conference on 8/7/18 at to documentation of the resolution of the repersonnel files." was observed there was not leat the agency and not hat for 2016 - 2018. During trator/ director of nursing ted the complaint log was indicated the complaint log in by the past office be J. record #8, start of care denced a complaint that was gency administrator or other nunication about the swas dated 9/28/17 from the stated, "Please complete and to use that note to of 923/17." This review	G 4	84			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _				C 16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 224 W JEFFERSON BLVD SOUTH BEND, IN 4660	STE 200			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
G 484	owner of the agency representative for pat visit notes. The patie of the records that he sign without receiving grabbing aides inappi stated, "[Patient #8] w aides." The owner administrator and told the patient representative on the patient representative was we would not sign the During a phone call to on 8/15/18 at 9:40 AM complaint had been fi was not present in the no evidence that this investigated or resolv representative indicate the agency visit notes refused to give him/ brepresentative indicated agency and to the care representative indicated agency and to the care representative indicated to sign the visit notes also indicated he/ she when the aide did not new aide, Employee the complaint. The precalled complaining administrator due to the smell of the smok	in 8/14/18 at 3:20 PM, the indicated the patient ient #8 refused to sign the nt representative wanted all / she signed and would not gopies. The patient was repriately. The owner was abusive and would grab indicated talking to the past at the past administrator that ative needed to sign the visit told [the patient buld not service [him/ her] if e visit notes." In patient #8's representative M, it was found that a filed in September 2017, that is complaint log. There was complaint had been led. The patient's led he/ she refused to sign is because the agency liter copies. The patient led he complained to the se manager. The patient led the agency was int because of his/ her refusal. The patient representative is complained to the agency is show up or called in sick. A K, HHA, was assigned after attent representative also to the owner and Employee K's smoking and	G	184				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED			
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	06/16/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 484	agency. Person C in complaint filed and the of the agency were at A letter dated Septem Patient #8] Date of 11/24/17, To Whom I to confirm that [Paties from our agency as of to noncompliance of of changes of [patient caregiver's refusal to with home health aid further questions or of matter please contact [past administrator." A letter dated 10/3/17. C, to the department to the past administrator. The letter 224 W. Jefferson Blv To Whom It May Conservice from 5/26/17 Concern: This letter received. I never refipaper work. You and me paper work to reaeverything had to be also said when you would give copies of your tablet. You never owner] no[sic] that we state. [Employee K, phone was shut off be	poliling concerns with the dicated there was a me administrator and owner ware of the complaint. Inber 26, 2017 stated, "[If Service: 5/26/17 - It May Concern: This letter is not #8] has been discharged of September 23, 2017 due caregiver to inform [agency] It #8] physician; also sign in order to be compliant the services. If you have any concerns regarding this it our office. Thank you. Ilirector of nursing] RN BSN, 7, was presented by Person. This letter was addressed	G 4	184		

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		TIPLE CON	(X3) DATE SURVEY COMPLETED		
			7. 50.25.				С
		15K070	B. WING			08/	16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			224 W	ET ADDRESS, CITY, STATE, ZIP CODE J JEFFERSON BLVD STE 200 ITH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 484	time that I would not sallowed to read first. tablet would not work get me the paperwork far as the [patient #8's just recently changed [Employee K] knew it appointment with us. you since we change Signed by the Guardi Person C, Case Mana Strengths, goals, and CFR(s): 484.55(c)(2)	ry day I told you at that sign any thing that I was not You also said that your in my house. I repeated, to read and I will sign it. As sign physician is concerned, I doctors for [patient #8]. I, [he/ she] went to [his/ her] I have not seen or talk to d doctors." Thank you. an for patient #8. Cc. ager. care preferences		530			
	used to demonstrate toward achievement of patient and the meast by the HHA; This ELEMENT is not Based on record revifailed to ensure the grand based on the confindings in 2 of 6 active (#2 and #9). The findings include: 1. The agency policy Assessment" dated 7 will be developed from assessment plan with family, and physician.	g information that may be the patient's progress of the goals identified by the urable outcomes identified of the them as evidenced by: wew, the home health agency coals were patient specific apprehensive assessment of clinical records reviewed of titled "Comprehensive of titled". titled "Comprehensive of the comprehensive of the comprehensi					

PRINTED: 09/13/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			1	C 46/2048
	ROVIDER OR SUPPLIER E HEALTH CARE INC	10.070	1	S 2:	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 6OUTH BEND, IN 46601	<u> U87</u>	16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 530	Based upon the goals actions must be taker 3. Clinical record rev for patient #2, start of document titled "Hom Plan of Care" for the c-7/31/18, with a primaulcer of sacral region administrator/ director physician signed this document had an are Rehabilitation potential blank. The following or re-assessment finding lead to the addition of Care / 485 informate evidenced the following Il sacrum / coccyx prepor; the patient had above knee amputation at a "3" level (0-10), with the back with prepain gets at a "9"; the productive cough desand COPD (chronic of disease) due to smoke evidenced the patient to neurogenic bladder waist level; the cathet Suprapubic catheter acentimeter milliliter) wasediment, bowel incompared to review of the goals and compared to smoke evidenced the patient to neurogenic bladder waist level; the catheter acentimeter milliliter) wasediment, bowel incompared to review of the goals.	seeded. To determine this sto be achieved, what in to achieve them?" liew on 8/13/18 and 8/16/18 care 12/4/17, included a le Health Certification and certification period of 6/2/18 ary diagnosis of pressure stage 2, signed by an of nursing on 5/31/18. The document on 6/7/18. This a subtitled "Goals / lal/ discharge plans was comprehensive gs dated 7/31/18, did not goals on the plan of care: Intification Follow up go OASIS elements with plan ion dated 7/31/18, ang: The patient had a Stage essure ulcer, skin turgor chronic pain issues with on sites that were presently with aching, throbbing and esent level "2" and worst patient had a chronic cribed as a smoker's cough bstructive pulmonary ing; elimination status had a urinary catheter due of due to paralysis below the ere was described as a lee French 10 cc ml (cubic with amber colored urine with notinence with removal of ulation and digital removal	G	530			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	10,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 530	the situation; paranoi trusted no one to set her] self; impaired de by trying to do self dis assistance; spasms: needs assist with trar daily living], IADLs [ir living] and assistance specialized transport above the knees; who assistance for transferegular w / c [wheelchelectric w / c when ou assistance and for safor falls. The section: patient's report about personal goals were gastrointestinal goals will be free of S / S (s (urinary tract infection including healing of wound care teaching of patient. 4. Clinical record reverse, start of care 6/27/titled "Home Health Care" for the certifica 8/25/18, with a prima C - 5 - C-7, signed by nursing on 6/28/18. document on 7/11/18 area subtitled "Goals discharge plans that comprehensive re-as	nen stressed or unfamiliar in d behaviors was noted - up medications but [him / cision making as evidenced simpaction of stool without abdomen, back, bladder; nsfers, ADLs [activities of astrumental activities of daily with leaving the home, ation; bilateral amputations eel chair bound; needed ers from bed to chair, used nair] in apartment and ut in the community with afety; and patient was at risk is were blank about the eitheir progress towards their ne HHA measurable goals. Ilisted as SN (skilled nurse) as, SN genitourinary goals: signs / symptoms) of UTI (signs / symptoms) of UTI	G 53	30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							C
		15K070	B. WING			08/	16/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	24 W JEFFERSON BLVD STE 200		
TMG HOM	IE HEALTH CARE INC			s	OUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 530	Continued From pag	e 33	G	530			
	elements with plan of dated 6/27/18, signer of nursing and patier evidenced the follow left chest; tracheostorespiratory distress streatments: albuterd access device. Gast 4 hours and 200 cc site wash with soap suprapubic catheter incontinence and pater french / 10 CC ballow on 6/7/18; colostomy wash with soap and quadriplegia with spatian injury date 12/6 with all activities of duadriplegia, fractur grips weak; needs attransfers, toileting, attransfers, toileting, attransfers, toileting, attransfers, toileting, attransfers toileting, attransfers document stated Patient Centered Gostatus start effective Respiratory Goals: I will demonstrate proproper use of respirate demonstrate trach ca 6/27/18, SN Cardiov state understanding manage disease and Gastrointestinal goal will remain intact with effective: 6/27/18, p	Ing SOC / ROC OASIS If care / 485 information If care / 485 information If care / 485 information If caregiver on this date Ing: Cardiac pacemaker in Imply with history of adult Ingular of adul					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 8/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 544	of the OASIS) as free condition warrants du improvement in the pless frequently than-This STANDARD is not a patient for 1 of 1 (#2) of patients with word and the patient for 1 of 1 (#2) of patients with word findings include: A review of clinical rean accurate assessment for 1 of 1 (#2). This was further A review of a visit not employee B, License evidenced the patient wound indicated a locother wound indicated ischial process. A review of the Recel assessment dated 7/3 administrator / director wounds that were not wound indicated it was sacrum/ buttock area centimeters, width of of 4 centimeters. The	assessment must be (including the administration quently as the patient's le to a major decline or atient's health status, but not not met as evidenced by: lew and interview, the re the Registered Nurse d assess a second wound active records reviewed wounds in a sample of 9. cord #2, failed to evidence ent of a wound for patient evidenced by the following: e on 7/30/18, completed by d Practical Nurse, had two wounds. One cation on the sacrum. The d it was to the right of the tification follow up 31/18, completed by the or of nursing, evidenced two led during this visit. The first les located at the coccyx/	G 5	44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
				_		(
		15K070	B. WING			08/	16/2018	
	ROVIDER OR SUPPLIER E HEALTH CARE INC			22	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
G 544	asked if the second w area or ischium as no administrator / directo error."	e 35 n 8/16/18 at 11:55 AM, when yound was on the sacral sted on the assessment, the or of nursing stated, "My	G	544				
G 550	Based on record reviagency failed to ensu completed a discharg patient's progress in r for 1 of 3 closed record sample of 9. The findings include: The policy titled "2.17 dated 2015 stated, "T process for the ongoin patient's continuing caneeds at the visit be patient and the physician shall be not summary which shall of discharge will be my physician with a copy The discharge summar reason for discharge and psychosocial state C. A summary of the D. Patient's progress	Discharge/ Transfer Policy" The agency will maintain a ang assessment of each are and discharge planning efore this discharge, the cian will be notified of the nts will receive discharge in his/ her ongoing care patient, the attending tified. A written discharge be prepared within 30 days	G	550				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7.1. 50.25.	_		(c
		15K070	B. WING _			08/	16/2018
	ROVIDER OR SUPPLIER			22	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 550	care 4/25/16 included certification period of clinical record failed to assessment or discharcompleted after a disc the agency due to the staff visit notes. The cof care did not eviden progress to. This was following: The home health cert the certification period included under the godischarge plans this sare no longer needed another source." The this plan of care. A review of the record "Comprehensive Adul 8/14/17, with time in complete PM. This note evider by Employee H, RN, and Under discharge plans "other" and stated, "When the product of the record visits completed on 8/12/17, 8/23/18, 8/24/17, 8/29/17, 8/30/17, 9/5/17, 9/6/17, 9/7/17/17/17/17/17/17/17/17/17/17/17/17/1	cord #8, diagnosis of icating pregnancy, start of a plan of care for the 8/18/17 - 10/16/17. The of evidence a discharge arge summary had been charge was requested by a caregiver's refusal to sign discharge plans on the plan ce goals the patient was to s further evidenced by the diffication and plan of care for the folial of 8/18/17 - 10/16/17, als/ rehabilitation potential/ statement, "When services or can be provided by the diffication and time out of 5 and signed on this date. So the patient was completed and signed on this d	G	550			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DATE COMP	SURVEY
		15K070	B. WING				C
	ROVIDER OR SUPPLIER	10000	5	224 W	ET ADDRESS, CITY, STATE, ZIP CODE JEFFERSON BLVD STE 200 TH BEND, IN 46601	USI	16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 550	Continued From page		G	550			
G 570	aide visit with no task. The note was signed Health Aide. A note of signature stated, "Por [illegible words after the signed by Employee In the only communicated the notes was dated of RN, which stated, "Plant 14/17. Need to use patient as of 9/23/17. 8/14/18 - 8/16/18. During an interview of administrator director patient went to a ground director of nursing incommunicated and summary were in the Care planning, coording CFR(s): 484.60 Patients are accepted reasonable expectation patient in the social needs in his or Each patient must reconstitute the plan of care, in additions. The individes specify the care and summary were assessive the patient-specific necomprehensive assessive identification of the result of the measurable outcomes.	tion about the discharge in 9/28/17 from Employee L, lease complete note on e that note to discharge "This review occurred" In 8/14/18 at 3:45 PM, the or of nursing indicated the up home. The administrator/dicated the discharge oasis of found in the record. ination, quality of care In that an HHA can meet the resing, rehabilitative, and ther place of residence. Including any revisions or clualized plan of care must be services necessary to meet eeds as identified in the sesment, including esponsible discipline(s), and omes that the HHA as a result of implementing	G	570			

AND DUAN OF CORDECTION		1 ' '	PLE CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 570	patient and caregiver Services must be furr accepted standards of This CONDITION is Based on observatio interview, the agency provided per the plan treatment and service of a physicians order ensure the plans of coduration of visits specified, failed to ensurall required elements provided and the goaf failed to ensure all parecorded on the plan to promptly notify the patient's condition (see the clinical record conthe patient's physicial representative was in discharge (See G 598 communication with a plan of care (see G 6	care must also specify the education and training. hished in accordance with if practice. In the record review and failed to ensure visits were of care and failed to ensure is were not provided absent (See G 572); failed to are contained frequency and sific to the certification in the plan of care contained including the tasks to be is to achieve (see G 574); tient care orders were of care (see G 576); failed physician of changes in the re G 590); failed to ensure intained documentation that in and the legal formed in advance of a si); failed to ensure the ordinated the patient's care medical equipment)	G 57	70		
G 572	resulted in the home ensure the provision safe environment for 484.60 Condition: Ca Quality of Care.	of these systemic problems health agency's inability to of quality health care in a the condition of participation are Planning, Coordination,	G 57	72		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION 3	COMPLETED	
		15K070	B. WING		08/16/2018	ł
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUS CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET	TION
G 572	Continued From pa	ge 39	G 57	72		
	services that are writed of care that identified outcomes and goals periodically reviewed medicine, osteopath scope of his or her stregistration. If a phyplan of care that care an evaluation visit, the approve additions of plan. This STANDARD is Based on observation interview, the agency provided per the plant records (#2, #4, #9) treatment and services.	eceive the home health of the in an individualized plan is patient-specific measurable is, and which is established, id, and signed by a doctor of any, or podiatry acting within the state license, certification, or sician refers a patient under a most be completed until after the physician is consulted to a modifications to the original of the individual in not met as evidenced by: on, record review and the individual in the individual in the individual in the individual individual in the individual				
	of Treatment" dated prepares a plan of treatment available to the ager are established and care services the agratients who a. Are physician for a diagonal have a health care restatus requiring mediadmitted to service and admitted to service at the agency policy. The agency policy properties are plant and admitted to service and admitted to service and admitted to service at the agency policy.	y titled "2.21 Physician's Plan 2015 stated, "A physician reatment and it is made ncy. 2. Physician's orders documented for the health tency provides to those being actively treated by a nosed health care problem b. need or change in physical dical intervention c. are				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	, ,	DATE SURVEY COMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC		,	STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 572	provision of nursing sperformance, directic care tasks pursuant to consistent with an extension and a sperformance. 3. The agency policy provided Registers nursing care by the volume trained professionals orders, monitor and it their care The licer assigned care under RN's are licensed in regulations and stand the state. 4. All LPN follow all regulations required by the state these services are professionals orders. 4. A review of clinication of care for the certification of care for the certification as evidenced by the care and services abouting the certification as evidenced by the care / 485 information of 7 AM and time of and was electronically administrator / directions of the provided were serviced as the constant of the care and services and during the certification of the care / 485 information of 7 AM and time of and was electronically administrator / directions of the care in the care and services and time of the care in the care i	ssion of nursing The services includes the on or supervision of health to a plan of care and sisting medical regimen." It titled "2.23 Services and Nurses provide quality follow the physician's instruct the patient regarding insed practical nurse provides the direction of a RN. 3. All Indiana and follow all dards of practice required by its are licensed in Indiana and and standards of practice Home health aides rovided in accordance with all record #1, included a plan station period of 6/6/18 - home health aide conducted sent of a physician order in period of 6/6/18 - 8/4/18, following: fication Follow - up g OASIS elements with Plan station dated 6/1/18 with time out of 10 AM, was completed by signed on 6/5/18 by the or of nursing. The services written as supervisory visits, HA (home health aide) 7	G	572		
	A verbal order for SN	l and Aide services was				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	.	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 572	nursing. The order of did not evidence frequently health aide visits, and the plan of care for the 6/6/18 - 8/4/18, failed aide orders. This order by the administrator of 6/5/18. A HHA visit note date Employee B, LPN, evidence of care including care, check pressure with medications, and am A HHA visit note date Employee B, evidence care including a bath check pressure areas medications, and am A HHA visit note date Employee C, HHA, evidence of care including personal care, hair cambulation assist, and A HHA visit note date Employee B, evidence care including personal care, assist preparation, and was HHA visit notes dated 7/19/18, signed by E	the administrator / director of only contained RN duties and quency, duration of home of the tasks to be completed. The certification period of the to evidence home health der was electronically signed of director of nursing on the defendence of the patient had 6 and a bath, personal care, hair eareas, nail hygiene, assist of ambulation assist. The defendence of the patient had 7 hours of the patient had 7 hours of the patient had 7 hours of the patient had 8 and 11/18 and signed by the defendence of the patient had 5 and a bath, assist with bulation assist. The defendence of the patient had 5 and a bath, assist with medications, and mobility assist. The defendence of the patient had 6 hours of the patient had	G	572		

PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) G 572 Continued From page 42 HHA visit notes dated 6/15/18, 7/13/18, 7/26/18, 7/27/18, and 7/31/18, signed by Employee B,		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC SOUTH BEND, IN 46601 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) G 572 Continued From page 42 HHA visit notes dated 6/15/18, 7/13/18, 7/26/18, 7/27/18, and 7/31/18, signed by Employee B,			15K070	B. WING			l	-
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) G 572 HHA visit notes dated 6/15/18, 7/13/18, 7/26/18, 7/27/18, and 7/31/18, signed by Employee B,			•		22	24 W JEFFERSON BLVD STE 200	1 00	10/2010
HHA visit notes dated 6/15/18, 7/13/18, 7/26/18, 7/27/18, and 7/31/18, signed by Employee B,	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
HHA, evidenced the patient had 6 hours of care including a bath and personal care. A HHA visit note dated 6/18/18, signed by Employee B, evidenced the patient had 4 hours of care including a bath and personal care. HHA visit notes dated 7/6/18, 7/9/18, 7/12/18, and 7/17/18, signed by Employee C, evidenced the patient had 6 hours of care including a bath and personal care. A HHA visit note dated 7/16/18, signed by Employee D, HHA, evidenced the patient had 6 hours of care including a bath and personal care. A HHA visit note dated 7/18/18, signed by Employee D, evidenced the patient had 6 hours of care including a bath and personal care. A HHA visit note dated 8/2/18, signed by Employee B, evidenced the patient received 8 hours of personal care and a bath and other care. 5. A review of clinical record #2, with a start of care 12/4/17, principal diagnosis of pressure ulcer of sacral region, failed to evidence skilled nurse and home health aide visits were provided per the physician ordered plan of care and the record evidenced SN and HHA conducted care and services absent of a physician's order as evidenced by: A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 -	G 572	HHA visit notes dated 7/27/18, and 7/31/18 HHA, evidenced the including a bath and A HHA visit note date Employee B, evidence care including a bath HHA visit notes dated 7/17/18, signed by Epatient had 6 hours of personal care. A HHA visit note date Employee D, HHA, en hours of care including a bath and the end of care 12/4/17, principal of sacral region, failed and home health aid physician ordered plate evidenced SN and H services absent of a evidenced by: A review of a Home in the end of the end of the end of the end of the evidenced by:	d 6/15/18, 7/13/18, 7/26/18, s, signed by Employee B, patient had 6 hours of care personal care. ed 6/18/18, signed by ced the patient had 4 hours of and personal care. d 7/6/18, 7/9/18, 7/12/18, and mployee C, evidenced the of care including a bath and ed 7/16/18, signed by evidenced the patient had 6 hours ath and personal care. ed 7/18/18, signed by ced the patient had 6 hours ath and personal care. ed 8/2/18, signed by ced the patient received 8 re and a bath and other care. el 8/2/18, signed by ced the patient received 8 re and a bath and other care. el record #2, with a start of al diagnosis of pressure ulcer ed to evidence skilled nurse e visits were provided per the an of care and the record lHA conducted care and physician's order as	G	572			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION IG	· /	ATE SURVEY OMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 572	hours a day, 3 days a HHA orders 6 hours a weeks. The plan of of tasks that would be of document was electroadministrator / directed electronically signed. A review of home head evidenced visits occut 6/10/18, 6/13/18, 6/13/18, 6/13/18, 6/13/18 (week 4), no 6/30/18 (week 5), no 7/7/18 (week 6), no 7/7/18 (week 6), no 7/12/18 and 7/14/18, 7), no visits between and 7/21/18 but two worders (week 8), no visits from 7/26/18, and 7/28/18 7/27/18 (week 9). The home health aide vision week. A review of a skilled 6/5/18, 6/9/18, 6/12/11 Employee B visited the day. Tasks completed vital signs, dressing of coccyx area and right catheter assessed. A review of a physicial completed by the physical completed by the physica	a week, for 26 weeks and a day, 7 days a week, 9 care failed to evidence the ompleted by the staff. This polically signed by the or of nursing on 5/31/18 and by the physician on 6/7/18.	G 5	572		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	PLE CONSTRUCTION G	COMPLETED
		15K070	B. WING		08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
G 572	completed by the ac nursing, evidenced visit 5 hours a day, and skilled nursing 2 for 26 weeks per ne The order failed to be certification period be and failed to include the skilled nurse and A review of a skilled 6/21/18, 6/27/18, 6/2 evidenced Employe completed absent of nursing assessment catheter monitoring, patient for 2 hoursoin than 2 hours on 7/6/2 A review of a skilled 6/25/18, evidenced patient. Tasks comporder were nursing a suprapubic catheter catheter was change (cubic centimeter) be A review of a skilled	ian order dated 6/20/18, and diministrator / director of the home health aide was to 7 days a week, for 26 weeks 2 hours a day, 3 days / week, w PA (prior authorization). The specific to the remaining between 6/20/18 to 7/31/18 of the tasks to be provided by displayed home health aide nurse visit note dated 29/18, 7/2/18, 7/6/18, 7/9/18, a B visited the patient. Tasks of a physician's order were 1, vital signs, and suprapubic 1 Employee B visited the 16/29, 7/2, 7/9/18 and less 18. nurse visit note dated Employee B visited the 16/29, 7/2, 7/9/18 and less 18. nurse visit note dated Employee B visited the 16/29, 7/2, 7/9/18 and less 18. nurse visit note dated Employee B visited the 16/29, 7/2, 7/9/18 and less 18.	G 5	72	
	patient for 2 hours. physician's order we signs, and supraput note failed to evider been conducted. A review of a skilled	Tasks completed absent of a sere nursing assessment, vital sic catheter monitoring. The side if dressing changes had nurse visit note dated Employee B visited the			

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	· /	ATE SURVEY DMPLETED
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 572	patient for 2 hours. physician's order we signs, the wound on measured, and supra The note failed to evhad been conducted A review of a skilled 7/23/18, evidenced Epatient for 1.5 hours a physicians order wigns, the wound on measure, and supra A review of a physician included orders for thorder of absorptive siceanses two times a conducted during this A review of a skilled 7/27/18, 7/30/18, evithe patient for 2 hour of a physician's orde vital signs, the wound measured, and supra was completed. The dressing changes had A review of a physicianing change had a review of	Tasks completed absent of a re nursing assessment, vital the sacral area was apubic catheter monitoring. Idence if dressing changes rurse visit note dated applyee B visited the Tasks completed absent of ere nursing assessment, vital the sacral area was pubic catheter monitoring. In order dated 7/23/18, and order dated 7/23/18, are right sacrum for dressing iliver and mepilex border with a week. Only 1 visit was as week (7/22/18 to 7/28/18). In order dated Tyzel to	G 5	72		

AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 572	Continued From page	e 46	G 5	72			
	OASIS elements with information dated 7/3 administrator / director. The wounds were medicansed with sterile colloidal silver and my with mepilex border. Wound was contamination were thoroughly was prior to dressing characontamination." The conducted absent of 6. A review of clinical care 12/13/17, and pressential hypertension nurse conducted care physician's order as of Review of the plan of period of 6/11/18 - 8/4 agency was to set up checking blood sugar. Review of A skilled may Employee B dated nurse set up the paties stated, "Medications Review of a skilled may Employee B dated evidenced the nurse medications for the medications for the medications for the medications."	and completed by the or of nursing on 7/31/18. Easured. The wounds were saline and then packed with statin cream and dressed. The document stated, "The lated with fecal matter, areas the with soap and water, are deviation of treatment was a physician's order. If record #3, with a start of rincipal diagnosis of on, evidenced the skilled and services absent of a revidenced by: If care for the certification 9/18, failed to evidence the pothe patient's medications or results. Fursing visit note completed the foliations or results. Fursing visit note completed the ent's medications. A note dispensed as ordered." Fursing visit note completed the ent's medications. A note dispensed as ordered."					
	administrator / director	or of nursing indicated the sont on the plan of care.					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				C 1 6/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601			10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 572	care 11/16/17, and programmed plan of care and the reconducted care and sphysician's order as a A review of the Home Plan of Care for the conducted care for the conducted care and sphysician's order as a A review of the Home Plan of Care for the conducted to the conducted to the plan of Care for the conducted to the plan of the	I record #4, with a start of cincipal diagnosis of covidence skilled nurse per the physician ordered record evidenced SN services absent of a revidenced by: Health Certification and rertification period of 7/14/18 restilled nurse was to visit lys a week. There were no ren on this document except renadicin 30 cc ml daily Extended Hour Nursing Flow and completed by Employee as were completed absent of A physical assessment nutritional assessment, rent, cardiovascular ory assessment, sement, genitourinary g suprapubic catheter retion, repositioning every 2 rent, skin assessment, trach ge with fenestrated size 4 d care on right buttock was seed with soap and water,	G	572			
		and completed by Employee					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	10/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
G 572	physician's order: A including vital signs, neurological assessment gastrointestinal asses assessment of supra repositioning every 2 skin assessment, trawith discussion abour increased protein to predications were set completed, shower granged, new dressing care completed, shower granged, new dressing care completed assessment assessment, respirat gastrointestinal assessment of supra repositioning every 2 skin assessment and patient education saf wheelchair, and med. A review of an Adult I Sheet dated 7/17/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment and patient education saf wheelchair, and med. A review of an Adult I Sheet dated 7/17/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment, respirat gastrointestinal assessment, respirat gastrointestinal assessment, respirat gastrointestinal assessment, respirat gastrointestinal assessments.	ere completed absent of a physical assessment nutritional assessment, anent, cardiovascular ory assessment, genitourinary pubic catheter and irrigation, hours, pain assessment, ch care, patient education to proper nutrition and promote wound healing, and placed and suprapubic eted. Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment, ment, cardiovascular ory assessment, wound care, trach care, ety while sitting in iterations provided. Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment, wound care, trach care, ety while sitting in iterations provided. Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment nutritional assessment, nutritional assessment, nutritional assessment, nutritional assessment, nutritional assessment, assessment, cardiovascular ory assessment,	G 5	72			

STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION G	COMPL	COMPLETED	
		15K070	B. WING		C 08/1	6/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		1 00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 572	pain assessment, sk care, trach care, and A review of an Adult Sheet dated 7/18/18 M, indicated tasks with physician's order: A including vital signs, neurological assessment, respiral gastrointestinal assessment of suprapain assessment, sk care, trach care, me program was completed. A review of an Adult Sheet dated 7/19/18 M, indicated tasks with physician's order: A including vital signs, neurological assessment, respiral gastrointestinal assessment of suprapain assessment, sk care, trach care, me collar replaced. A review of an Adult Sheet dated 7/20/18 M, indicated tasks with physician's order: A including vital signs, neurological assessment, respiral gastrointestinal assessment, respiral gastrointestinal assessment, respiral gastrointestinal assessment of supragastrointestinal assessment of supragastroin	Extended Hour Nursing Flow and completed by Employee vere completed absent of a hypysical assessment, ment, cardiovascular and completed absent of a hypysical assessment, ment, cardiovascular and assessment, genitourinary apubic catheter and irrigation, kin assessment and wound dications set up, and bowel eted. Extended Hour Nursing Flow and completed by Employee vere completed absent of a hypysical assessment, ment, cardiovascular and assessment, genitourinary apubic catheter and irrigation, kin assessment, genitourinary apubic catheter and irrigation, kin assessment and wound dications set up, and trach Extended Hour Nursing Flow and completed by Employee vere completed absent of a hypysical assessment and wound dications set up, and trach	G 57	72			

i ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · · · · · · · · · · · · · · · · ·		COMPLETE	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _		08/16/20	118	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COM	(X5) MPLETION DATE	
G 572	Sheet dated 7/21/18 B, evidenced the nuapproximately 3 hour Tasks completed abover a physical association assessment, gastroigenitourinary assessment, gastroigenitourinary assessment, shand medication administration of a physicia assessment includir assessment, neurole cardiovascular assessment, gastroigenitourinary assessment, neurole cardiovascular assessment, gastroigenitourinary assessment, shand medication administration administration of a physicia assessment, gastroigenitourinary assessment, shand medication administration administra	Extended Hour Nursing Flow and completed by Employee rse had completed ur visit from 8:49 AM - 12 PM. sent of a physician's order ressment including vital signs, ent, neurological assessment, ssment, respiratory intestinal assessment, trach care, sinistration. Extended Hour Nursing Flow and completed by Employee rse had completed a 1 hour 7:51 PM. Tasks completed n's order were a physical rigidital signs, nutritional rigidital assessment, ssment, respiratory intestinal assessment, ssment, respiratory intestinal assessment, ssment, respiratory intestinal assessment, stin assessment, trach care, sinistration. Extended Hour Nursing Flow and completed by Employee rse had completed by Employee rse had completed a 1:45 - 8:45 AM. Tasks completed	G 5				
	absent of a physicia assessment includir assessment, neurol cardiovascular asse assessment, gastro genitourinary assess	n's order were a physical ng vital signs, nutritional ogical assessment,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	E	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
G 572	medication administra A review of an Adult E Sheet dated 7/22/18 a B, indicated tasks we physician's order: A p including vital signs, r neurological assessm assessment, respirate gastrointestinal asses assessment of suprap assessment, skin ass A review of an Adult E Sheet dated 7/23/18 a M, indicated tasks we physician's order: A p including vital signs, r neurological assessm assessment, respirate gastrointestinal asses assessment of suprap pain assessment, skin care, trach care, and administration. A review of an Adult E Sheet dated 7/27/18 a M, indicated tasks we physician's order: A p including vital signs, r neurological assessm assessment, respirate gastrointestinal asses assessment, respirate gastrointestinal asses assessment of suprap pain assessment, skin	extended Hour Nursing Flow and completed by Employee re completed absent of a physical assessment autritional assessment, sent, cardiovascular pry assessment, and trach care. Extended Hour Nursing Flow and completed by Employee re completed absent of a physical assessment autritional assessment autritional assessment, sent, cardiovascular pry assessment, sent, cardiovascular pry assessment, sent, genitourinary public catheter and irrigation, assessment and wound medications set up and extended Hour Nursing Flow and completed by Employee re completed absent of a physical assessment and wound medications set up and extended Hour Nursing Flow and completed by Employee re completed absent of a physical assessment autritional assessment, ent, cardiovascular pry assessment, assess	G	572		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COMPLE	COMPLETED	
		15K070	B. WING		C 08/16	6/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/10	0/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 572	A review of an Adult I Sheet dated 7/28/18 M, evidenced the nur visit from 8 am - 1:30 absent of a physician Suprapubic catheter cc catheter, and track During an interview of administrator / director record lacked a compression of a physician's ordered plan of care skilled nursing provider of Care for the CPT of a physician's ordered Plan of Care for the CPT of a complete of care skilled nursing providered plan of care skilled nursing providered plan of care for the CPT of a complete of a care skilled nursing providered plan of care skilled nursing providered plan of care for the CPT of a complete of a care skilled nursing providered plan of care skilled nursing providered plan of care for the CPT of a complete of the CPT of a care skilled nursing providered plan of care skilled nursing providered plan of care for the CPT of a care skilled nursing providered plan of care for the CPT of a care skilled nursing providered plan of care for the CPT of a care skilled nursing providered plan of care skilled nursing providered plan of care skilled nursing providered plan of care for the CPT of a care skilled nursing providered plan of care skilled nur	extended Hour Nursing Flow and completed by Employee se completed a 5 1 / 2 hour PM. Tasks completed I's order: Assessments, change with a 26 French 10 in care. In 8/16/18 at 12:05 PM, the per of nursing indicated the plete plan of care. The reders for the care received. In a station of the home visit on patient #9 was observed to with an air mattress. The per of nursing was observed by taking vital signs and an ebulizer treatment with rest treatment was started at I.M. The CPT treatment was mately 9:50 AM. Also pulizer treatment with the suctioning of the 14 French suction tube and lided per the physician and the record evidenced ed care and services absent	G 5	72			

· · ·		IDENTIFICATION NUMBER.		IPLE CONSTRUCTION NG	' '	COMPLETED	
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	,	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 572	evidenced a start of document evidenced administrator / direction indicated the patient catheter, and a feedi indicated orders for the boluses 240 CC ever family. Tasks perform order were: A physic site was washed with dry, suprapubic cathet water, rinsed well, and A review of an Adult I Sheet dated 7/2/18 and administrator / direction urse had completed physic assessment (the patimouth); neurological assessment, respirate humidification, CPT gastrointestinal assection colostomy); genito - usuprapubic catheter soapy H20 (Catheter balloon); reposition eassessment; skin assection and inner catracheal suctioning corecorded.	prehensive Adult Assessment care on 6/27/18. This a visit from the corrof nursing. The document had a colostomy, suprapubicing tube. The document he enteral feedings were by 4 hours, performed by hed absent of a physicians call assessment, feeding tube in soap and water and patted eter washed with soap and had patted dry. Extended Hour Nursing Flow and completed by the corrof nursing, evidenced the lata 8 hour visit from 8 AM - 4 dabsent of a physician's call assessment, nutritional ent receives nothing by assessment with a note: vest treatment completed, ssment (patient has a urinary assessment with warm exite is 24 French, 10 cc every 2 hours; pain sessment; trach ties annula changed; oral and ompleted; and intake	G	572			
	Sheet dated 7/9/18 a	Extended Hour Nursing Flow and completed by the or of nursing, evidenced the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			S. WWY.			С	
		15K070	B. WING			08/16/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
TMC HOM	IE HEALTH CARE INC			224 W JEFFERSON BLVD STE 200			
TIVIG HOIV	IE NEALIN CARE INC			SOUTH BEND, IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 572	PM. Tasks complet order were: A physical assessment (the parmouth); neurological assessment, respiration concerning humidiffication for the parmouth); neurological assessment, respiration for the parmouth of the parmouth o	ge 54 ed a 8 hour visit from 8 AM - 4 ded absent of a physician's dical assessment, nutritional ditient receives nothing by al assessment, cardiovascular datory assessment with note datory assessment and appliance datory assessment and appliance datory assessment with rechains description assessment; trach description and description and description assessment; trach description and description assessment description assessment description assessment description	G	572			
	nurse had complete PM. Tasks complete PM. Tasks complete order were: A physiassessment (the paramouth); neurological assessment, respiration concerning humidification testinal assessment; genitosuprapubic cathetetes soapy H20; reposition assessment; skin a changed and inner humidification remossibiley, uncuffed tra	ed a 6 hour visit from 8 AM - 2 ted absent of a physician's ical assessment, nutritional itient receives nothing by al assessment, cardiovascular atory assessment with note cation, CPT vest X 1/2 hour; essment (patient has a - urinary assessment with r site cleansed with warm on every 2 hours; pain ssessment; trach ties					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG	· ,	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 8/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 0	0/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 572	intervals at 14 pressure upper and lower extre Isosource 240 cc follof flush. A review of an Adult E Sheet dated 7/30/18 administrator / director nurse had completed Tasks completed abswere: A trach ties chochange, cough assist gastric tube feeding of flushed with 240 cc who who who with 240 cc who who who with 240 cc who	placed on for 15 minute are; range of motion on emities; and feeding of owed by 200 cc of water for extended Hour Nursing Flow and completed by the or of nursing, evidenced the a visit from 8 AM - 3:15 PM. ent of a physician's order ange and inner cannula used, suctioned trach, given bolus as ordered fater, and bed bath given. Extended Hour Nursing Flow and completed by the or of nursing, evidenced the a visit from 8 AM - 4 PM. ent of a physician's order anged and inner cannula rach, gastric tube feeding ered, flushed with water; and a 8/13/18 at 10 AM, the	G 5	72		
G 574	administrator / director plan of care was not of Plan of care must inc CFR(s): 484.60(a)(2)	lude the following	G 5	74		
	the following: (i) All pertinent diag	d plan of care must include noses; ntal, psychosocial, and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		COMPLETED	
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER	10.000		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		06/16/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 574	equipment required (iv) The frequency made; (v) Prognosis; (vi) Rehabilitation provided (ivi) Functional limit (viii) Activities provided (ixi) Autritional requipment (ixi) Adescription of emergency department re-admission, and an address the underly (ixii) Patient and training to facilitate (ixiv) Patient-speeducation; measural identified by the HH (ixiv) Information reladirectives; and (ixiv) Any addition may choose to incluing the tasks of the plan of care contained frequency for 5 of 6 may find the plan of the pl	ervices, supplies, and ; and duration of visits to be potential; ations; permitted; premitted; prements; and treatments; and treatments; and treatments injury; and the patient injury; and caregiver education and atimely discharge; actific interventions and able outcomes and goals and the patient; atted to any advanced and items the HHA or physician and i	G 5	74			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP COL 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	DE	00/10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 574	and documented for agency provides to the being actively treated health care need or can a diagnosed health care need or can a diagnosed health care need or can diagnosed health care to service with the agplan of treatment must the attending physicial days after the admissional include the type are provided specific of necessary medical care and the certification per to evidence home health aide. The failed to evidence the home health aide. The following: A review of a docume Follow - up assessments with Plan or dated 6/1/18, with time 10 AM, was completed signed on 6/5/18 by the nursing. The docume be provided were supprecertification, and the visits 7 days a week to administrator / direction order for only RN duties.	n's orders are established the health care services the lose patients who a. are by a physician b. have a hange in physical status for are problem c. are admitted ency 4. A physician's at be signed and dated by an and in the chart within 30 sion to the agency and must ad frequency of services raders and frequency of visits equipment." If record #1, the plan of care eriod of 6/6/18 - 8/4/18 failed alth aide frequency, duration a certification period and attasks to be provided by the his was evidenced by the entitled "Recertification ent" that included OASIS of Care / 485 information are in of 7 AM and time out of ead and was electronically the administrator / director of ent indicated the services to be provided by the core of nursing, evidenced an ites and did not evidence on of home health aide visits	G	574		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	E	33713/2313	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
G 574	Continued From page		G 5	74			
	6/6/18 - 8/4/18, failed and duration of home the certification perio provided by the home care was electronical	e health aide. This plan of					
	6/13, 6/14, 6/15, 6/18 7/16, 7/17, 7/18, 7/19 indicated specific AD assistance with medi washing clothes were	notes dated 6/7, 6/9, 6/11, 8, 6/20, 7/6, 7/9, 7/12, 7/13, 9, 7/27, 7/31, and 8/2/18 L's/ personal care including cations, meal preps, and e provided by a licensed ome health aide from 4 to 8					
	for the certification per to contain all the requevidence skilled nurs frequency and duration certification period, a	all record #2, the plan of care eriod of 6/6/18 - 8/4/18 failed uired elements, failed to ing and home health aide on of visits specific to the nd the tasks to be provided the home health aide. This e following:					
	by the physician, evic cleanse all wounds, p with absorptive silver border; the peri anal	ted 4/30/18, and completed denced wound care orders to back the right sacrum wound and cover with mepilex area was to be clean and tow was to be protected.					
	patient was to have s services. There was	5/30/18, evidenced the skilled nursing and aide no frequency and duration for the staff to complete.					
	A physician order dat	ted 5/31/18, and completed					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		33/10/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 574	day, 3 days a week, medication monitorin suprapubic catheter of program 3 times a word The home health aid with ADLs and IADLs preparation, houseked shopping, errands, and arranging special order failed to include skilled nursing and his specific to the 6/2/18 period. A review of a Home of Care for the certific 7/31/18, evidenced shours a day, 3 days and HAA orders 6 hours a weeks. The plan of contasks that would be condicated on the 5/31 failed to evidence go and discharge plans, (durable medical equipmeasures, activities sections were all bland electronically signed director of nursing or signed by the physicial A review of home head 6/2, 6/3, 6/4, 6/5, 6/6	director of nursing, I nurse was to visit 3 hours a for 26 weeks for wound care, g, health monitoring, changes and care and bowel eek by digital disimpaction. e was to visit for assistance s, supervision, meal eeping, laundry, grocery ssistance with appointments, dized transportation. The e a duration and frequency of ome health aide visits to 7/31/18 certification Health Certification and Plan cation period of 6/2/18 - killed nursing orders for 3 a week, for 26 weeks and a day, 7 days a week, 9 care failed to evidence the completed by the staff as /18 physician's order and als, rehabilitation potential, and the mental status, DME sipment) and supplies, safety permitted, and allergies nk. This document was by the administrator / n 5/31/18 and electronically an on 6/7/18. alth aide visit notes dated n 6/7, 6/8, 6/9, 6/10, 6/13,	G &	574			
	6/23, 7/13, 7/18, 7/20 indicated HHAs com	7, 6/18, 6/19, 6/21, 6/22, 0, 7/25, and 7/27/18, pleted tasks such as bathing, are, catheter care, record					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING		C 08/16/2018		
NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601 X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX TAG TAG TO CROSS-REFERENCED TO THE APPROPFICIENCY) G 574 Continued From page 60 output / input, inspect / reinforce dressing, ambulation assist and other tasks. A review of skilled nurse visit notes evidenced visits occurred on 6/5, 6/9, 6/12, 6/16, 6/21, 6/25, 6/27, 6/29, 7/2, 7/6, 7/9, 7/18, 7/20, 7/23, 7/27, and 7/30/18, and indicated nursing assessments, vital signs, dressing change for wounds on sacral, coccyx area and right elbow area, wound measurements, suprapubic catheter assessments, suprapubic catheter was changed using a 26 French / 30 cc (cubic centimeter) bulb. A review of the "Recertification Follow - up assessment" including OASIS elements with plan of care / 485 dated 7/31/18 and completed by the administrator / director of nursing on 7/31/18, indicated the wounds were measured. A review of a Home Health Certification and Plan				1 00.10/2010			
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION		
G 574	output / input, inspect ambulation assist an A review of skilled no visits occurred on 6/8 6/27, 6/29, 7/2, 7/6, and 7/30/18, and indivital signs, dressing coccyx area and right measurements, supragassessments, supragassessments, supragassessments, supragassessments, including of care / 485 dated 7 administrator / direct indicated the wounds. A review of a Home of Care for the certificular of care and failed supplies, safety mean orders evidenced a shours a day 3 days a orders for 5 hours a weeks. A review of skilled nuture assessments, vital situation of carea, wound measurassessments, and carea, wound measurassessments, and carea con formal saline.	et / reinforce dressing, d other tasks. urse visit notes evidenced 5, 6/9, 6/12, 6/16, 6/21, 6/25, 7/9, 7/18, 7/20, 7/23, 7/27, icated nursing assessments, change for wounds on sacral, at elbow area, wound apubic catheter was changed 30 cc (cubic centimeter) bulb. ertification Follow - up and OASIS elements with plantal ration period of 8/1/18, were measured. Health Certification and Plantal cation period of 8/1/18 - led by administrator/ director 3. This plan of care was not to include the DME/sures, and goals. The SN frequency and duration 2 at week for 26 weeks and HHA day, 7 days a week for 26 urse visit noted dated 8/1,	G 57	74			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 574	hypertension, the plaperiod of 6/11/18 - 8/skilled nurse was to smedications. This was following: Review of A skilled roby Employee B dated evidenced the nurse medications for the following in the following an interview of administrator / direct medication set up was 5. A review of clinical care 11/16/17 and programmed for following in the plaperiod of 7/14/18 - 9/stasks to be completed was evidenced by the A review of the Home Plan of Care for the following day/7 days additional tasks writted under Medications: It irrigation. A review of an Adult Sheet dated 7/14, 7/7/20, 7/21 (x2 visits), and 7/28/18, indicated	incipal diagnosis of essential n of care for the certification 9/18 failed to evidence the set up the patient's as evidenced by the nursing visit notes, completed 6/16, 6/23, and 6/3018, set up the patient's following week. A note on ications dispensed as on 8/16/18 at 12 noon, the for of nursing indicated the set not on the plan of care. If record #4 with a start of incipal diagnosis of n of care for the certification 11/18 failed to evidence the deby the skilled nurse. This is efollowing: If the Health Certification and certification period of 7/14/18 the skilled nurse was to visit a week. There were noten on this document except Renadicin 30 cc ml daily Extended Hour Nursing Flow 15, 7/16, 7/17, 7/18, 7/19, 7/22 (x2 visits), 7/23, 7/27, d physical assessment nutritional assessment,	G 5	574			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 8/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	CODE	0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETION DATE	
G 574	gastrointestinal as assessment includ assessment and ir hours, pain assess care, and trach chauncuffed trach, wo measured and cleapatted dry, with dreeducation with discadministered, blad suprapubic and tracand new dressings being completed a with a 26 French 1 During an interview administrator / directord lacked a corecord was lacking 6. During an obse 8/13/18 at 9:10 AM be in a hospital be administrator / directord to assess the patie then give the patie albuterol. The CP approximately 9:28 completed at approximately was a redication albuter tracheostomy with cough assist. A review of clinical	ratory assessment, sessment, genitourinary ing suprapubic catheter rigation, repositioning every 2 sment, skin assessment, trach ange with fenestrated size 4 und care on right buttock was ansed with soap and water, essing applied, patient cussion, medications were der irrigated, shower given, ich care, trach collar changed is placed, bowel program was not suprapubic catheter change in occ catheter was completed. In on 8/16/18 at 12:05 PM, the ector of nursing indicated the implete plan of care. The in orders for the care received. In orders for the care received. In patient #9 was observed to do with an air mattress. The ector of nursing was observed and by taking vital signs and into a nebulizer treatment with it is a complete to the colling of the colling of the interest of the care received at the section of the home visit on the colling of the interest with the colling of the interest with the colling of the interest with a start of care interest.	G	574			
	evidenced the Cor	oal diagnosis of Quadriplegia, nprehensive Adult Assessment e document indicated the					

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	` ′	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	75, 15, 2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 574	admission and indical was completed, the parapubic catheter, document indicated of feedings was a bolust performed by family, site was washed with dry and the suprapuble soap and water, rinson Review of the plan of period of 6/27/18 - 8/10 nurse was to visit 60 care failed to contain such a as safety meanutritional requireme potential / discharge to include size of supcare, gastric tube cattasks to be provided evidenced by the follow A review of an Adult Sheet dated 7/2,7/9, the administrator/ dirphysical assessment patient receives noth assessment, cardiov respiratory assessment patient receives noth assessment, cardiov respiratory assessment suprapubic catheter soapy H20; reposition assessment; skin assechanged and inner catracheal suctioning contractions.	or of nursing conducted the sted a physical assessment patient had colostomy, and a feeding tube. The proders for the enteral is 240 CC every 4 hours to be a soap and water and patted poic catheter was washed with ead well, patted dry. If care for the certification (25/18, evidenced the skilled hours a month. The plan of all the required elements assures, DME and supplies, ints, and goals/ rehabilitation plans box were blank, failed brapubic catheter, colostomy are and failed to evidence the by skilled nursing. This was owing: Extended Hour Nursing Flow 7/30, and 8/6/18, evidenced ector of nursing conducted a st, nutritional assessment (the ing by mouth); neurological ascular assessment, ent with a note: west treatment completed, sesment (patient has a urinary assessment with site cleansed with warm in every 2 hours; pain	G	574		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1	00/16/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 574	urine; full and passive on upper and lower e. A review of an Adult E. Sheet dated 7/16/18 administrator / director physical assessment, patient receives nothing assessment, cardiovarespiratory assessment humidification, CPT v. Gastrointestinal assess colostomy); genito - usuprapubic catheter soapy H20; reposition assessment; skin assessment; sk	e range of motion completed atremities; bed bath given; Extended Hour Nursing Flow and completed by the or of nursing, indicated a nutritional assessment (the eng by mouth); neurological ascular assessment, not with note concerning est X 1/2 hour; assment (patient has a rinary assessment with ite cleansed with warm a every 2 hours; pain essment; Trach ties annula changed; and from tracheotomy #6 and midline secured with Dale et in place to aid with laced on for 15 minute re. Range of motion on	G 5	74		
G 576	administrator / director plan of care was not of All orders recorded in CFR(s): 484.60(a)(3)	plan of care	G 5	76		
	must be recorded in the This ELEMENT is not Based on record reviews all patient care	s, including verbal orders, the plan of care. t met as evidenced by: ew, the agency failed to e orders were recorded on of 6 active records reviewed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			1	C / 16/2018
	ROVIDER OR SUPPLIER			22	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 576	(#1, #2). The findings included 1. A review of clinical evidence all patient of the updated plan of cevidenced by the follow. A review of a docume Follow - up assessment elements with Plan of dated 6/1/18, was confused for 26 weeks. The document indical provided were supervand HHA (home healf for 26 weeks. The document, oriented to place instructions. Become believing that someon Lung sounds essential becomes short of brewalker when inside the distances. Uses man Needs supervision and activities, ADLs [active [Instrumental Activities] Medication reminders reminders to eat, remote to leating and changing Housekeeping, laund	I record #1, failed to are orders were recorded on are. This was further owing: Int titled "Recertification ent" including OASIS Care / 485 information enter of the administrator and electronically signed on trator / director of nursing. The area of the services to be arisory visits, recertification, the aide) for 7 days a week ocumented reason for arices stated, "Awake and the and person. Follows are paranoid at times are is out to get [him / her]. The ally clear bilaterally, ath with activity. Uses the home and for short and we / c for distances. The arise of daily living], IADLs	G	576			
		and Aide services was the administrator / director of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		15K070	B. WING_			C 8/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		0/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 576	vital signs with SPO2 emotional; integumer nutrition/ elimination/ pain management wareview the plan of ca effectiveness and mafor drug interactions areconciliation if indicasafety, home safety, There was no order fhome health aide vis completed on this verelectronically signed director of nursing on period of 6/6/18 - 8/4 6/1/18 order on the understand of the certification period of evidence that all the were recorded on the certification period of evidenced by the follow. A physician, evidenthe right sacrum area pack into the wound border. The peri anal dry. Also the right ell The areas were to be a physician's order dry the administrator of evidenced the skilled day for 3 days a wee care, medication more	s to incorporate with sive assessment inclusive of a (oxygen) saturation, neuro / ntary; cardiopulmonary; hydration assessments and as adequate. The RN would be and medications for a ske needed revisions, check and complete, medication ated, assess for fall risk, fire DME supplies and or needs. For frequency and duration of a stand tasks to be a stand to stand the stand tasks to be a stand to stand the stand tasks to be a stand to be	G 5	76		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING		C 08/16/2018
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
G 576	The home health aide ADLs and IADLs, suphousekeeping, laund errands, assistance varranging specialized. A physician's order dathe physician evidence the right sacrum to be silver into the wound border. The peri anadry. Also the right ell. A physician's order dathe administrator / evidenced the home hours a day, 7 days a skilled nurse 2 hours weeks per new PA (physician's order dather and cleanses two times a Promptly alert relevant CFR(s): 484.60(c)(1). The HHA must promphysician(s) to any cleanses the are not being achieved care should be altered this ELEMENT is not based on record revagency failed to prome changes in the patient.	eek by digital disimpaction. e was to visit for assist with pervision, meal preparation, ry, grocery shopping, with appointments, and I transportation. ated 6/18/18 completed by sed wound care orders for e cleansed, pack absorptive and then cover with mepilex I area was to be clean and bow was to be protected. ated 6/20/18 and completed director of nursing, health aide was to visit 5 a week, for 26 weeks and a day, 3 days/ week, for 26 rior authorization). ated 7/23/18 included orders or dressing order of mepilex border with week. Int physician of changes otly alert the relevant hanges in the patient's at suggest that outcomes ed and/or that the plan of	G 55		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP C 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		3371372013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 590	Continued From page aide services ordered		G t	590		
	The findings include:	r by the agency.				
	Health Aide Documer Health Aides are to d provided on the visit concurrence with card documentation of car the home health aide documentation of the observations during t client's progress or documentation of the observations during t client's progress or documentation of the observations during t client's progress or documentation of the observations during the supervising nurse not limited to a). Incressin, foul smelling uring the original documer and filled in the chart. 2. A review of clinical 12/8/17 included a constant of the observations and the to evidence the agento patient #1's changing including rash and did assessment including of Care / 485 informat this assessment was administrator / direct electronically signed	e plan. Purpose 1. Provides e / services provided during visit. 2. Provides home health aide's he visits and evidence of emise. Special instruction: ide is responsible for s in the client's condition to e, such as the following but eased pain, reddened area to ne, falls, fatigue, edema. 2. Intation is to be completed within 14 days of the visit." I record #1, start of care entification period of 6/6/18 - r skilled nursing. The e following documents failed cy staff alerted the physician e of condition and concerns earrhea: Fication Follow - up g OASIS elements with Plan tion dated 6/1/18, evidenced completed by the or of nursing and on 6/5/18 by the				
		or of nursing. This nt assessment evidenced n in the buttocks and rectal				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				2	
NAME OF P	ROVIDER OR SUPPLIER	138070	B. WINO		TREET ADDRESS, CITY, STATE, ZIP CODE	08/	16/2018	
	E HEALTH CARE INC			2	24 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601			
	OLIMAN DV OT	ATEMENT OF DEFICIENCIES					0.5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
G 590	Continued From page	e 69	G	590				
		There was no notice of of this change of condition						
	Employee B, HHA, ev	d 6/7/18 and signed by videnced the following h has odor. Perianal rash						
	Employee B, HHA, ev	d 6/9/18 and signed by videnced the following improved. Pain when						
	Employee B, HHA, ev							
	Employee B, HHA, ev	d 6/18/18 and signed by videnced the following ness on perianal area."						
	Employee B, HHA, ev	d 7/13/18 and signed by videnced the following not irritated at this time."						
	Employee B, HHA, ev	d 7/26/18 and signed by videnced the following ure wounds. Perianal						
	Employee B, HHA, ev	area irritation worse. Extra						
	A HHA visit note date	d 7/31/18 and signed by						

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25	_		(c	
		15K070	B. WING _			08/	16/2018	
	ROVIDER OR SUPPLIER E HEALTH CARE INC			2:	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
G 590	mild perianal irritation A HHA visit note date. Employee B, HHA, experianal irritation at the During an interview of administrator / director Budreau butt cream in not in the record or record or record in the record or record revisions related discharge must be correpresentative, caregion or the HHA play primary care practition professional who will care and services to the record in the HHA (if any). This ELEMENT is not a Based on record revision and the leginformed in advance of closed records review. Findings include: A review of a clinical in the record in advance of closed records review.	d 8/2/18 and signed by ridenced the patient had no is time. n 8/16/18 at 10:15 AM, the or of nursing indicated that ad been used and this was ported to the Registered or other staff. munication iii) to plans for the patient's mmunicated to the patient, ever, all physicians issuing an of care, and the patient's her or other health care be responsible for providing the patient after discharge be the clinical record tion that the patient's had representative was of a discharge for 1 of 3 ared in a sample of 9. (#8)		590	DEFICIENCY)			
	pregnancy, generalize deficit hyperactivity di	physical abuse complicating ed epilepsy and attention - sorder, failed to evidenced a vestigated by the agency						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	DE	33, 13, 23 13
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
G 598	record, failed to evide inform the patient's prepresentative in advintentions to disharge the following: A review of the record "Comprehensive Adu 8/14/17, with time in PM. This note evide by Employee H, RN, Under discharge plar "other" and stated, "Vneeded or can be provisits completed on 8/22/17, 8/23/18, 8/28/17, 8/29/17, 8/39/5/17, 9/6/17, 9/13/17, 9/12/17, 9/13/17, 9/12/17, 9/13/17, 9/19/17, 9/20/17, 9/2 nurse visit was compounded visit with no task The note was signed Health Aide. A note of signature stated, "Po [illegible words after signed by Employee] Review of the clinical communication about was dated 9/28/17 frostated, "Please compto use that note to distance to distance to distance to distance to distance the signature to distance to distance to distance the signature to distance to distance the signature to distance the si	r staff. Review of the closed ence that the agency failed to hysician and legal ance notice of their e the patient as evidenced by devidenced a lit Assessment" dated of 3:42 PM and time out of 5 inced a visit was completed and signed on this date. Ins., Employee H checked box When services are no longer ovided by another source." Independent of evidenced home health (18/17, 8/19/17, 8/21/17, 18/25/17, 8/26/17, 19/17, 8/31/17, 9/17, 9/11/17, 9/15/17, 9/18/17, 1/17, 9/15/17, 9/18/17, 1/17, 9/22/17. A supervisory leted on 8/18/17. Independent of evidenced a home health as completed on 10/2/17. The purpose K, Home on this note under patient's like of attorney verbalized this.]" This was electronically K on 10/19/17. The record, the only the discharge in the notes of Employee L, RN, which elete note on 8/14/17. Need	G	598		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		15K070	B. WING		08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	7 30/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
G 598	the notes was dated RN, which stated, "F 8/14/17. Need to us patient as of 9/23/17 8/14/18 - 8/16/18. During an interview owner of the agency representative for payisit notes. The patiof the records that his sign without receiving rabbing aides in apstated, "[Patient #8] aides." The owner administrator and to the patient representative] we wishe would not sign to state of the patient representative of the patient repr	ation about the discharge in 19/28/17 from Employee L, Please complete note on see that note to discharge 7." This review occurred on 8/14/18 at 3:20 PM, the vindicated the patient atient #8 refused to sign the ent representative wanted all e / she signed and would not ag copies. The patient was propriately. The owner was abusive and would grab er indicated talking to the past ald the past administrator that tative needed to sign the visit of the patient would not service [him / her] if	G 59	<u> </u>	
	discharge oasis and the record. During an interview patient representative refusing to sign the atthe agency refused complaining to the and the agency discord her / his refusal to patient representative to the agency when called in sick. A new	on 8/15/18 at 9:40 AM, the ve of patient #8 indicated agency visit notes because to give him / her copies and gency and case manager harging the patient because is sign the visit notes. The ve also indicated complaining the aide did not show up or vaide, Employee K, HHA, he complaint. The patient			

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING		C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	00/10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
G 598	representative recalled and administrator due and the smell of the second and the smell of the case of indicated there was a administrator and own aware of the complain. A letter dated Septem Patient #8] Date of 11/24/17, To Whom It to confirm that [Patient from our agency as of to noncompliance of of changes of [patient caregiver's refusal to with home health aided further questions or compatter please contact [past administrator." Communication with a CFR(s): 484.60(d)(1) Assure communication involved in the plan of This ELEMENT is not Based on record reviagency failed to ensurphysicians involved in the plan of the pl	and complaining to the owner of to Employee K's smoking moke in the home. In 8/15/18 at 10:18 AM, manager for patient #8, erns with the agency. She complaint filed and the mer of the agency were nt. In 8/15/18 at 10:18 AM, manager for patient #8, erns with the agency. She complaint filed and the mer of the agency were nt. In 8/15/18 at 10:18 AM, manager for patient #8, erns with the agency. She complaint filed and the mer of the agency were nt. In 8/15/18 at 10:18 AM, manager for patient #8, erns with the agency. She complaint filed and the mer of the agency were nt. In 8/15/18 at 10:18 AM, manager for patient #8, erns with the agency. She complaint filed and the mer of the agency were nt. In 8/15/18 at 10:18 AM, manager for patient #8, erns with the agency. She complaint is a service: 5/26/17 - May Concern: This letter is nt #8] has been discharged for services and services. If you have any encerns regarding this a cour office. Thank you. In service in the mer of the owner in the mer of the agency were nt.	G 59		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING		08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00:10:20:10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
G 602	The agency policy tit Service" dated 2015 Nursing Functions In standards and deper family need, all or a nursing functions ma coordination of service other services as new The agency policy tit Services" dated 2015 services in order to posservices established plan of congoing evaluation apatient's home care channels of communicative caregivers and record e. Scheduling conferences." A review of clinical record in order to posservices	stated, "Professional keeping with professional keeping with professional hiding upon each patient / selection of the following by be performed ces, including referral to eded." Iled "Coordination of 5 stated, "To coordinate provide comprehensive home intinuity of care the staff is responsible for the fessional coordination of all by ensuring that the lare is carried out c. the land assessment of the ineeds. d. Maintaining lication between / among all did documents same on patient grand participation in case ecord #2 on 8/16/18, start of incipal diagnosis of pressure in, failed to evidence the home health agency in the physician ordering an A) for this patient and the inspicion. This	G 602		
	completed by Physic orders for the right s and pack the wound then cover with mep	an order dated 4/50/16, cian A, evidenced wound care acrum area to be cleansed with absorptive silver and cilex border. The peri anal and dry. Also the right			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	I	06/16/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 602	elbow was to be prot failed to evidence that with the patient's atternoon of Care for the certification of Care for the certification of 3 hou 26 weeks and HHA 6 week, for 9 weeks. The evidence any wound was signed by the particular of 25/31/18. This plan of the patient was received wound clinic and the from Physician A at the from Physician for dressing mepilex border with the Care for the certification of Care for the certification (B). A review of a Home In of Care for the certification (B). A review of a Home In of Care for the certification (B). A review of a Home In of Care for the certification (B).	ected. The clinical record at this order was coordinated ending physician (B). Health Certification and Plan cation period of 6/2/18 - N orders for the frequency ars a day / 3 days a week for 5 hours a day, for 7 days a This plan of care failed to care orders. This document attent's attending physician, sically on 6/7/18 and signed of director of nursing on a freare failed to evidence that wing services from the agency may accept orders	G 6	02		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING	B. WING			C 16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			2:	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601		10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 602	Continued From page clinic.	e 76	G	602			
	administrator/ director coordination of care v	_					
G 608	Coordinate care deliv CFR(s): 484.60(d)(4)	ery	G	808			
	needs, and involve th any), and caregiver(s coordination of care a This ELEMENT is no Based on observatio interview, the home h ensure the Registered patient's care with a E equipment) company	of met as evidenced by: n, record review and ealth agency failed to d Nurse coordinated the					
	The findings included	:					
	Service" dated 2015 s Nursing Functions In standards and depen family need, all or a s nursing functions may	keeping with professional ding upon each patient / election of the following / be performed es, including referral to					
	services in order to po care, and assure con- professional nurse is	stated, "To coordinate rovide comprehensive home tinuity of care the staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING	B. WING		1	C 16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			224	REET ADDRESS, CITY, STATE, ZIP CODE 4 W JEFFERSON BLVD STE 200 DUTH BEND, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 608	home care services be established plan of care ongoing evaluation and patient's home care in channels of communicative caregivers and record e. Scheduling conferences." During a home visit of 4:10 PM, patient #2's mattress was evident order. The bed was be of the bed area where region would rest. The have pressure ulcers right hip region. Empinurse, observed to cannot engage the patient contact the durable matter the durable matter the durable matter company's contact the durable matter the durable ma	ensuring that the are is carried out c. the ad assessment of the eeds. d. Maintaining cation between / among all documents same on patient and participation in case bservation on 8/14/18 at hospital bed with an air ed to not be in working owing upward in the middle the patient's lower back are patient was observed to in the sacral region and loyee B, licensed practical are for this patient and did at in discussion about how to redical equipment company. Ct information was written are agency staff in the past I months. Inical record #2 on 8/16/18, we of communication notes able medical equipment enumber of this DME ecord and found on the up assessment dated no evidence in the record of hospital bed,	G	608			
G 640	communication with t involvement with the concern. Quality assessment/p CFR(s): 484.65		G	640			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
15K070	B. WING			C	
101010		STREET ADDRESS, CITY, STATE, ZIP	CODE	08/16/2018	
		224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		X (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
78	G	640			
am. The HHA-wide, am. The HHA's governing the program reflects the zation and services; es (including those r contract or on indicators related to cluding the use of the hospital admissions and the sactions that address the coss the spectrum of care, the and reduction of medical maintain documentary to opram and be able to to the CMS. In the tas evidenced by: the record review and tailed to ensure the quality the scapable of showing tent and must measure, the indicators, including and other aspects of the the agency to assess the services, and operations the services, and operations the services are services and operations the services are services and operations the services and operations the services are services and operations the services are services and operations the services and the services are services and the s					
The second secon	IDENTIFICATION NUMBER: 15K070 EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	15K070 B. WING IDENTIFICATION NUMBER: A. BUILDI 15K070 B. WING MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) TAG TO CUAILITY ASSESSMENT Vernent (QAPI). In implement, evaluate, and ingoing, HHA-wide, am. The HHA's governing the program reflects the exation and services; es (including those in contract or indicators related to cluding the use of its, hospital admissions and ites actions that address the moss the spectrum of care, in and reduction of medical maintain documentary orgam and be able to on to CMS. In the tast evidenced by: record review and ailed to ensure the quality is capable of showing that and must measure, the indicators, including and other aspects of e the agency to assess a services, and operations insure the quality ized quality indicator data, inved from OASIS and monitor the effectiveness and quality of care and improvement (see Given a quality assurance orgam activities (see Given a quality assurance orgam activities (see Given a quality assurance)	15K070 15K070	15K070 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601 PREPIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG G 640 G 640	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG	(XX	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	I	08/16/2018
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 640	problem prone areas ensure the quality as: the incidence, prevale problems (see G 650 assurance program le correction of any ider potentially threaten the patient (see G 652); fimprovement activitie events, analyzed their preventive actions (see actions aimed at perfoccurred and were sufailed to ensure the g	(see G 648); failed to surance program considered ence and severity of); failed to ensure the quality	G	540		
G 642	resulted in the home ensure the provision safe environment for participation: 484: 65 Assessment / Perform Program scope CFR(s): 484.65(a)(1) Program scope. (1) The program mus showing measurable for which there is evic those indicators will in patient safety, and quality indicators, inclevents, and other asp	t at least be capable of improvement in indicators dence that improvement in mprove health outcomes, uality of care. easure, analyze, and track luding adverse patient pects of performance that issess processes of care,	G	542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 642	Based on observation interview, the agency assurance program measurable improve analyze and track quadverse patient ever performance that en processes of care, If for 1 of 1 quality assorthe findings include. The agency policy to Delegation Policy administration shall operations on a day signed by the adminimated, "As part of the program, a committer reviews the results of collection activities a minutes of meetings agency's office." During the Entrance 11:10 AM, the adminimated the quality monitored the changareas were wound to She stated, "We folle the plans of care." Sthe staff keeping up documentation.	not met as evidenced by: on, record review and y failed to ensure the quality was capable of showing ement and must measure, uality indicators, including ints, and other aspects of able the agency to assess dHA services, and operations urance program reviewed. : tled "Administration ated 7/6/18 stated, "The be responsible for all to day basis. This was istrator / director of nursing. tled "Committees" dated 2015 the agency's quality assurance the of professional personnel of quality assurance data at least quarterly. Written are maintained at the conference on 8/7/18 at histrator/ director of nursing assurance program the direction tracking. The focus are and infection tracking.	G 6	42		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
G 642	the program was mist During this time, the assurance binder material employee, a past off seen on security more office. She indicated with this concern. During an interview of administrator/ director quality assurance has had been in the role 2018. During an observation owner was observed with binders including binder and infection. A review of document binder evidenced no	rector of nursing indicated sing and could not be found. owner indicated the quality ay have been taken by a past ice coordinator, who was nitors taking items from the I having a lawyer involved on 8/15/18 at 2:10 PM, the or of nursing indicated the d not occurred and that she of administrator since June on on 8/15/18 at 3 PM, the coming out of a back room g the quality assurance control binder.	G	342		
	1/10/14 was kept in the There were other skind 1/12/14, 1/24/14, 1/3 2/20/14, 3/4/14, 3/11 dated 3/18/14 evider page which stated, " 2. Also noted where Quarterly Report dath March 31, 2013 with 1/8/13 "Prophylactic 300 mg / 5 ml INH evidence of the skind of the s	se visit note for Patient #3 for the quality assurance book. lled nursing visit notes dated 1/14, 2/2/14, 2/13/14, /14, and 3/18/14. The note need a note at the top of the Before Corrections." ere the Infection Control ed 1st Quarter January 1 - notes related to dates of on admission Tobramycin very 12 hours ongoing This is to list dates through				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING		08/16/2	018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/10/2	010
(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 SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE CO	(X5) MPLETION DATE
G 642	"No trends noted. Ouniversal precaution 3. Also noted w Quarterly Report dat June 30, 2013 with r 4/27/13, "UTI Keflex days. Resolved 5/1 dates and antibiotics	vere the Infection Control ted 2nd Quarter April 1st to notes related to dates of 500 mg every 6 hours X 10 //13. More notes listed other a. A note at the bottom of the nds noted. Infection Control	G 64	42		
G 644	quarterly Report for September 31, 2013 Program data CFR(s): 484.65(b)(1 Program data. The program must us including measures	vas the Infection Control the 3rd Quarter of July 1 - s and 4th Quarter 2013.),(2),(3) tilize quality indicator data, derived from OASIS, where r relevant data, in the design	G 64	14		
	The HHA must use to the effectiveness and quality of care; and is improvement. The frequency and comust be approved by This STANDARD is Based on observation interview, the agency assurance program including measures.	he data collected to monitor d safety of services and dentify opportunities for detail of the data collection by the HHA's governing body. The not met as evidenced by: son, record review and by failed to ensure the quality utilized quality indicator data, derived from OASIS and to monitor the effectiveness				

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION G	(X3	OMPLETED		
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	I	00/10/2010
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 644	and safety of services identify opportunities quality assurance proof The findings include: The agency policy titl Delegation Policy" da administration shall be operations on a day to signed by the administration shall be operations on a day to signed by the administration shall be operations on a day to signed by the administration shall be operations on a day to signed by the administrated by the administrated, "As part of the program, a committee reviews the results of collection activities at minutes of meetings agency's office." During the Entrance of 11:10 AM, the administrated the quality amonitored the change areas were wound cashe stated, "We follo the plans of care." So the staff keeping up we documentation. During an interview of assurance / performance indicated the program be found. During this the quality assurance taken by a past emplicoordinator, who was supplied to the plans of care.	ed "Administration ted 7/6/18 stated, "The e responsible for all o day basis. This was strator / director of nursing. ed "Committees" dated 2015 e agency's quality assurance e of professional personnel quality assurance data least quarterly. Written are maintained at the conference on 8/7/18 at strator / director of nursing assurance program es in patient. The focus are and infection tracking, we the guidelines and go by the indicated a concern with with the charting / In 8/7/18 at 4 PM, the quality ance program was inistrator / director of nursing and surface program was inistrator / director of nursing and surface program was inistrator / director of nursing and surface program was inistrator / director of nursing and surface program was inistrator / director of nursing and surface program was inistrator / director of nursing and surface program was inistrator / director of nursing and surface program was inistrator / director of nursing and could not surface the binder may have been	G 6	44		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 8/16/2018	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		0/16/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 644	During an interview of administrator / direct quality assurance proccurred and that shadministrator since of During an observation owner was observed with binders including binder and infection. A review of document binder evidenced not since 2014. This was following documents. 1. A skilled nurse 1/10/14 was kept in 1/10/14 was kept in 1/12/14, 1/24/14, 1/3/2/20/14, 3/4/14, 3/11 dated 3/18/14 evider page which stated, " 2. Also noted word Quarterly Report dated March 31, 2013 with 1/8/13 "Prophylactic 300 mg / 5 ml INH evidence document proceeded 3/29/13. A note at the state of th	on 8/15/18 at 2:10 PM, the or of nursing indicated the orgram meetings had not e had been in the role of une 2018. In on 8/15/18 at 3 PM, the coming out of a back room g the quality assurance control binder. In the quality assurance documentation of meetings is further evidenced by the from this binder: Se visit note for Patient #3 for the quality assurance book. Illed nursing visit notes dated 1/14, 2/2/14, 2/13/14, 1/14, and 3/18/14. The note inced a note at the top of the Before Corrections." For the Infection Control ed 1st Quarter January 1 - notes related to dates of on admission Tobramycin very 12 hours ongoing This is to list dates through the bottom of the page stated,	G 6	44			
	universal precaution: 3. Also noted w Quarterly Report dat	ere the Infection Control ed 2nd Quarter April 1st to notes related to dates of					

		(X3) DATE COMP	SURVEY LETED				
		15K070	B. WING				C 16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			2	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 COUTH BEND, IN 46601	, 00.	10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 644	days. Resolved 5/1/ dates and antibiotics. page stated, "No tren measures to instruct 4. Also noted wa quarterly Report for the	00 mg every 6 hours X 10 13. More notes listed other A note at the bottom of the ds noted. Infection Control to clients." as the Infection Control ne 3rd Quarter of July 1 -	G	644			
G 646	September 31, 2013 Program activities CFR(s): 484.65(c) Program activities This STANDARD is a Based on observation	not met as evidenced by: n, record review and failed to ensure the quality nust include program	G	646			
	administration shall be operations on a day to signed by the administrated, "As part of the program, a committee reviews the results of collection activities at minutes of meetings agency's office."	ted 7/6/18 stated, "The e responsible for all o day basis. This was strator / director of nursing. ed "Committees" dated 2015 e agency's quality assurance e of professional personnel quality assurance data least quarterly. Written are maintained at the conference on 8/7/18 at strator / director of nursing					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			(3) DATE SURVEY COMPLETED		
		15K070	B. WING			C 8/16/2018
	ROVIDER OR SUPPLIER	1 10.0070		STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 646	areas were wound complete She stated, "We follow the plans of care." So the staff keeping up a documentation. During an interview of assurance / performs requested. The admindicated the programe found. During this the quality assurance taken by a past emploored coordinator, who was taking items from the having a lawyer involution. During an interview of administrator / direct quality assurance procurred and that she administrator since Juring an observation owner was observed with binders including binder and infection of A review of document binder evidenced no	es in patient. The focus are and infection tracking. On the guidelines and go by the indicated a concern with with the charting / on 8/7/18 at 4 PM, the quality cance program was sinistrator / director of nursing m was missing and could not so time, the owner indicated to binder may have been loyee, a past office as seen on security monitors to office. She indicated lived with this concern. on 8/15/18 at 2:10 PM, the or of nursing indicated the	G 64			
	1/10/14 was kept in t There were other ski 1/12/14, 1/24/14, 1/3	se visit note for Patient #3 for the quality assurance book. lled nursing visit notes dated 1/14, 2/2/14, 2/13/14, /14, and 3/18/14. The note				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	()	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C	
NAME OF PR	ROVIDER OR SUPPLIER	1011070		STREET ADDRESS, CITY, STATE, ZIP CO	I_ DDE	08/16/2018	
T110 1101	E LIEAL THE GARE INC			224 W JEFFERSON BLVD STE 200			
IMG HOM	E HEALTH CARE INC			SOUTH BEND, IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 646	Continued From page	e 87	G 6	546			
	dated 3/18/14 evidence page which stated, "E	ced a note at the top of the sefore Corrections."					
G 648	Quarterly Report date March 31, 2013 with a 1/8/13 "Prophylactic of 300 mg / 5 ml INH ev document proceeded 3/29/13. A note at the "No trends noted. Co- universal precautions 3. Also noted we Quarterly Report date June 30, 2013 with no 4/27/13 "UTI Keflex 5 days. Resolved 5/1/ dates and antibiotics. page stated, "No tren measures to instruct to 4. Also noted wa quarterly Report for th September 31, 2013 a High risk, high volume	e bottom of the page stated, intinue to educate clients on ." ere the Infection Control at 2nd Quarter April 1st to otes related to dates of 00 mg every 6 hours X 10 13. More notes listed other A note at the bottom of the ds noted. Infection Control to clients." est the Infection Control at the Infection Control are 3rd Quarter of July 1 - and 4th Quarter 2013. e, or problem-prone area	Ge	548			
	must focus on high ris problem-prone areas. This ELEMENT is no Based on observatio interview, the agency	t met as evidenced by: n, record review and failed to ensure the quality ocused on high risk, high					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	ı	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 648	The findings include: The agency policy titl Delegation Policy" da administration shall be operations on a day the signed by the administration shall be operations on a day the signed by the administration shall be operations on a day the signed by the administration activities at the program, a committee reviews the results of collection activities at minutes of meetings agency's office." During the Entrance of 11:10 AM, the administrated the quality amonitored the change areas were wound cashed the plans of care. So the stated, "We follow the plans of care." So the staff keeping up we documentation. During an interview of assurance / performance requested. The administrated the program be found. During this the quality assurance taken by a past employed coordinator, who was taking items from the having a lawyer involution.	ed "Administration ated 7/6/18 stated, "The e responsible for all o day basis. This was strator / director of nursing. ed "Committees" dated 2015 agency's quality assurance of professional personnel quality assurance data are maintained at the experience on 8/7/18 at strator / director of nursing assurance program as in patient. The focus are and infection tracking. We the guidelines and go by the indicated a concern with with the charting / In 8/7/18 at 4 PM, the quality ance program was an instrator / director of nursing to was missing and could not as time, the owner indicated to binder may have been	G 64	48		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	CODE	36, 16, 23 16
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 648	occurred and that sh administrator since J During an observation owner was observed with binders including binder and infection. A review of document binder evidenced no since 2014. This was following documents 1. A skilled nurs 1/10/14 was kept in 1/10/14 was kept in 1/12/14, 1/24/14, 1/3/2/20/14, 3/4/14, 3/11 dated 3/18/14 evider page which stated, " 2. Also noted w Quarterly Report dat March 31, 2013 with 1/8/13 "Prophylactic 300 mg / 5 ml INH evidocument proceeded 3/29/13. A note at the	ogram meetings had not e had been in the role of une 2018. In on 8/15/18 at 3 PM, the coming out of a back room g the quality assurance control binder. Its in the quality assurance documentation of meetings s further evidenced by the from this binder: Se visit note for Patient #3 for the quality assurance book. Illed nursing visit notes dated 1/14, 2/2/14, 2/13/14, /14, and 3/18/14. The note need a note at the top of the Before Corrections." For the Infection Control and 1st Quarter January 1 - notes related to dates of on admission Tobramycin very 12 hours ongoing This do to list dates through the bottom of the page stated, ontinue to educate clients on	Ge	648		
	Quarterly Report dat June 30, 2013 with r 4/27/13 "UTI Keflex s days. Resolved 5/1 dates and antibiotics	ere the Infection Control ed 2nd Quarter April 1st to notes related to dates of 500 mg every 6 hours X 10 /13. More notes listed other . A note at the bottom of the nds noted. Infection Control				

			3) DATE SURVEY COMPLETED			
		15K070	B. WING			C
	ROVIDER OR SUPPLIER E HEALTH CARE INC	10.000		STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	CODE	08/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 648	quarterly Report for th		G	648		
G 650	Incidence, prevalence CFR(s): 484.65(c)(1)(1)(1). The HHA's performan must consider incider of problems in those at This ELEMENT is not Based on observation interview, the agency assurance program of prevalence and sever agency. The findings include: The agency policy title Delegation Policy'' data administration shall be operations on a day to signed by the administrated, "As part of the program, a committee reviews the results of collection activities at minutes of meetings at agency's office." During the Entrance of 11:10 AM, the administindicated the quality as	e, severity of problems (iii) nce improvement activities nce, prevalence, and severity areas; and it met as evidenced by: n, record review and failed to ensure the quality considered the incidence, rity of problems for 1 of 1 ed "Administration ted 7/6/18 stated, "The e responsible for all to day basis. This was strator / director of nursing. ed "Committees" dated 2015 e agency's quality assurance e of professional personnel quality assurance data least quarterly. Written are maintained at the	G	650		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OATE SURVEY OMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		33/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 650	Continued From pag		G 6	550		
	She stated, "We follo	are and infection tracking. What the guidelines and go by the indicated a concern with with the charting /				
	assurance / performarequested. The admindicated the programbe found. During this the quality assurance taken by a past emploordinator, who was taking items from the	inistrator / director of nursing in was missing and could not is time, the owner indicated be binder may have been				
	administrator / director quality assurance pro	on 8/15/18 at 2:10 PM, the or of nursing indicated the ogram meetings had not e had been in the role of une 2018.				
	owner was observed	n on 8/15/18 at 3 PM, the coming out of a back room g the quality assurance control binder.				
	binder evidenced no	ts in the quality assurance documentation of meetings s further evidenced by the from this binder:				
	1/10/14 was kept in t There were other ski 1/12/14, 1/24/14, 1/3 2/20/14, 3/4/14, 3/11	the visit note for Patient #3 for he quality assurance book. Illed nursing visit notes dated 1/14, 2/2/14, 2/13/14, //14, and 3/18/14. The note noted a note at the top of the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	\ , ,	ATE SURVEY DMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	56/16/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 650	page which stated, "E 2. Also noted wo Quarterly Report date March 31, 2013 with 1/8/13 "Prophylactic of 300 mg / 5 ml INH eve document proceeded 3/29/13. A note at th "No trends noted. Co universal precautions 3. Also noted wo Quarterly Report date June 30, 2013 with n 4/27/13 "UTI Keflex 5 days. Resolved 5/1/ dates and antibiotics. page stated, "No tren measures to instruct 4. Also noted wo quarterly Report for ti September 31, 2013 Activities lead to an in CFR(s): 484.65(c)(1) The HHA's performan must lead to an immediantified problem that potentially threaten the patients. This ELEMENT is no Based on observation interview, the agency assurance program le correction of any ider	Before Corrections." Bere the Infection Control and 1st Quarter January 1 - notes related to dates of on admission Tobramycin very 12 hours ongoing This I to list dates through a bottom of the page stated, ontinue to educate clients on s." Bere the Infection Control and Quarter April 1st to otes related to dates of 500 mg every 6 hours X 10 (13). More notes listed other and A note at the bottom of the ods noted. Infection Control to clients." Beas the Infection Control to clients. The second control of the 3rd Quarter of July 1 - and 4th Quarter 2013. Beas the Infection Control to clients. The second correction of any and the correction of any and directly or the health and safety of the second review and of failed to ensure the quality		650		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	, ,	ATE SURVEY OMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	'	30.10.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 652	patients for 1 of 1 ag The findings include: The agency policy tit Delegation Policy" da administration shall to operations on a day signed by the admini The agency policy tit stated, "As part of the program, a committe reviews the results o collection activities a minutes of meetings agency's office." During the Entrance 11:10 AM, the admin indicated the quality monitored the chang areas were wound ca She stated, "We follo the plans of care." Se the staff keeping up of documentation. During an interview of assurance / performar requested. The admindicated the prograr be found. During this the quality assurance taken by a past emplooredinator, who was	led "Administration ated 7/6/18 stated, "The peresponsible for all to day basis. This was strator / director of nursing. led "Committees" dated 2015 agency's quality assurance of professional personnel for quality assurance data at least quarterly. Written are maintained at the conference on 8/7/18 at istrator / director of nursing assurance program as in patient. The focus are and infection tracking. The indicated a concern with with the charting / con 8/7/18 at 4 PM, the quality ance program was inistrator / director of nursing massurance are program was inistrator / director of nursing massurance program was missing and could not as time, the owner indicated as binder may have been	G 6	52		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	, COV		OMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	E	33/13/23/13
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 652	Continued From pag	e 94	G 6	52		
	administrator / direct quality assurance pro occurred and that sh administrator since J During an observation	n on 8/15/18 at 3 PM, the coming out of a back room g the quality assurance				
	A review of documer binder evidenced no	ts in the quality assurance documentation of meetings s further evidenced by the				
	1/10/14 was kept in the There were other sking 1/12/14, 1/24/14, 1/3 2/20/14, 3/4/14, 3/11	the visit note for Patient #3 for the quality assurance book. Illed nursing visit notes dated 1/14, 2/2/14, 2/13/14, 1/14, and 3/18/14. The note fixed a note at the top of the Before Corrections."				
	Quarterly Report dat March 31, 2013 with 1/8/13 "Prophylactic 300 mg / 5 ml INH ev document proceeded 3/29/13. A note at the	ere the Infection Control ed 1st Quarter January 1 - notes related to dates of on admission Tobramycin very 12 hours ongoing This It to list dates through e bottom of the page stated, ontinue to educate clients on s."				
	Quarterly Report dat June 30, 2013 with n 4/27/13 "UTI Keflex 9	ere the Infection Control ed 2nd Quarter April 1st to otes related to dates of 500 mg every 6 hours X 10 /13. More notes listed other				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 50.25			(С
		15K070	B. WING			08/	16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			22	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 652	page stated, "No tren measures to instruct to 4. Also noted wa quarterly Report for the	A note at the bottom of the ds noted. Infection Control	G	652			
G 654	Track adverse patient CFR(s): 484.65(c)(2)		G	654			
	adverse patient event implement preventive This STANDARD is r During observation, r the agency failed to e improvement activitie	not met as evidenced by: record review and interview, rnsure Performance s tracked adverse patient r causes, and implemented					
	The findings include:						
	administration shall be operations on a day to signed by the administration. The agency policy title stated, "As part of the	ted 7/6/18 stated, "The e responsible for all o day basis. This was strator / director of nursing. ed "Committees" dated 2015 e agency's quality assurance					
	reviews the results of collection activities at minutes of meetings a agency's office." During the Entrance of	e of professional personnel quality assurance data least quarterly. Written are maintained at the conference on 8/7/18 at strator / director of nursing					

	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		33, 13, 23 13
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 654	areas were wound of She stated, "We follow the plans of care." So the staff keeping up documentation. During an interview of assurance / performs requested. The admindicated the program be found. During this the quality assurance taken by a past empocoordinator, who was taking items from the having a lawyer invoording an interview of administrator / direct quality assurance proccurred and that she administrator since of the program of the process of the plant of the p	assurance program les in patient. The focus are and infection tracking. by the guidelines and go by the indicated a concern with with the charting / on 8/7/18 at 4 PM, the quality ance program was aninistrator / director of nursing m was missing and could not stime, the owner indicated the binder may have been loyee, a past office seen on security monitors to office. She indicated lived with this concern. on 8/15/18 at 2:10 PM, the or of nursing indicated the ogram meetings had not the had been in the role of lune 2018. on on 8/15/18 at 3 PM, the of coming out of a back room to gethe quality assurance	G 6			
	since 2014. This wa following documents 1. A skilled nurs 1/10/14 was kept in there were other ski	documentation of meetings is further evidenced by the from this binder: se visit note for Patient #3 for the quality assurance book. Illed nursing visit notes dated 11/14, 2/2/14, 2/13/14,				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		15K070	B. WING _		C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/10/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
G 654	2/20/14, 3/4/14, 3/11/dated 3/18/14 evident page which stated, "E 2. Also noted we Quarterly Report date March 31, 2013 with 1/8/13 "Prophylactic of 300 mg / 5 ml INH evidocument proceeded 3/29/13. A note at the	14, and 3/18/14. The note ced a note at the top of the defore Corrections." ere the Infection Control and 1st Quarter January 1 - notes related to dates of con admission Tobramycin ery 12 hours ongoing This to list dates through a bottom of the page stated, intinue to educate clients on	G	554	
G 656	Quarterly Report dates June 30, 2013 with not 4/27/13 "UTI Keflex 5 days. Resolved 5/1/ dates and antibiotics. page stated, "No tren measures to instruct to 4. Also noted was quarterly Report for the September 31, 2013 a Improvements are su CFR(s): 484.65(c)(3) The HHA must take a performance improve implementing those a measure its success a ensure that improvem This ELEMENT is no Based on observatio interview, the agency	as the Infection Control ne 3rd Quarter of July 1 - and 4th Quarter 2013. stained ctions aimed at ment, and, after ctions, the HHA must and track performance to nents are sustained. t met as evidenced by:	G	356	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		10,2010	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 656	The findings include: The agency policy titl Delegation Policy" da administration shall b operations on a day t signed by the adminis The agency policy titl stated, "As part of the program, a committee reviews the results of collection activities at minutes of meetings a agency's office." During the Entrance of 11:10 AM, the admini indicated the quality a monitored the change areas were wound ca She stated, "We follow the plans of care." Si the staff keeping up w documentation. During an interview of assurance / performat requested. The admit indicated the program be found. During this the quality assurance taken by a past employer.	ed "Administration ted 7/6/18 stated, "The e responsible for all o day basis. This was strator / director of nursing. ed "Committees" dated 2015 agency's quality assurance e of professional personnel quality assurance data least quarterly. Written are maintained at the conference on 8/7/18 at strator / director of nursing assurance program es in patient. The focus re and infection tracking. We the guidelines and go by the indicated a concern with with the charting / In 8/7/18 at 4 PM, the quality nice program was missing and could not a time, the owner indicated binder may have been on security monitors	G 68	56			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		10/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
G 656	administrator / director quality assurance productive and that she administrator since Journing an observation owner was observed with binders including binder and infection of A review of document binder evidenced no since 2014. This was following documents 1. A skilled nurs 1/10/14 was kept in the There were other skill 1/12/14, 1/24/14, 1/3 2/20/14, 3/4/14, 3/11/14 dated 3/18/14 evident page which stated, "Example 1/12/14 and 1/12	n 8/15/18 at 2:10 PM, the or of nursing indicated the orgram meetings had not e had been in the role of une 2018. In on 8/15/18 at 3 PM, the coming out of a back room of the quality assurance control binder. Its in the quality assurance documentation of meetings is further evidenced by the from this binder: The visit note for Patient #3 for the quality assurance book. Ited nursing visit notes dated 1/14, 2/2/14, 2/13/14, 14, and 3/18/14. The note deed a note at the top of the	G 6	,			
	1/8/13 "Prophylactic of 300 mg / 5 ml INH evidocument proceeded 3/29/13. A note at the "No trends noted. Couniversal precautions 3. Also noted we Quarterly Report date June 30, 2013 with ne 4/27/13 "UTI Keflex 5	on admission Tobramycin ery 12 hours ongoing This to list dates through e bottom of the page stated, ontinue to educate clients on					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	· /	COMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	,	00.10.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 656	page stated, "No tren measures to instruct 4. Also noted wa quarterly Report for the	. A note at the bottom of the ads noted. Infection Control	G 6	56		
G 658	Performance improve CFR(s): 484.65(d)(1) Performance improve Beginning July 13, 2 performance improve and scope of distinct conducted annually recomplexity, and past services and operation document the quality undertaken, the reast projects, and the mean on these projects. This STANDARD is Based on observation interview, the agency assurance program to had distinct projects a progress for 1 of 1 age. The findings include: The agency policy titl Delegation Policy" data administration shall be operations on a day to signed by the administration title.	ement projects (2) ement projects. 018 HHAs must conduct ement projects. The number improvement projects must reflect the scope, performance of the HHA's ons. The HHA must improvement projects ons for conducting these asurable progress achieved not met as evidenced by: on, record review and a failed to ensure the quality racked adverse events and and noted measurable gency reviewed.	G 6	58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 8/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		0/10/2010	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 658	program, a committe reviews the results or collection activities at minutes of meetings agency's office." During the Entrance 11:10 AM, the adminindicated the quality monitored the changareas were wound cas she stated, "We follow the plans of care." So the staff keeping up and documentation. During an interview of assurance / performarequested. The admindicated the program be found. During this the quality assurance taken by a past emploary coordinator, who was taking items from the having a lawyer involutional process of the program of the having and interview of administrator / direction of the difference of the program of the having and interview of the having and that she administrator since Juring an observation owner was observed with binders including binder and infection of the program of the pr	e of professional personnel f quality assurance data t least quarterly. Written are maintained at the conference on 8/7/18 at istrator / director of nursing assurance program es in patient. The focus are and infection tracking. We the guidelines and go by the indicated a concern with with the charting / con 8/7/18 at 4 PM, the quality ance program was inistrator / director of nursing in was missing and could not is time, the owner indicated es binder may have been oyee, a past office is seen on security monitors office. She indicated ved with this concern. on 8/15/18 at 2:10 PM, the por of nursing indicated the orgam meetings had not the had been in the role of the coming out of a back room in the quality assurance.	G 65	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRI	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _				C / 16/2018
	ROVIDER OR SUPPLIER			224 W JEF	DRESS, CITY, STATE, ZIP CODE FERSON BLVD STE 200 END, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
G 658	since 2014. This was following documents of the following document stated, "But a substitution of the following document proceeded 3/29/13. A note at the "No trends noted. Couniversal precautions of the following document proceeded 3/29/13. A note at the "No trends noted. Couniversal precautions of the following document proceeded 3/29/13. A note at the "No trends noted. Couniversal precautions of the following document proceeded 3/29/13. A note of the "No trends noted were Quarterly Report dates June 30, 2013 with not 4/27/13 "UTI Keflex 5 days. Resolved 5/1/dates and antibiotics. page stated, "No trendessures to instruct the dates of the following documents o	documentation of meetings further evidenced by the from this binder: e visit note for Patient #3 for the quality assurance book, and nursing visit notes dated /14, 2/2/14, 2/13/14, 14, and 3/18/14. The note deed a note at the top of the defore Corrections." The the Infection Control of the defore Corrections of the defore Corrections of the defore the Infection Control of the deformal of the page stated, and the Infection Control of Colients."	G 6	58			
G 660	September 31, 2013 a Executive responsibili CFR(s): 484.65(e)(1)(ties for QAPI	G 6	60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		15K070	B. WING		08/16/2018
	ROVIDER OR SUPPLIER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
G 660	body is responsible for the control of the control	program for quality tient safety is defined, aintained; ide quality assessment and ement efforts address did quality of care and patient aprovement actions are eness; ctations for patient safety are ented, and maintained; and is of fraud or waste are sed. In the second review and in failed to ensure the involved with the ongoing orgam for 1 of 1 agency. Ided "Administration ated 7/6/18 stated, "The interesponsible for all to day basis. This was strator / director of nursing. Ided "Committees" dated 2015 agency's quality assurance en of professional personnel of quality assurance data at least quarterly. Written are maintained at the	G 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 8/16/2018	
	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
mail South the document of the tax	reas were wound cathe stated, "We follow he plans of care." Some staff keeping up woocumentation. Furing an interview of ssurance / performate dependent of the program of	es in patient. The focus are and infection tracking. We the guidelines and go by the indicated a concern with with the charting / on 8/7/18 at 4 PM, the quality ance program was inistrator / director of nursing in was missing and could not at time, the owner indicated a binder may have been oyee, a past office as seen on security monitors office. She indicated wed with this concern. on 8/15/18 at 2:10 PM, the proof nursing indicated the orgam meetings had not be had been in the role of the coming out of a back room on the quality assurance control binder. Its in the quality assurance documentation of meetings as further evidenced by the	G 66				

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _		08/16/20	118
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	,10
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) IPLETION DATE
G 660	2. Also noted word Quarterly Report date March 31, 2013 with 1/8/13 "Prophylactic 300 mg / 5 ml INH evidocument proceeded 3/29/13. A note at the "No trends noted. Couniversal precautions 3. Also noted word Quarterly Report date June 30, 2013 with note 4/27/13 "UTI Keflex 8 days. Resolved 5/1/1/13 dates and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page stated," No trends and antibiotics page stated, "No trends and antibiotics page s	ere the Infection Control ed 1st Quarter January 1 - notes related to dates of on admission Tobramycin very 12 hours ongoing This it to list dates through e bottom of the page stated, ontinue to educate clients on s." ere the Infection Control ed 2nd Quarter April 1st to otes related to dates of 500 mg every 6 hours X 10 /13. More notes listed other . A note at the bottom of the nds noted. Infection Control to clients." as the Infection Control he 3rd Quarter of July 1 - and 4th Quarter 2013. and control and control. ain and document an aram which has as its goal ontrol of infections and		680		
	Based on observation interview, the home had infection control guid					

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				2
	ROVIDER OR SUPPLIER E HEALTH CARE INC	101010		STF 224	REET ADDRESS, CITY, STATE, ZIP CODE 4 W JEFFERSON BLVD STE 200 DUTH BEND, IN 46601	<u> </u>	16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 680	control, and investiga communicable diseas the HHA's quality ass improvement program. The cumulative effect resulted in the home is ensure the provision of safe environment for	dentification, prevention, tion of infectious and ses that is an integral part of essment and performance in (see G 684). Tof these systemic problems health agency's inability to of quality health care in a the condition of Condition of participation:		680			
	practice, including the precautions, to prever infections and community in the precautions and community in the strand on observation interview, the home him infection control guide (#2) with a Licensed For the findings include: The findings include: The undated agency procedure" stated, "To contamination and spure in the state of the stat	nt the transmission of unicable diseases. not met as evidenced by: n, record review, and ealth agency failed to follow elines in 1 of 1 home visits Practical Nurse(#B).					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER E HEALTH CARE INC			2	STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 682	If caring for patient wi a. Take equipment paper towels, lotion to b. Use one paper tow other items. The secused for washing and and after care has be forearms. Then lathe starting at the fingertif forearm for no less th touch the sink. e. Rittowels or bars of soap bacteria. f. Dry hand the forearm. G. Turn paper towel; then discipled."	th a drug - resistant bacteria to wash hands [liquid soap, of the sink area in bathroom ell on which to place the bond and third towels are drying the hands before en given. c. Wet hands and r, using vigorous friction, os, ad working toward the an 15 seconds. d. Do not hase Avoid using cloth of for these are a haven of s from the fingers toward off water faucet with a dry card the towel into trash	G	682			
	4:10 PM, Employee E was observed to give After the patient's bat gloves and washed he bar soap kept by the I dried her hands with p towels were found on	bservation on 8/14/18 at 8, Licensed Practical Nurse, a bed bath to patient #2. h, Employee B removed her er hands with the patient's pathroom sink. She then paper towels. The paper the patient's box where a sit. This area was covered					
G 684	administrator / director indicated using bar so policy and handwashi supplied to all direct of	2)	G 6	684 -			

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X3) PROVIDER/SUPPLIER/CLIA (X3) PROVIDER/SUPPLIER/CLIA (X3) PROVIDER/SUPPLIER/CLIA (X3) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/CLIA (X5) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/SUPP			(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 684	identification, preverinvestigation of infect diseases that is an interest quality assessment improvement (QAPI control program mut). A method for identification communicable diseases (2) A plan for the antification. This STANDARD is During observation the agency failed to agency-wide progration identification, preverinvestigation of infect diseases as part of and performance imagency. The findings includes The agency policy to administration shall operations on a day signed by the admir. The agency policy to stated, "As part of the program, a committer reviews the results of collection activities a minutes of meetings agency's office."	m for the surveillance, ntion, control, and ctious and communicable ntegral part of the HHA's and performance) program. The infection st include: entifying infectious and ase problems; and ppropriate actions that are n improvement and disease s not met as evidenced by: , record review, and interview, maintain a coordinated m for the surveillance, ntion, control, and ctious and communicable the HHA's quality assessment approvement program for 1 of 1	G 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	<u>'</u>	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 684	indicated the quality monitored the changareas were wound cannot stated, "We follow the plans of care." So the staff keeping up and documentation. During an interview of assurance / performarequested. The admindicated the programe found. During this the quality assurance taken by a past emploor coordinator, who was taking items from the having a lawyer involution. During an interview of administrator / direct quality assurance profoccurred and that she administrator since Journal that she had started agency. A document titled "In 8/8/18 stated, "Infect Administration, Approximental forms of the program of the profocular titled and the program of the program of the profocular titled and that she had started agency. A document titled "In 8/8/18 stated, "Infect Administration, Approximental forms of the program of the program of the profocular titled and the program of the profocular titled and the profocular titl	istrator / director of nursing assurance program es in patient. The focus are and infection tracking. In the guidelines and go by he indicated a concern with with the charting / on 8/7/18 at 4 PM, the quality ance program was inistrator / director of nursing in was missing and could not at time, the owner indicated es binder may have been oyee, a past office is seen on security monitors office. She indicated eved with this concern. on 8/15/18 at 2:10 PM, the por of nursing indicated the formal indicated th	G 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC	•		STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 684	Continued From pag	e 110	G 6	584		
	owner was observed with binders including binder and infection. A review of documer binder evidenced no since 2014. This was following documents 1. A skilled nurs 1/10/14 was kept in 17 There were other ski 1/12/14, 1/24/14, 1/32/20/14, 3/4/14, 3/11 dated 3/18/14 evider page which stated, " 2. Also noted w Quarterly Report dat March 31, 2013 with 1/8/13 "Prophylactic 300 mg / 5 ml INH evidocument proceeded 3/29/13. A note at the "No trends noted. C universal precautions	ants in the quality assurance documentation of meetings is further evidenced by the from this binder: se visit note for Patient #3 for the quality assurance book. Illed nursing visit notes dated 11/14, 2/2/14, 2/13/14, /14, and 3/18/14. The note need a note at the top of the Before Corrections." The interest of the late of the				
	Quarterly Report dat June 30, 2013 with r 4/27/13 "UTI Keflex s days. Resolved 5/1 dates and antibiotics	ed 2nd Quarter April 1st to notes related to dates of 500 mg every 6 hours X 10 /13. More notes listed other. A note at the bottom of the note noted. Infection Control				
	4. Also noted w	as the Infection Control				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		15K070	B. WING				C 16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			224	EET ADDRESS, CITY, STATE, ZIP CODE W JEFFERSON BLVD STE 200 UTH BEND, IN 46601	<u> </u>	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 684	September 31, 2013 Skilled professional s CFR(s): 484.75 Condition of participal services. Skilled professional s nursing services, physeech-language pat occupational therapy, this chapter, and physwork services as spechapter. Skilled profeservices to HHA paties arrangement must participate of care. This CONDITION is Based on observation interview, the Register the plans of care conduration of visits specified to ensure all required elements provided, and the goaf failed to ensure visits of care and failed to eservices were not profer (see G 710); failed to ensure visits and the goaf alled to eservices were not profer (see G 710); failed to eservices were not profer (see G 710); failed to ensure visits of care and failed to eservices were not profer (see G 710); failed to ensure visits of care and failed to eservices were not profer (see G 710); failed to ensure visits of care and failed to eservices were not profered to the professional services were not professional services.	ne 3rd Quarter of July 1 - and 4th Quarter 2013. ervices tion: Skilled professional ervices include skilled sical therapy, hology services, and as specified in §409.44 of sician and medical social cified in §409.45 of this ssionals who provide ents directly or under inticipate in the coordination not met as evidenced by: n, record review, and ered Nurse failed to ensure tained frequency and cific to the certification re the plan of care contained including the tasks to be als to achieve (see G 708); were provided per the plan		700			
	attending physician (sensure skilled professin a quality assurance	o ensure coordination linic physician and the see G 718); and failed to sional services participated e program (see G 720).					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		4-1/0-0				С	
		15K070	B. WING			08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 700	ensure the provision of safe environment for participation: 484: 75 Professional Services	nealth agency's inability to of quality health care in a the condition of Condition: Skilled		700			
G 708	CFR(s): 484.75(b)(2) Development and evaluation partnership with the pany), and caregiver(s). This ELEMENT is not Based on observation interview, the Register the plans of care confiduration of visits specified period, failed to ensurall required elements provided, and the goal active records review of 9. The findings include: 1. A review of the polyplan of Treatment are agency. 2. Physiciar and documented for the agency provides to the being actively treated health care need or call a diagnosed health care need or call diagnosed health care the admission of treatment must be attending physicial days after the admission.	t met as evidenced by: n, record review, and ord Nurse failed to ensure ained frequency and	G	708			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 708	2. A review of clinical for the certification per to evidence home here of visits specific to the failed to evidence the home health aide. The following: A review of a docume Follow - up assessmelements with Plan of dated 6/1/18, with tim 10 AM, was complete signed on 6/5/18 by the following. The documbe provided were supprecertification, and the visits 7 days a week. A verbal order dated administrator / direction order for only RN duffrequency and durations well as the tasks to the plan of care for the 6/6/18 - 8/4/18, failed and duration of home the certification periodical provided by the home care was electronical administrator / direction following the certification periodical provided by the home care was electronical administrator / direction following following the following	anders and frequency of visits I equipment." all record #1, the plan of care eriod of 6/6/18 - 8/4/18 failed halth aide frequency, duration are certification period and attasks to be provided by the his was evidenced by the his was evidenced by the ent titled "Recertification nent" that included OASIS of Care / 485 information ne in of 7 AM and time out of red and was electronically the administrator / director of nent indicated the services to be provided by the period of and the tasks to be provided. The certification period of a to evidence the frequency of the halth aide visits specific to dealth aide. This plan of	G 7	708			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	E	30/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 708	assistance with mediwashing clothes were practical nurse and hours on these days 3. A review of clinicator the certification per to contain all the requevidence skilled nursifrequency and duratic certification period, a by skilled nursing an was evidenced by the A physician order dato by the physician, evic cleanse all wounds, with absorptive silver border; the peri anal dry, and the right elboration was to have services. There was of the visits or tasks of the visits or tasks of the skilled day, 3 days a week, medication monitoring suprapubic catheter.	L's/ personal care including cations, meal preps, and e provided by a licensed some health aide from 4 to 8 al record #2, the plan of care eriod of 6/6/18 - 8/4/18 failed uired elements, failed to sing and home health aide on of visits specific to the and the tasks to be provided d the home health aide. This e following: ted 4/30/18, and completed denced wound care orders to pack the right sacrum wound and cover with mepilex area was to be clean and ow was to be protected. 5/30/18, evidenced the skilled nursing and aide no frequency and duration for the staff to complete ded for director of nursing, I nurse was to visit 3 hours a for 26 weeks for wound care,	G 7	,		
	The home health aid with ADLs and IADLs preparation, houseke shopping, errands, a	e was to visit for assistance				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				C 46/2048
	ROVIDER OR SUPPLIER		-	2	STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 06/	16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 708	skilled nursing and ho specific to the 6/2/18 period. A review of a Home Hof Care for the certific 7/31/18, evidenced shours a day, 3 days a HHA orders 6 hours a weeks. The plan of c tasks that would be condicated on the 5/31/failed to evidence goand discharge plans, (durable medical equimeasures, activities psections were all bland electronically signed lidirector of nursing on signed by the physicial A review of home hea 6/2, 6/3, 6/4, 6/5, 6/6, 6/14, 6/15, 6/16, 6/17, 6/23, 7/13, 7/18, 7/20 indicated HHAs comppersonal care, hair caputput / input, inspect ambulation assist and A review of skilled nuvisits occurred on 6/5 6/27, 6/29, 7/2, 7/6, 7 and 7/30/18, and indivital signs, dressing occeyx area and right measurements, supra	e a duration and frequency of ome health aide visits to 7/31/18 certification dealth Certification and Plan extion period of 6/2/18 - killed nursing orders for 3 a week, for 26 weeks and a day, 7 days a week, 9 are failed to evidence the ompleted by the staff as /18 physician's order and als, rehabilitation potential, and the mental status, DME ipment) and supplies, safety permitted, and allergies alk. This document was by the administrator / 5/31/18 and electronically an on 6/7/18. Alth aide visit notes dated 6/7, 6/8, 6/9, 6/10, 6/13, 7/25, and 7/27/18, pleted tasks such as bathing, are, catheter care, record at / reinforce dressing, dother tasks. Alterial visit notes evidenced (a) 6/9, 6/12, 6/16, 6/21, 6/25, 7/9, 7/18, 7/20, 7/23, 7/27, cated nursing assessments, thange for wounds on sacral, at elbow area, wound	G	708			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 708	A review of the "Recassessment" includir of care / 485 dated 7 administrator / direct indicated the wounds. A review of a Home of Care for the certifi 9/29/18 was complet of nursing on 7/31/18 complete and failed supplies, safety mea orders evidenced a Shours a day 3 days a orders for 5 hours a weeks. A review of skilled nursessments, vital si wounds on sacral, coarea, wound measur assessments, and care of normal saline. 4. A review of clinicaticare 12/13/17 and pur hypertension, the platestart.	ertification Follow - up ng OASIS elements with plan /31/18 and completed by the or of nursing on 7/31/18, s were measured. Health Certification and Plan cation period of 8/1/18 - ed by administrator/ director 3. This plan of care was not to include the DME/ sures, and goals. The SN frequency and duration 2 to week for 26 weeks and HHA day, 7 days a week for 26 urse visit noted dated 8/1, indicated nursing gns, dressing change for occyx area and right elbow ements, suprapubic catheter atheter was irrigated with 60 all record #3 with a start of incipal diagnosis of essential an of care for the certification 19/18 failed to evidence the set up the patient's	G 7	708		
	by Employee B dated evidenced the nurse	nursing visit notes, completed d 6/16, 6/23, and 6/3018, set up the patient's ollowing week. A note on				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(XX	COMPLETED			
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	DE	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 708	6/16/18 stated, "Med ordered." During an interview of administrator / director medication set up was 5. A review of clinical care 11/16/17 and pri Quadriplegia, the pla period of 7/14/18 - 97 tasks to be completed was evidenced by the A review of the Home Plan of Care for the C-9/11/18 evidenced to 5 hours day/ 7 days and additional tasks writted under Medications: Firrigation. A review of an Adult I Sheet dated 7/14, 7/7/20, 7/21 (x2 visits), and 7/28/18, indicated including vital signs, neurological assessment, respirated gastrointestinal assessment and irrighours, pain assessment care, and trach changuncuffed trach, woun measured and cleans patted dry, with dress	in 8/16/18 at 12 noon, the or of nursing indicated the s not on the plan of care. I record #4 with a start of incipal diagnosis of in of care for the certification in 1/18 failed to evidence the diby the skilled nurse. This is efollowing: Health Certification and certification period of 7/14/18 he skilled nurse was to visit a week. There were noten on this document except Renadicin 30 cc ml daily Extended Hour Nursing Flow 15, 7/16, 7/17, 7/18, 7/19, 7/22 (x2 visits), 7/23, 7/27, diphysical assessment nutritional assessment, sement, cardiovascular ory assessment, sement, genitourinary graphic catheter ation, repositioning every 2 ent, skin assessment, trach ge with fenestrated size 4 dicare on right buttock was seed with soap and water,	G 7	708		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED			
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	,	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 708	and new dressings p being completed and with a 26 French 10 or During an interview of administrator / director record lacked a compression of the control of	care, trach collar changed laced, bowel program was suprapubic catheter change oc catheter was completed. In 8/16/18 at 12:05 PM, the or of nursing indicated the olete plan of care. The orders for the care received. In a collar that the olete plan of care in the care received. In a collar that the olete plan of care. The orders for the care received. In a collar that the olete plan of care. The orders for the care received. In a collar that the care received is the care received. In a collar that the order that the orders for the care diagnosis of Quadriplegia, rehensive Adult Assessment continuent indicated the order of nursing conducted the order of nursing conducted the orders for the enteral catheter was washed with olic catheter was washed with catheter was washed with	G 7	08		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
G 708	period of 6/27/18 - 8/ nurse was to visit 60 care failed to contain such a as safety mea nutritional requiremen potential / discharge to include size of sup care, gastric tube car tasks to be provided evidenced by the follo A review of an Adult I Sheet dated 7/2,7/9, the administrator/ dire physical assessment patient receives noth assessment, cardiova respiratory assessmen humidification, CPT v gastrointestinal asses colostomy); genito - 0 suprapubic catheter is soapy H20; reposition assessment; skin ass changed and inner ca tracheal suctioning co leg bag applied to su urine; full and passive on upper and lower e A review of an Adult I Sheet dated 7/16/18 administrator / directo physical assessment patient receives noth assessment, cardiova	care for the certification 25/18, evidenced the skilled hours a month. The plan of all the required elements issures, DME and supplies, ints, and goals/ rehabilitation plans box were blank, failed trapubic catheter, colostomy the and failed to evidence the by skilled nursing. This was owing: Extended Hour Nursing Flow 7/30, and 8/6/18, evidenced the ector of nursing conducted a secular assessment (the ing by mouth); neurological asscular assessment, and with a note: The extended Hour Nursing Flow assessment (patient has a surinary assessment with site cleansed with warm in every 2 hours; pain the sessment; trach ties annula changed; oral and completed; intake recorded; prapubic catheter draining the range of motion completed extremities; bed bath given; Extended Hour Nursing Flow and completed by the or of nursing, indicated a secular assessment, indicated a secular assessment, the ing by mouth); neurological asscular assessment, and with note concerning	G 7	708		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7. 50.25			(c
		15K070	B. WING			08/	16/2018
	ROVIDER OR SUPPLIER			224 W JEI	DDRESS, CITY, STATE, ZIP CODE FFERSON BLVD STE 200 BEND, IN 46601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
G 708	suprapubic catheter's soapy H20; reposition assessment; skin assessment; skin assechanged and inner cathumidification removes Shiley, uncuffed trach straps; Pacimuir valve speaking; CPT vest printervals at 14 pressuration upper and lower extra lsosource 240 cc following an interview of administrator / director plan of care was not consider the soap of	ssment (patient has a urinary assessment with lite cleansed with warm a every 2 hours; pain lessment; Trach ties unnula changed; led from tracheotomy #6 a, midline secured with Dale le in place to aid with laced on for 15 minute are. Range of motion on lemities; Feeding of lowed by 200 cc of water for la 8/13/18 at 10 AM, the lor of nursing indicated the complete.		708			
	plan of care was not complete.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	567 167 2015	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 710	care services the accepatients who a. Are physician for a diagnatus a health care is status requiring meadmitted to service. 2. The agency police Nursing Service state services practice of the profes provision of nursing performance, direct care tasks pursuant consistent with an experience of the professional orders, monitor and their care The lice assigned care under RN's are licensed in regulations and start the state. 4. All LP follow all regulations required by the state these services are pure the plan of care." 4. A review of clinical care 12/4/17, princip of sacral region, fail were provided per the care and the record	documented for the health gency provides to those being actively treated by a mosed health care problem b. need or change in physical dical intervention c. are	G 7	710			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	I	00/10/2010
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 710	of Care for the certification 7/31/18, evidenced shours a day, 3 days a plan of care failed to would be completed was electronically signification of nursing or signed by the physical A review of a skilled 6/5/18, 6/9/18, 6/12/2 Employee B visited to day. Tasks completed vital signs, dressing a coccyx area and right catheter assessed. A review of a physical completed by the administration of a physical completed by the administration of a physical completed by the administration of a physical completed by the administration, evidenced the visit 5 hours a day, 7 and skilled nursing 2 for 26 weeks per new The order failed to be	Health Certification and Plan cation period of 6/2/18 - killed nursing orders for 3 a week, for 26 weeks. The evidence the tasks that by the staff. This document gned by the administrator / in 5/31/18 and electronically	G7	10		
	the skilled nurse.	the tasks to be provided by nurse visit note dated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 710	6/21/18, 6/27/18, 6/2 evidenced Employed completed absent of nursing assessment, catheter monitoring. patient for 2 hourson than 2 hours on 7/6/2 A review of a skilled 6/25/18, evidenced Epatient. Tasks comporder were nursing a suprapubic catheter catheter was change (cubic centimeter) but A review of a skilled 7/18/18, evidenced Epatient for 2 hours. physician's order we signs, and suprapub note failed to evidence been conducted. A review of a skilled 7/20/18, evidenced Epatient for 2 hours. physician's order we signs, the wound on measured, and supra The note failed to evhad been conducted. A review of a skilled 7/23/18, evidenced Epatient for 1.5 hours. a physicians order we signs, the wound on weigns, the wound on signs, the wound on seviment for 1.5 hours.	19/18, 7/2/18, 7/6/18, 7/9/18, a B visited the patient. Tasks a physician's order were vital signs, and suprapubic Employee B visited the 16/29, 7/2, 7/9/18 and less 18. Inurse visit note dated Employee B visited the 18 leted absent of a physicians assessment, vital signs, and monitoring. The suprapubic ad using a 26 French / 30 cc 18 lb. Inurse visit note dated Employee B visited the Tasks completed absent of a re nursing assessment, vital ic catheter monitoring. The ce if dressing changes had Inurse visit note dated Employee B visited the Tasks completed absent of a re nursing assessment, vital the sacral area was apubic catheter monitoring. Indence if dressing changes Inurse visit note dated Employee B visited the Tasks completed absent of a re nursing assessment, vital the sacral area was apubic catheter monitoring. Indence if dressing changes Inurse visit note dated Employee B visited the Tasks completed absent of a re nursing assessment, vital the sacral area was apubic catheter monitoring. Indence if dressing changes Inurse visit note dated Employee B visited the Tasks completed absent of the Tasks completed absent	G 7	10			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		DENTIFICATION NUMBER.		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		08/16/2018	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 710	Continued From pag	ge 124	G 7	10			
	included orders for torder of absorptive scleanses two times conducted during the A review of a skilled 7/27/18, 7/30/18, evithe patient for 2 hou of a physician's ordevital signs, the wour measured, and suprivas completed. The dressing changes have A review of a physicianghal signed by the admir evidenced HHA was day, 7 days a week, with ADLs' and IADI grocery shopping, e skilled nurse was to	ian order dated 7/23/18, he right sacrum for dressing silver and mepilex border with a week. Only 1 visit was is week (7/22/18 to 7/28/18). nurse visit note dated idenced Employee B visited irs. Tasks completed absent er were nursing assessment, id on the sacral area was rapubic catheter monitoring e note failed to evidence if ad been conducted. ian order dated 7/31/18, iistrator / director of nursing, is to visit the patient 5 hours a for 26 weeks for assistance as, housekeeping, laundry, rrands and meal prep. The visit 2 hours daily, 3 days a e, nursing assessment,					
		ng, catheter care and					
	OASIS elements with information dated 7/ administrator / direct The wounds were more cleansed with sterile colloidal silver and movement wound was contaminated were thoroughly was prior to dressing characteristics.	31/18 and completed by the tor of nursing on 7/31/18. Deasured. The wounds were a saline and then packed with mystatin cream and dressed. The document stated,"The nated with fecal matter, areas shed with soap and water,					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING		08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 33/10/2010	
(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 CORR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
G 710	conducted absent of 5. A review of clinical care 12/13/17, and presential hypertension nurse conducted carphysician's order as Review of the plan operiod of 6/11/18 - 8/4 agency was to set unchecking blood sugar Review of A skilled in by Employee B dated nurse set up the pating stated, "Medications Review of a skilled in by Employee B dated nurse set up the pating stated, "Medications Review of a skilled in by Employee B dated evidenced the nurse medications for the incomplete of the condition of the incomplete of the	a physician's order. al record #3, with a start of rincipal diagnosis of on, evidenced the skilled e and services absent of a evidenced by: f care for the certification 9/18, failed to evidence the p the patient's medications or r results. ursing visit note completed d 6/16/18, evidenced the ent's medications. A note dispensed as ordered." ursing visit note completed d 6/23/18 and 6/30/18, set up the patient's next week. on 8/16/18 at 12 noon, the or of nursing indicated the as not on the plan of care. al record #4, with a start of rincipal diagnosis of to evidence skilled nurse per the physician ordered record evidenced SN	G 710	,		
	A review of the Home Plan of Care for the - 9/11/18 evidenced					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		OATE SURVEY COMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		33713/2313
(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 COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 710	under Medications: Firrigation. A review of an Adult I Sheet dated 7/14/18 M, RN, indicated task a physician's order: including vital signs, neurological assessment, respirat gastrointestinal asses assessment including assessment and irrighours, pain assessment	en on this document except Renadicin 30 cc ml daily Extended Hour Nursing Flow and completed by Employee as were completed absent of A physical assessment nutritional assessment, nent, cardiovascular	G 7	10		
	uncuffed trach, woun measured and cleans patted dry, and dress education with discus medications were addications were addicated and A review of an Adult I Sheet dated 7/15/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment, respirat gastrointestinal asses assessment of supra repositioning every 2 skin assessment, track with discussion about increased protein to predications were set.	d care on right buttock was sed with soap and water, sing applied, patient ssion about proper hydration, ministered, bladder irrigation iven, suprapubic and trach d new dressings placed. Extended Hour Nursing Flow and completed by Employee are completed absent of a physical assessment nutritional assessment, nent, cardiovascular ory assessment, ssment, genitourinary pubic catheter and irrigation, hours, pain assessment, care, patient education				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	00/10/2010
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 710	A review of an Adult I Sheet dated 7/16/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment, respirat gastrointestinal asses assessment of supra repositioning every 2 skin assessment and patient education saf wheelchair, and med A review of an Adult I Sheet dated 7/17/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment, respirat gastrointestinal asses assessment of supra pain assessment, ski care, trach care, and A review of an Adult I Sheet dated 7/18/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment assessment, respirat gastrointestinal asses assessment assessment, respirat yellow of an Adult I Sheet dated 7/18/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment, respirat	Extended Hour Nursing Flow and completed absent of a physical assessment, nent, cardiovascular ory assessment, genitourinary pubic catheter and irrigation, hours, pain assessment, ications provided. Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment, nent, cardiovascular ory assessment, ications provided. Extended Hour Nursing Flow and completed absent of a physical assessment nutritional assessment, nent, cardiovascular ory assessment, genitourinary pubic catheter and irrigation, in assessment and wound if medications provided. Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment nutritional assessment nutritional assessment, nent, cardiovascular	G 7	10		
	physician's order: A including vital signs, neurological assessment assessment, respirat gastrointestinal asses assessment of supra pain assessment, ski care, trach care, and A review of an Adult I Sheet dated 7/18/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment, respirat gastrointestinal asses assessment of supra	physical assessment nutritional assessment, nent, cardiovascular ory assessment, ssment, genitourinary pubic catheter and irrigation, in assessment and wound d medications provided. Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment nutritional assessment, nent, cardiovascular ory assessment,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		30/10/2010
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 710	A review of an Adult Sheet dated 7/19/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment, respirat gastrointestinal asses assessment of supra pain assessment, ski care, trach care, med collar replaced. A review of an Adult Sheet dated 7/20/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment, respirat gastrointestinal asses assessment of supra pain assessment, respirat gastrointestinal asses assessment of supra pain assessment, ski and medication admit A review of an Adult Sheet dated 7/21/18 B, evidenced the nur approximately 3 hour Tasks completed abswere a physical asses nutritional assessment, gastroing enitourinary assess	Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment nutritional assessment, nent, cardiovascular ory assessment, sement, genitourinary pubic catheter and irrigation, in assessment and wound dications set up, and trach Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment nutritional assessment, nent, cardiovascular ory assessment, sement, genitourinary pubic catheter and irrigation, in assessment, reaction, in assessment, trach care, nistration. Extended Hour Nursing Flow and completed by Employee se had completed rivisit from 8:49 AM - 12 PM. Sent of a physician's order ressment including vital signs, int, neurological assessment, respiratory	G 7	10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING_			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	CODE	00/10/2010
(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 O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 710	and medication admir A review of an Adult E Sheet dated 7/21/18 a B, evidenced the nurs visit from 6:41 PM - 7 absent of a physician assessment including assessment, neurolog cardiovascular assess assessment, gastroin genitourinary assessr pain assessment, skir and medication admir A review of an Adult E Sheet dated 7/22/18 a B, evidenced the nurs hour visit from 7 AM - absent of a physician assessment including assessment, neurolog cardiovascular assess assessment, gastroin genitourinary assessr pain assessment, skir medication administra A review of an Adult E Sheet dated 7/22/18 a B, indicated tasks we physician's order: A p including vital signs, r neurological assessm assessment, respirato gastrointestinal asses assessment of supraga	extended Hour Nursing Flow and completed by Employee se had completed a 1 hour is 151 PM. Tasks completed is order were a physical vital signs, nutritional gical assessment, sment, respiratory testinal assessment, ment of suprapubic catheter, in assessment, trach care, histration. Extended Hour Nursing Flow and completed by Employee se had completed by Employee se had completed a 1:45 8:45 AM. Tasks completed is order were a physical vital signs, nutritional gical assessment, sment, respiratory testinal assessment, ment of suprapubic catheter, in assessment, trach care, ation, and digital stimulation. Extended Hour Nursing Flow and completed by Employee re completed absent of a physical assessment inutritional assessment, sent, cardiovascular ory assessment, sent, cardiovascular ory assessment, sement, genitourinary	G 7	710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K070		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		0/10/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 710	Sheet dated 7/23/18 M, indicated tasks we physician's order: A including vital signs, in neurological assessmassessment, respirate gastrointestinal asses assessment of suprapain assessment, ski care, trach care, and administration. A review of an Adult E Sheet dated 7/27/18 M, indicated tasks we physician's order: A including vital signs, in neurological assessmassessment, respirate gastrointestinal asses assessment of suprapain assessment, ski care, trach care, med collar replaced. A review of an Adult E Sheet dated 7/28/18 M, evidenced the nur visit from 8 am - 1:30 absent of a physician Suprapubic catheter oc catheter, and track	Extended Hour Nursing Flow and completed absent of a physical assessment nutritional assessment, and, cardiovascular ory assessment, genitourinary public catheter and irrigation, assessment and wound medications set up and Extended Hour Nursing Flow and completed by Employee are completed absent of a physical assessment nutritional assessment, genitourinary ory assessment, genitourinary ory assessment, genitourinary or assessment and wound ications set up, and trach Extended Hour Nursing Flow and completed by Employee see completed absent of a physical assessment, genitourinary or assessment, genitourinary or assessment and wound ications set up, and trach Extended Hour Nursing Flow and completed by Employee see completed a 5 1 / 2 hour PM. Tasks completed 's order: Assessments, change with a 26 French 10	G 7*				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 710	8/13/18 at 9:10 AM, pe in a hospital bed wadministrator / director to assess the patient then give the patient then give the patient albuterol. The CPT wapproximately 9:25 A completed at approxicompleted was a net medication albuterol, tracheostomy with a cough assist. A review of clinical refe/27/18, and principal failed to evidence ski aide visits were proviordered plan of care skilled nursing provide of a physician's order A review of the Home Plan of Care for the C-8/25/18, evidenced 60 hours a month. The written on this document a start of document evidenced administrator / director indicated the patient catheter, and a feedin indicated orders for the boluses 240 CC ever family. Tasks perform order were: A physical patient catheter and a feedin indicated orders for the control of the control of the patient catheter. A physical patient catheter and a feedin indicated orders for the control of the contro	ation of the home visit on patient #9 was observed to with an air mattress. The per of nursing was observed by taking vital signs and an ebulizer treatment with vest treatment was started at LM. The CPT treatment was mately 9:50 AM. Also pulizer treatment with the suctioning of the 14 French suction tube and 14 French suction tube and 15 cord #9, with a start of care all diagnosis of Quadriplegia, and the record evidenced led care and services absent or as evidenced by: 18 Health Certification and certification period of 6/27/18 the skilled nurse was to visit there were no additional tasks ment.	G 7	10			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
15K070	B. WING		C 08/16/2018	
		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		
MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPROPRIES OF THE	JLD BE COMPLETION	
er washed with soap and patted dry. Intended Hour Nursing Flow dompleted by the sof nursing, evidenced the sa 8 hour visit from 8 AM - 4 absent of a physician's I assessment, nutritional interceives nothing by seessment, cardiovascular ry assessment with a note: set treatment completed, sment (patient has a inary assessment with the cleansed with warm site is 24 French, 10 cc sery 2 hours; pain resident; trach ties anula changed; oral and impleted; and intake Intended Hour Nursing Flow dompleted by the sof nursing, evidenced the sa 8 hour visit from 8 AM - 4 absent of a physician's I assessment, nutritional interceives nothing by sessment, cardiovascular ry assessment with note ion, CPT vest X 1/2 hour; sment and appliance colostomy); genito - urinary apubic catheter site is part and appliance colostomy); genito - urinary apubic catheter site is	G 71			
	IDENTIFICATION NUMBER:	15K070 B. WING TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION) 132 Gr washed with soap and I patted dry. Attended Hour Nursing Flow d completed by the of nursing, evidenced the a 8 hour visit from 8 AM - 4 absent of a physician's II assessment, nutritional nt receives nothing by ssessment (patient has a inary assessment with a note: est treatment completed, sment (patient has a inary assessment with te cleansed with warm site is 24 French, 10 cc ery 2 hours; pain essment; trach ties inula changed; oral and impleted; and intake A. BUILDING B. WING PREFIX TAG G 71 C 71 A absent of a physician's II assessment, nutritional int receives nothing by ssessment, cardiovascular ry assessment, nutritional int receives nothing by ssessment, cardiovascular ry assessment, cardiovascular ry assessment, nutritional int receives nothing by ssessment, cardiovascular ry assessment, cardiovascular ry assessment, cardiovascular ry assessment, outritional int receives nothing by ssessment, cardiovascular ry assessment, cardiovascular ry assessment with note tion, CPT vest X 1/2 hour; sment and appliance colostomy); genito - urinary apubic catheter site bapy H20, Catheter site is on; reposition every 2	15K070 15K070	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 710	passive range of mo lower extremities; leg catheter draining uris suctioning; and positioning; and positioning; and positioning and positioning. A review of an Adult Sheet dated 7/16/18 administrator / direct nurse had completed PM. Tasks completed order were: A physical assessment (the pat mouth); neurological assessment, respiral concerning humidificigastrointestinal assecolostomy); genitosuprapubic catheter soapy H20; repositional assessment; skin as changed and inner of humidification removes Shiley, uncuffed tract straps; pacimuir valves speaking; CPT vest intervals at 14 pressupper and lower extiles source 240 cc fol flush. A review of an Adult Sheet dated 7/30/18 administrator / direct nurse had completed abovere: A trach ties of	ner cannula changed; full and tion completed on upper and g bag applied to suprapubic ne; cough assist with tracheal tion changes every 15 Extended Hour Nursing Flow and completed by the for of nursing, evidenced the da 6 hour visit from 8 AM - 2 and absent of a physician's cal assessment, nutritional itent receives nothing by assessment, cardiovascular tory assessment with note cation, CPT vest X 1/2 hour; assessment (patient has a urinary assessment with site cleansed with warm on every 2 hours; pain sessment; trach ties	G 7	10		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						(
		15K070	B. WING _			08/	16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			22	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 710	flushed with 240 cc w A review of an Adult E Sheet dated 8/6/18 ar administrator / director nurse had completed Tasks completed absorber: Trach ties char changed; suctioned tr given bolused as order partial bed bath given During an interview of administrator / director plan of care was not of Communication with p CFR(s): 484.75(b)(7) Communication with a plan of care and other (as appropriate) related care; This ELEMENT is no Based on observation interview, the Registe the attending physicia in a patient's condition coordination between and the attending phy records reviewed (#2) impairments in a sam The findings included 1. The agency policy Nursing Service" date	iven bolus as ordered ater, and bed bath given. Extended Hour Nursing Flow and completed by the part of nursing, evidenced the a visit from 8 AM - 4 PM. The ent of a physician's order anged and inner cannula trach, gastric tube feeding ered, flushed with water; and the ent of nursing indicated the complete. The ent of his area practitioners and to the current plan of the trace practitioners and the ent of hurse failed to ensure and was notified in a change and failed to ensure the wound clinic physician resician 2 of 2 active clinical of a patient with skin ple of 9.		710			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	'	33, 13, 23 13
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 718	patient / family need, following nursing fund	e 135 ds and depending upon each all or a selection of the ctions may be performed ces, including referral to	G 7	18		
	Services" dated 2015 services in order to p care, and assure comprofessional nurse is following: a. the profhome care services be established plan of congoing evaluation a patient's home care rechannels of communactive caregivers and	essional coordination of all				
	12/8/17 included a ce 8/4/18, with orders fo clinical record and the to evidence the agen	Il record #1, start of care ertification period of 6/6/18 - or skilled nursing. The e following documents failed cy staff alerted the physician e of condition and concerns arrhea:				
	of Care / 485 informathis assessment was administrator / directed electronically signed administrator / directed assessment docume the patient had a rasi	g OASIS elements with Plan tion dated 6/1/18, evidenced completed by the or of nursing and on 6/5/18 by the				

AND DI AN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _				C / 16/2018	
	ROVIDER OR SUPPLIER	I		224 W JE	DDRESS, CITY, STATE, ZIP CODE FFERSON BLVD STE 200 BEND, IN 46601	RESS, CITY, STATE, ZIP CODE ERSON BLVD STE 200		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
G 718	on this document. A HHA visit note date Employee B, HHA, estatement, "Groin rasimproving. A HHA visit note date Employee B, HHA, estatement, "Rash has moving bowels." A HHA visit note date Employee B, HHA, estatement, "Assistant protective cream to pimprovement on perioda HHA visit note date Employee B, HHA, estatement, "Note reduction of the statement, "Note reduction of the statement, "Perianal A HHA visit note date Employee B, HHA, estatement, "Perianal A HHA visit note date Employee B, HHA, estatement, "No pressirritation noted." A HHA visit note date Employee B, HHA, estatement, "No pressirritation noted."	of this change of condition d 6/7/18 and signed by videnced the following the has odor. Perianal rash of 6/9/18 and signed by videnced the following simproved. Pain when of 6/13/18 and signed by videnced the following the with pericare. Applied the erianal area see anal rash." d 6/18/18 and signed by videnced the following the see on perianal area." d 7/13/18 and signed by videnced the following the irritated at this time." d 7/26/18 and signed by videnced the following the irritated at this time." d 7/26/18 and signed by videnced the following the irritated at the following the irritated at the following the irritation worse. Extra	G 7	718				
		videnced the patient had						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING		C 08/16/2018	
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		1 00.10.2010	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
G 718	Employee B, HHA, e perianal irritation at to During an interview of administrator / direct Budreau butt cream not in the record or r Nurse by Employee 4. A review of clinical of care 12/4/17 and pressure ulcer of said documentation that the coordinated care with wound care (Physici patient's attending place was further evidence A review of a physici completed by Physici orders for the right sand pack the wound then cover with mep	ed 8/2/18 and signed by evidenced the patient had no this time. on 8/16/18 at 10:15 AM, the for of nursing indicated that had been used and this was eported to the Registered B or other staff. all record #2 on 8/16/18, start principal diagnosis of cral region, failed to evidence the home health agency he the physician ordering an A) for this patient and the hysician, Physician B. This	G 718			
	failed to evidence the with the patient's atternative of a Home of Care for the certification of 3 hours and duration of 3 hours 26 weeks and HHA 6 week, for 9 weeks.	tected. The clinical record at this order was coordinated ending physician (B). Health Certification and Plan lecation period of 6/2/18 - 8N orders for the frequency surs a day / 3 days a week for 6 hours a day, for 7 days a This plan of care failed to 1 care orders. This document attent's attending physician,				

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, ST 224 W JEFFERSON BLVD SOUTH BEND, IN 4660		STATE, ZIP CODE D STE 200	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD B TO THE APPROPRIA	
G 718	by the administrator / 5/31/18. This plan of the patient was received wound clinic and the from Physician A at the A review of a physician A, dated 7/23/18, inclus acrum for dressing of mepilex border with of The clinical record fairorder was coordinated physician (B). A review of a Home Hof Care for the certifical 9/29/18 was completed director of nursing on was not complete. The physician name, Physician name, Physician name, Physician name, Physician name, Physician name, Physician of the work of the work of the physician of	director of nursing on care failed to evidence that ving services from the agency may accept orders be wound clinic. In order written by Physician uded orders for the right order of absorptive silver and leanses two times a week. It did not the patient's attending the leath Certification and Plan reation period of 8/1/18 - and by administrator / 7/31/18. This plan of care the patient's attending	G	718		
G 720	_	r of nursing indicated the was lacking.	G 7	720		
		HA's QAPI program; and t met as evidenced by: n, record review and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		33/13/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 720	The findings include The agency policy tit Delegation Policy" d administration shall I operations on a day signed by the admin The agency policy tit stated, "As part of th program, a committe reviews the results o collection activities a minutes of meetings agency's office." During the Entrance 11:10 AM, the admir indicated the quality monitored the chang areas were wound o She stated, "We follo the plans of care." S the staff keeping up documentation.	y failed to ensure the skilled is participated in a quality for 1 of 1 agency reviewed. Iled "Administration ated 7/6/18 stated, "The peresponsible for all to day basis. This was istrator / director of nursing. Iled "Committees" dated 2015 agency's quality assurance are of professional personnel of quality assurance data to least quarterly. Written are maintained at the conference on 8/7/18 at istrator / director of nursing assurance program assurance program assurance program as in patient. The focus are and infection tracking. The focus are and infection tracking with the charting /	G 7			
	assurance / perform- requested. The admindicated the program be found. During this the quality assurance taken by a past emp coordinator, who wa	ninistrator / director of nursing m was missing and could not s time, the owner indicated e binder may have been				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
			756.25	<u> </u>		С	
		15K070	B. WING _		01	3/16/2018	
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODI 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 720	administrator / director quality assurance had had been in the role of 2018. During an observation owner was observed with binders including binder and infection of A review of document.	n 8/15/18 at 2:10 PM, the or of nursing indicated the dinot occurred and that she of administrator since June on 8/15/18 at 3 PM, the coming out of a back room of the quality assurance	G 7	20			
G 800	(i) Ordered by the phy (ii) Included in the pla (iii) Permitted to be po and (iv) Consistent with the This ELEMENT is not Based on record revi- health aide failed to en- per the plan of care for reviewed, failed to en- provided absent of a active records (#1, #2 ensure the home head services beyond their active record reviewe	rovides services that are: ysician;	G 8				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 8/16/2018	
	ROVIDER OR SUPPLIER	10.00.0		STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		6/16/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 800	Plan of Treatment" s a plan of treatment a agency. 2. Physicia and documented for agency provides to the being actively treated health care need or a diagnosed health of to service with the agplan of treatment must the attending physicidays after the admissinclude the type all provided specific of necessary medical. 2. The policy titled "Service" dated 2015 health aide a. The nodemonstrate or obsethey are performed to not have documente performing the tasks care. It is the legal retherapist responsible to assure that the History and the same suppose the same supposed to the performing the tasks care.	olicy titled "2.21 Physician's tated, "A physician prepares and it is made available to the n's orders are established the health care services the nose patients who a. are done by a physician b. have a change in physical status for are problem c. are admitted gency 4. A physician's state be signed and dated by an and in the chart within 30 sion to the agency and must and frequency of services orders and frequency of visits	G 86		()		
	following patient care not to be performed demonstrated / obse apply simple, non 3. A review of clinica of care for the certific 8/4/18, evidence the care and services ab	e procedures are generally until they have been rved in each patient situation					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		15K070	B. WING				C / 16/2018
	ROVIDER OR SUPPLIER	10.00.0		224 W	ET ADDRESS, CITY, STATE, ZIP CODE / JEFFERSON BLVD STE 200 TH BEND, IN 46601	1 00.	110/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 800	as evidenced by the A review of a Recerti assessment including of Care / 485 informa in of 7 AM and time of and was electronicall administrator / direct to be provided were recertification, and H days a week for 26 w. A verbal order for SN completed 6/1/18 by nursing. The order of did not evidence frequenth aide visits, and The plan of care for the 6/6/18 - 8/4/18, failed aide orders. This order of the administrator / 6/5/18. A HHA visit note date Employee B, LPN, exhours of care including care, check pressure with medications, and A HHA visit note date Employee B, evidence care including a bath check pressure areas medications, and am	following: fication Follow - up g OASIS elements with Plan tion dated 6/1/18 with time but of 10 AM, was completed y signed on 6/5/18 by the or of nursing. The services written as supervisory visits, HA (home health aide) 7 reeks. and Aide services was the administrator / director of nly contained RN duties and uency, duration of home d the tasks to be completed. the certification period of to evidence home health ler was electronically signed d director of nursing on ad 6/7/18 and signed by ridenced the patient had 6 ng a bath, personal care, hair areas, nail hygiene, assist d ambulation assist. ad 6/9/18 and signed by the ded the patient had 7 hours of the personal care, hair care, so, nail hygiene, assist with bulation assist.	Gi	800			
		videnced the patient had 5 ng a bath, assist with bath,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	'	33,13,2310	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 800	personal care, hair of ambulation assist, and A HHA visit note date Employee B, evidencare including personal care, assigned preparation, and was HHA visit notes date 7/19/18, signed by Epatient had 5 hours of personal care. HHA visit notes date 7/27/18, and 7/31/18 HHA, evidenced the including a bath and A HHA visit note date Employee B, evidencare including a bath HHA visit notes date 7/17/18, signed by Epatient had 6 hours of personal care. A HHA visit note date 7/17/18, signed by Epatient had 6 hours of care including a bath and Care including a bath a	are, assist with medications, and mobility assist. ed 6/13/18, signed by ced the patient had 6 hours of nal care, check pressure ist with medications, meal sh clothes. d 6/14/18, 6/20/18, and imployee C, evidenced the of care including a bath and d 6/15/18, 7/13/18, 7/26/18, 8, signed by Employee B, patient had 6 hours of care personal care. ed 6/18/18, signed by ced the patient had 4 hours of and personal care. d 7/6/18, 7/9/18, 7/12/18, and imployee C, evidenced the of care including a bath and ed 7/16/18, signed by evidenced the patient had 6 ng a bath and personal care. ed 7/18/18, signed by ced the patient had 6 ng a bath and personal care.	G 8				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, , ,	PLE CONSTRUCTION G	COMPLETED		
		15K070	B. WING		C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
G 800	care 12/4/17, princip of sacral region, faile aide visits were provordered plan of care HHA conducted care physician's order as A review of a Home of Care for the certifit 7/31/18, evidenced I days a week, 9 weel evidence the tasks to the staff. This docur	al record #2, with a start of pal diagnosis of pressure ulcer ed to evidence home health rided per the physician and the record evidenced e and services absent of a	G 80			
	physician on 6/7/18. A review of home he evidenced visits occi 6/10/18, 6/13/18, 6/13 3), 6/17/18, 6/18/18, 6/23/18 (week 4), no 6/30/18 (week 5), no 7/7/18 (week 6), no 7/12/18 and 7/14/18 7), no visits between and 7/21/18 but two (week 8), no visits from 7/26/18, and 7/28/18 7/27/18 (week 9). Thome health aide visweek. 5. The personnel file Home Health Aide, of this employee stated.	ranically signed by the salth aide visits notes urred on 6/2/18 (Week 1), 14/18, 6/15/18, 6/16/18 (week 6/19/18, 6/21/18, 6/22/18, o visits between 6/14/18 to o visits between 7/1/18 to visits between 7/8/18 to, but 1 visit on 7/13/18 (week 17/15/18 to 7/17/18, 7/19/18, visits on 7/18/18 and 7/20/18 om 7/22/19 to 7/24/18, 8 but two visits on 7/25/18 and the agency failed to ensure sits were provided 7 days a decoument of Employee I, dated 9/26/17 and signed by dr. "Must have successfully empetency evaluation training				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING				C / 16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			2	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)			(X5) COMPLETION DATE
G 800	program which conformal program which completed the house on patient #5. Employen this task. This was following: 1. A review of a Care Assistant Skills. Home Health Aide, evenot competent to chath the competency check list employee, Employee 2. A review of F6/14/18, 6/15/18, 6/15/18, 6/22/18, 6/22/18, 6/28/18, 6/29/18, 7/2/17/18, 7/9/18, 7/10/17/16/18, 7/17/18, 7/18, 7/23/18, 7/24/18, 7/24/18, 7/24/18, 7/24/18, 8/2/14 evidenced the bandar changed at each visit	cord #5 on 8/16/18, it was me health aide, Employee I, sing changes for a peg tube yee I was not competencied in further evidenced by the document titled "Personnel check list" for Employee I, sidenced this employee was not a peg tube dressing. It was completed by past H, RN. HA visit notes dated 6/13/18, 8/18, 6/19/18 6/20/18, 6/27/18, 18, 7/3/18, 7/5/18, 7/6/18, 8, 7/11/18, 7/12/18, 7/13/18, 8/18, 7/19/18, 7/20/18, 8/18, 7/26/18, 7/27/18, 8/18, 7/26/18, 7/26/18, 7/27/18, 8/18, 7/26/18, 7/27/18, 8/18, 7/26/18, 7/26/18, 7/27/18, 8/18, 7/26/18	G	800			
G 804	administrator/ directo Employee I was not of dressing changes. Aides are members of CFR(s): 484.80(g)(4) Home health aides m	n 8/16/18 at 12:35 PM, the of nursing indicated that competent in the task of finterdisciplinary team ust be members of the	G	804			
		, must report changes in the a registered nurse or other					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING		,	C 98/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		10,2010	
(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 SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 804	complete appropriate the HHA's policies and This ELEMENT is in Based on record rewind health aide failed to changes in the patiencial records reviewed in the patiencial records reviewed in the findings include. A review of a policy Health Aide Document Health Aide Document Health Aides are to a provided on the visit concurrence with cast documentation of cast the home health aided documentation of the observations during client's progress or an another limited to a). Increasing any change the supervising nurse not limited to a). Increasing filed in the chart A review of clinical results of the case man of condition and condition and condition and condition and condition document the case man of condition and condition and condition document the case man of condition and condi	rofessional, and must e records in compliance with nd procedures. ot met as evidenced by: view and interview, the home notify the case manager of nt's condition in 1 of 3 active ewed (#1) with home health a sample of 9. : dated 7/6/18 titled "Home entation" stated, "Home document care / services record and be in re plan. Purpose 1. Provides re / services provided during	G 8	04			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				C 16/2018
	ROVIDER OR SUPPLIER		•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	, 00.	10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 804	Employee B, HHA, ev statement, "Groin ras improving. A HHA visit note date: Employee B, HHA, ev statement, "Rash has moving bowels." A HHA visit note date: Employee B, HHA, ev statement, "Assistance protective cream to poimprovement on perial A HHA visit note date: Employee B, HHA, ev statement, "Note redress tatement, "Perianal restatement, "Perianal restatement, "No pressi irritation noted." A HHA visit note date: Employee B, HHA, ev statement, "No pressi irritation noted." A HHA visit note date: Employee B, HHA, ev statement, "No pressi irritation noted."	d 6/7/18 and signed by videnced the following h has odor. Perianal rash d 6/9/18 and signed by videnced the following simproved. Pain when d 6/13/18 and signed by videnced the following se with pericare. Applied erianal area see anal rash." d 6/18/18 and signed by videnced the following ness on perianal area." d 7/13/18 and signed by videnced the following not irritated at this time." d 7/26/18 and signed by videnced the following ure wounds. Perianal	G	804	DEFICIENCY)		
		d 7/31/18 and signed by videnced the patient had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	101070] 3		STREET ADDRESS, CITY, STATE, ZIP CODE	1 08/	16/2018
TMG HOM	E HEALTH CARE INC				224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 804	Employee B, HHA, experianal irritation at the During an interview of administrator / director Budreau butt cream hot in the record or reconsite supervisory vis CFR(s): 484.80(h)(1) of the following patient who is received or occupational therain pathology services, a appropriate skilled prowith the patient, the powritten patient care in	d 8/2/18 and signed by videnced the patient had no nis time. n 8/16/18 at 10:15 AM, the or of nursing indicated that had been used and this was exported to the Registered 8 or other staff.		804			
	days. The home health present during this vising this vising this vising this ELEMENT is not assed on record reving the requested of the supervisory visit were frequently every 14 diskilled nursing and how (#3) in a sample of 9. The findings include The agency policy "Horevised 7/13/18 states home health aide seriand supervision of a light size."	It met as evidenced by: ew and interview, the ed to ensure aide					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		15K070	B. WING				C 46/2048
NAME OF PE	ROVIDER OR SUPPLIER	i one o		_	STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	16/2018
			224 W JEFFERSON BLVD STE 200				
TMG HOM	E HEALTH CARE INC				SOUTH BEND, IN 46601		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
G 808	6 808 Continued From page 149		G	808	3		
		cian. The frequency of					
supervision will be in Medicaid regulations,		response to Medicare /					
		agency policy and other					
	state or federal requir						
	completed at least ev	nealth aide services will be					
	regulations."	ory oo dayo or per					
	A review of clinical re						
		skilled nursing and home The clinical record failed to					
		rvision of a home health					
	aide within every 14 c						
	supervisory visit was	·					
		sment visit on 6/8/18 and					
	on 8/8/18 for a visit th	sory visit was documented					
	7/12/18.	at was sompleted on					
	During an interview o	n 8/16/18 at 12:30 PM, the					
	_	r of nursing stated, "I was in					
	-	reference to the 8/7/18					
	supervisory visit note						
G 940	Organization and adn CFR(s): 484.105	ninistration of services	G	940			
	Condition of participa administration of serv	tion: Organization and rices.					
	_	ize, manage, and administer					
		and maintain the highest					
		capacity, including providing				ĺ	
optimal care to achieve the goals and ou identified in the patient's plan of care, fo		_				ĺ	
		sing, and rehabilitative				ĺ	
	needs. The HHA mus	t assure that administrative				ĺ	
	'	ions are not delegated to					
	another agency or orgoin not furnished directly	ganization, and all services				ĺ	
	not furnished directly	are monitored and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	,	35.16.2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOOTH CROSS-REFERENCED TO THE APPLICATION OF THE APPLI	IOULD BE	(X5) COMPLETION DATE
G 940	organizational structural authority, and services This CONDITION is Based on record revolution, the ager governing body was in quality assurance produdinistrator failed to agency's ongoing fund Clinical Manager failed place for tracking refeassessed within 48 h. Clinical Manager failed provided per the plant treatment and services of a physicians order, care contained freques specific to the certificen ensure the plan of care	must set forth, in writing, its are, including lines of as furnished. not met as evidenced by: iew, interview, and arcy failed to ensure the arcolor of architecture and direct the critical store and direct the arctions (see G 942); the arctions (see G 948); the arctions (see G 964); and the arctions (see G 964); and the arctions are patients are pours (see G 964); and the arctical to ensure visits were arction of care, failed to ensure the plans of ency and duration of visits artion period, and failed to are contained all required to etasks to be provided and	G 9	140		
G 942	resulted in the home ensure the provision safe environment for participation: 484.10 and Administration of Governing body CFR(s): 484.105(a) Standard: Governing A governing body (or functioning) must assiresponsibility for the amanagement and open	5 Condition: Organization Services. 1 body. designated persons so ume full legal authority and	G 9	142		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	PLE CONSTRUCTION G	· /	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	·	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 942	the agency's budget and its quality asses improvement progra This STANDARD is Based on observation interview, the agency governing body was quality assurance properties. The findings include The agency policy to administration shall loperations on a day signed by the administration shall loperations on a day signed by the administration shall loperations on a day signed by the administration shall loperations on a day signed by the administration shall loperations on a day signed by the administration shall loperations on a day signed by the administration activities a minutes of meetings agency's office." During the Entrance 11:10 AM, the adminindicated the quality monitored the changareas were wound continued the changareas were wound continued the plans of care. So the staff keeping up documentation. During an interview of assurance/ performation administrator / continued to the continued to the changareas were wound continued to the plans of care. So the staff keeping up documentation.	and its operational plans, sment and performance m. not met as evidenced by: on, record review and y failed to ensure the involved with the ongoing ogram for 1 of 1 agency. Iteld "Administration ated 7/6/18 stated, "The performance of all to day basis. This was istrator/ director of nursing. Iteld "Committees" dated 2015 the agency's quality assurance per of professional personnel of quality assurance data at least quarterly. Written are maintained at the conference on 8/7/18 at histrator/ director of nursing assurance program assurance program assurance program are in patient. The focus are and infection tracking. Ow the guidelines and go by the indicated a concern with	G 9-	42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER E HEALTH CARE INC			2	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 001	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 942	assurance binder mapast employee, a pass was seen on security the office. She indicated with this concern. During an interview of administrator director quality assurance productive and that she administrator since Juding an observation owner was observed with binders including binder and infection of the second of the se	owner indicated the quality by have been taken by a state office coordinator, who monitors taking items from sted having a lawyer involved in 8/15/18 at 2:10 PM, the reference of the gram meetings had not a had been in the role of the gram meetings had not a had been in the role of the gram of the quality assurance control binder. It is in the quality assurance documentation of meetings any-to-day operations of the state as evidenced by: In record review and strator failed to organize and angoing functions for 1 of 1		942			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				C 16/2018
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 COUTH BEND, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 948	Regarding closed office. During an observation was observed the office one answered the kninside the office. A sit the agency was closed. A review of state depevidenced the agency Tuesdays from 9:00 - Wednesdays, and opfrom 10 AM - 4 PM. A review of a letter day Whom It May Concertinc. has changed the closed, Tuesday - Fri was signed by the admirsing. During an interview of owner indicated a lett about 2 weeks ago with changes and the change of the change of the change of operation. Regarding Patient Right The administrator fail patient representative.	ce on a Monday on 8/6/18 In on 8/6/18 at 10:34 AM, it ide door was locked and no lock. The lights were offigin on the door evidenced ed on Mondays. artment documents by was open Monday and ed:00 PM, closed len Thursdays and Fridays ated June 1, 2018 stated, "To m: TMG Home Health Care hours of operation: Monday day - 9 AM - 4 PM. This liministrator / director of len 8/7/18 at 10:35 AM, the let was sent to the state lith the administrative lith the administ	G	948			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		35.16.20.10	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 948	Notice of Privacy Rig treatment. (See G 41 The administrator fail patient representative agency administrator and business phone complaints. (see G 4 The administrator fail of the patient's rights provided within 4 bus assessment. (see G 4 The administrator fail patient representative informed of the HHA' discharge. (see G 45 The administrator fail health agency arrang transfer to another care	nowledgement Forms, and hts before the initiation of 0) ed to ensure the patients / es received the home health 's name, business address, number in order to receive 14) ed to ensure written notice and responsibilities was siness days of the initial 422) ed to ensure the patient / e had the right to be s policy for transfer and	G 9				
	The administrator fail physician and the leg informed in advance The administrator fail complaint made by a representative. (see the distribution of the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that is the administrator fail existence of a complaint made that the administrator fail existence of a complaint made that the administrator fail existence of a complaint made that the administrator fail existence of a complaint made that the administrator fail existence of a complaint made that the administrator fail existence of a complaint made that the administrator fail existence of a complaint made	patient's legal G 478)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 8/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		0/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 948	The administrator fail patient specific and be assessment findings. The administrator fail Nurse accurately ider wound on a patient. The administrator fail Nurse completed a condischarge summer progress in meeting to 550) In regards to Care pland Quality of Care and Significant fail provided per the plan treatment and services of a physicians order. The administrator fail care contained freques specific to the certificate plan of care contained including the tasks to to achieve. (see G 57) The administrator fail orders were recorded 576) The administrator fail orders were recorded 576)	ed to ensure the goals were ased on the comprehensive (see G 530) ed to ensure the Registered of the comprehensive assess a second (see G 544 and G 706) ed to ensure the Registered of the care plan goals. (see G 544 and G 706) ed to ensure the Registered of the care plan goals. (see G 544 and G 706) ed to ensure the Registered of the care plan goals. (see G 544 and G 706) ed to ensure visits were of care and failed to ensure as were not provided absent as were not provided absent and G 572 and G 708) ed to ensure the plans of the ency and duration of visits ation period, failed to ensure as and all required elements abe provided and the goals (4 and G 710) ed to ensure all patient care of the plan of care. (see G 544 and G 710) ed to promptly notify the in the patient's condition.	G 9	48		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	DATE SURVEY COMPLETED
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	I	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 948	record contained doe physician and the leginformed in advance. The administrator fai with all physicians in (see G 602 and G71. The administrator fai Nurse coordinated the (durable medical equation 608). In regards to Quality Improvement and Sk. The administrator fai assurance program of measurable improve analyze and track quadverse patient ever performance that energy processes of care, Hose G 642. The administrator fai assurance program of including measures of content of the relevant data, and safety of service identify opportunities 644.) The administrator fai assurance program of a content of the administrator fai assurance program of a content of the administrator fai assurance program of a content of the administrator fai assurance program of a content of the administrator fai assurance program of a content of the administrator fai assurance program of a content of the administrator fai assurance program of a content of the administrator fai assurance program of a content of the administrator fai assurance program of a content of the administrator fai assurance program of a content of the administrator fai assurance program of the administrator fai assurance	led to ensure the clinical cumentation that the patient's gal representative was of a discharge. (see G 598) led to ensure communication volved in the plan of care. 8) led to ensure the Registered he patient's care with a DME uipment) company. (see G Assessment/ Performance cilled Professional Services led to ensure the quality was capable of showing ment and must measure, reality indicators, including hits, and other aspects of able the agency to assess IHA services, and operations. led to ensure the quality utilized quality indicator data, derived from OASIS and to monitor the effectiveness as and quality of care and a for improvement. (see G	G 9	48		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	, ,	ATE SURVEY OMPLETED
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 948	volume, or problem problem problem problem problem provided assurance program of prevalence and several the administrator fair assurance program I correction of any idea potentially threaten the patient. (see G 652) The administrator fair improvement activities events, analyzed the preventive actions. (so The administrator fair at performance improsustained. (see G 65) The administrator fair body was involved was unance program. The administrator fair professional services assurance program. In regards to Infection The administrator fair guidelines. (see G 68) The administrator fair guidelines. (see G 68) The administrator fair agency-wide program identification, preventive program identification identifi	led to ensure the quality considered the incidence, rity of problems. (see G 650) led to ensure the quality ed to ensure the quality ed to an immediate ntified problem that directly or ne health and safety of led to ensure Performance es tracked adverse patient ir causes, and implemented see G 654) led to ensure actions aimed overment occurred and were 8) led to ensure the governing ith the ongoing quality (see G 660) led to ensure skilled a participated in a quality (see G 720) In Prevention and Control led to follow infection control 32) led to maintain a coordinated in for the surveillance,	G 94	48		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _				C 16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			2	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 948			G	948			
	quality assessment an improvement program						
	In regards to Home H	ealth Aide Services					
	aide visits were provid failed to ensure home not provided absent of failed to ensure the ho	ed to ensure home health ded per the plan of care, health aide services were of a physicians order, and tome health aide did not and their scope of practice.					
	The administrator failed to ensure home health aides notify the case manager of changes in the patient's condition. (see G 804)						
	Nurse aide superviso	ed to ensure the Registered ry visit were conducted no 14 days. (see G 808)					
	In regards to Clinical	Records					
		ed to ensure the goals were ased on the comprehensive (see G1016					
	Nurse completed a di	ed to ensure the Registered scharge assessment and vith the patient's progress in goals. (see G 1022)					
G 964	were completed and swere rendered. (see	·	G s	964			

NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC (X31) D PREENT TAG (X31) T PREENT T PROVIDERS REPAROFICE TO T PREVIOUS T PREVIOUS T PROVIDER T PROVI		DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	, ,	DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC (X4) ID PREFIX (MA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICENCY MUST BE PRECEDED BY PULL PREFIX TAG (SA) CONTINUED TO THE APPROPRIATE DEFICIENCY AND THE PRECEDED BY PULL PROVIDERS PLAN OF CORRECTION SHOULD BE COMPETCH AND THE PROVIDERS PLAN OF CORRECTION COMPETCH AND THE PROVID			15K070	B. WING			C 08/46/2048
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE CAMPILETION DATE					224 W JEFFERSON BLVD STE 200	I	00/10/2010
Coordinating referrals; This ELEMENT is not met as evidenced by: Based on record review and interview, the Clinical Manager failed to ensure a system was in place for tracking referrals to ensure patients are assessed within 48 hours for 5 of 6 active patients whose clinical records were reviewed (#1 - #4, #9) in a sample of 9. The findings include: 1. Review of the policy titled "2.7 Guidelines for Assessment" dated 2015 stated, " 2. The initial assessment will be made within 48 hours" 2. Review of the clinical record of patient #1, start of care date of 12/8/17, failed to evidence a physician order start of care and/ or referral documentation to determine if the initial assessment' start of care was conducted within the 48 hours. 3. Review of the clinical record of patient #2, start of care date of 12/4/17, failed to evidence a physician order start of care and/ or referral documentation to determine if the initial assessment' start of care was conducted within the 48 hours.	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI	HOULD BE	COMPLETION
This ELEMENT is not met as evidenced by: Based on record review and interview, the Clinical Manager falled to ensure a system was in place for tracking referrals to ensure patients are assessed within 48 hours for 5 of 6 active patients whose clinical records were reviewed (#1 - #4, #9) in a sample of 9. The findings include: 1. Review of the policy titled "2.7 Guidelines for Assessment" dated 2015 stated, " 2. The initial assessment will be made within 48 hours" 2. Review of the clinical record of patient #1, start of care date of 12/8/17, failed to evidence a physician order start of care and/ or referral documentation to determine if the initial assessment/ start of care was conducted within the 48 hours. 3. Review of the clinical record of patient #2, start of care date of 12/4/17, failed to evidence a physician order start of care and/ or referral documentation to determine if the initial assessment/ start of care and/ or referral documentation to determine if the initial assessment/ start of care was conducted within the 48 hours.	G 964	Continued From pag	e 159	G 9	964		
start of care date of 12/13/17, failed to evidence a physician order start of care and/ or referral documentation to determine if the initial assessment/ start of care was conducted within the 48 hours.		This ELEMENT is not Based on record reversity Clinical Manager fail place for tracking refeassessed within 48 his patients whose clinically assessed within 48 his patients whose clinically assessment with the findings included and the findings included assessment with the findings included and the findings included assessment with the findings included and the findings included assessment with the findings included and the finding	ot met as evidenced by: riew and interview, the ed to ensure a system was in errals to ensure patients are rours for 5 of 6 active al records were reviewed (#1 of 9. ricy titled "2.7 Guidelines for 2015 stated, " 2. The ll be made within 48 hours rical record of patient #1, 12/8/17, failed to evidence a of care and/ or referral termine if the initial care was conducted within rical record of patient #2, 12/4/17, failed to evidence a of care and/ or referral termine if the initial care was conducted within rical record of patient #3, 12/13/17, failed to evidence a of care and/ or referral termine if the initial care was conducted within				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				C 16/2018
	ROVIDER OR SUPPLIER		•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 COUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 964	a physician order star documentation to det assessment/ start of of the 48 hours. During an interview of administrator / director questioned about the mouth through [name agency]." 6. Review of the clinic of care date of 6/27/1 physician order start of care date of 6/27/1 physician order start of commentation to det assessment/ start of of the 48 hours. Assure implementation CFR(s): 484.105(c)(5) Assuring the develop updates of the individing This ELEMENT is not assed on record reviolational Manager failed provided per the plan records (#2, #4, #9), and services were not physicians order for 5 reviewed (#1, #2, #3, the plans of care confiduration of visits specific period, and failed to econtained all required tasks to be provided assessment/ start of the services were not physicians order for 5 reviewed (#1, #2, #3, the plans of care confiduration of visits specific period, and failed to econtained all required tasks to be provided assessment/ start of the services were not physicians order for 5 reviewed (#1, #2, #3, the plans of care confiduration of visits specific period, and failed to econtained all required tasks to be provided assessment/ start of the services were not physicians order for 5 reviewed (#1, #2, #3, the plans of care confiduration of visits specific period, and failed to econtained all required tasks to be provided.	1/16/17, failed to evidence of of care and/ or referral ermine if the initial care was conducted within on 8/16/18 at 12:06 PM, the or of nursing when referral stated, "Word of of other home health of cal record of patient #9 start 8, failed to evidence a of care and/ or referral ermine if the initial care was conducted within on of plan of care of plan of care. It ment, implementation, and ualized plan of care. It met as evidenced by: It was as evidenced by: It was and interview, the end to ensure visits were of care for 3 of 6 active failed to ensure treatment to provided absent of a so of 6 active records #4, #9), failed to ensure		964			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		15K070	B. WING		08/16/20	118
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/10/20	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COM	(X5) PLETION DATE
G 968	Continued From pag	e 161	G 96	8		
	Plan of Treatment's a plan of treatment a agency. 2. Physicia and documented for agency provides to the being actively treated health care need or a diagnosed health to service with the agplan of treatment muthe attending physicidays after the admissinclude the type ar	olicy titled "2.21 Physician's tated, "A physician prepares and it is made available to the n's orders are established the health care services the nose patients who a. are do by a physician b. have a change in physical status for are problem c. are admitted gency 4. A physician's st be signed and dated by an and in the chart within 30 sion to the agency and must and frequency of services orders and frequency of visits				
	Nursing Service" statemean the services proportion of the profession of nursing sperformance, directic care tasks pursuant to consistent with an example of the provided Register nursing care by the work trained professionals orders, monitor and in their care The licent assigned care under RN's are licensed in regulations and standard professionals orders, and their care under their care under their care under their care under their care and their care under their care u	on or supervision of health				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	9.10.2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 968	required by the state these services are p the plan of care." In regards to the Plate 4. A review of clinic of care for the certification as evidenced by the care and services all during the certification as evidenced by the A review of a Recert assessment including of Care / 485 inform in of 7 AM and time and was electronical administrator / direct to be provided were recertification, and he days a week for 26 of A verbal order for SI completed 6/1/18 by nursing. The order of did not evidence free health aide visits, ar The plan of care for 6/6/18 - 8/4/18, faile aide orders. This or	and standards of practice a Home health aides rovided in accordance with an of Care al record #1, included a plan cation period of 6/6/18 - home health aide conducted beent of a physician order on period of 6/6/18 - 8/4/18, following: iffication Follow - up og OASIS elements with Plan ation dated 6/1/18 with time out of 10 AM, was completed ally signed on 6/5/18 by the tor of nursing. The services written as supervisory visits, and Aide services was at the administrator / director of conly contained RN duties and quency, duration of home and the tasks to be completed. the certification period of d to evidence home health der was electronically signed	G 9	068			
	6/5/18. A HHA visit note dat Employee B, LPN, e	/ director of nursing on ed 6/7/18 and signed by videnced the patient had 6 ng a bath, personal care, hair					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		OATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	CODE	03.10.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 968	care, check pressure with medications, an A HHA visit note date Employee B, evidence care including a bath check pressure area medications, and am A HHA visit note date Employee C, HHA, e hours of care including personal care, hair cambulation assist, an A HHA visit note date Employee B, evidence care including personal care, ass preparation, and was HHA visit notes date 7/19/18, signed by Epatient had 5 hours of personal care. HHA visit notes date 7/27/18, and 7/31/18 HHA, evidenced the including a bath and A HHA visit note date Employee B, evidence care including a bath and HHA visit notes date 7/17/18, signed by Employee B, evidence care including a bath HHA visit notes date 7/17/18, signed by Employee B, evidence care including a bath	e areas, nail hygiene, assist d ambulation assist. ed 6/9/18 and signed by ced the patient had 7 hours of personal care, hair care, so, nail hygiene, assist with abulation assist. ed 6/11/18 and signed by evidenced the patient had 5 and a bath, assist with bath, are, assist with medications, and mobility assist. ed 6/13/18, signed by ced the patient had 6 hours of care including a bath and and 6/15/18, 7/13/18, 7/26/18, patient had 6 hours of care personal care.	G	968		

AND BLAN OF CORRECTION IDENTIFICATION NUMBER	PLE CONSTRUCTION G	· ,	ATE SURVEY DMPLETED			
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
G 968	Continued From pa	ge 164	G 96	68		
	Employee D, HHA, hours of care included A HHA visit note da Employee D, evider of care including a land A HHA visit note da Employee B, evider hours of personal care 12/4/17, principle of sacral region, fail and home health air physician ordered pevidenced SN and land hours of care 12/4/19.	evidenced the patient had 6 ling a bath and personal care. ted 7/18/18, signed by need the patient had 6 hours bath and personal care. ted 8/2/18, signed by need the patient had 6 hours bath and personal care. ted 8/2/18, signed by need the patient received 8 are and a bath and other care. cal record #2, with a start of pal diagnosis of pressure ulcer led to evidence skilled nurse de visits were provided per the plan of care and the record HHA conducted care and a physician's order as				
	A review of a Home of Care for the certi 7/31/18, evidenced hours a day, 3 days HHA orders 6 hours weeks. The plan of tasks that would be document was elected administrator / directed electronically signed A review of home heavidenced visits occ 6/10/18, 6/13/18, 6/13/18, 6/13/18 (6/23/18 (week 4), n	Health Certification and Plan fication period of 6/2/18 - skilled nursing orders for 3 a week, for 26 weeks and a day, 7 days a week, 9 for care failed to evidence the completed by the staff. This tronically signed by the etor of nursing on 5/31/18 and d by the physician on 6/7/18. The ealth aide visits notes curred on 6/2/18 (Week 1), 14/18, 6/15/18, 6/16/18 (week 1, 6/19/18, 6/21/18, 6/22/18, o visits between 6/14/18 to o visits between 7/1/18 to				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIR 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	
G 968	7/7/18 (week 6), no volume 7/12/18 and 7/14/18, 7), no visits between and 7/21/18 but two volume 8, no visits from 7/26/18, and 7/28/18 7/27/18 (week 9). The home health aide visweek. A review of a skilled 6/5/18, 6/9/18, 6/12/12 Employee B visited the day. Tasks completed vital signs, dressing coccyx area and right catheter assessed. A review of a physicial completed by the physicare orders to cleans sacrum wound with a with mepilex border; clean and dry, and the protected. A review of a physicial completed by the physicare orders to cleans sacrum wound with a with mepilex border; clean and dry, and the protected. A review of a physicial completed by the admirsing, evidenced the visit 5 hours a day, 7 and skilled nursing 2 for 26 weeks per new The order failed to be certification period be and failed to include the skilled nurse and	risits between 7/8/18 to but 1 visit on 7/13/18 (week 7/15/18 to 7/17/18, 7/19/18, visits on 7/18/18 and 7/20/18 om 7/22/19 to 7/24/18, but two visits on 7/25/18 and he agency failed to ensure its were provided 7 days a nurse visit note dated 18, and 6/16/18, evidenced he patient for 2 hours each and were nursing assessment, change for wounds on sacral, the elbow area. Suprapubic an order dated 6/18/18, visician, evidenced wound see all wounds, pack the right absorptive silver and cover the peri anal area was to be the right elbow was to be an order dated 6/20/18, and ministrator / director of the home health aide was to days a week, for 26 weeks hours a day, 3 days / week, w PA (prior authorization). The specific to the remaining etween 6/20/18 to 7/31/18 the tasks to be provided by	GS	968		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 968	evidenced Employee completed absent of nursing assessment, catheter monitoring. patient for 2 hourson than 2 hours on 7/6/1 A review of a skilled 6/25/18, evidenced Epatient. Tasks comporder were nursing a suprapubic catheter catheter was change (cubic centimeter) but a review of a skilled 7/18/18, evidenced Epatient for 2 hours. Physician's order were signs, and suprapubinote failed to evidence been conducted. A review of a skilled 7/20/18, evidenced Epatient for 2 hours. Physician's order were signs, the wound on measured, and suprapubinote failed to evidence been conducted. A review of a skilled 7/20/18, evidenced Epatient for 2 hours. Physician's order were signs, the wound on measured, and suprapubinote failed to evidence to the stilled to evidence to the sti	B visited the patient. Tasks a physician's order were vital signs, and suprapubic Employee B visited the 6/29, 7/2, 7/9/18 and less 18. nurse visit note dated imployee B visited the leted absent of a physicians assessment, vital signs, and monitoring. The suprapubic dusing a 26 French / 30 cc 11b. nurse visit note dated imployee B visited the rasks completed absent of a re nursing assessment, vital are nursing assessment, vital are catheter monitoring. The ce if dressing changes had the rasks completed absent of a re nursing assessment, vital the sacral area was apubic catheter monitoring. The rasks completed absent of a re nursing assessment, vital the sacral area was apubic catheter monitoring. In the sacral area was apubic catheter monitoring. The rasks completed absent of a re nursing assessment, vital and the sacral area was apubic catheter monitoring. The rasks completed absent of a re nursing assessment, vital and rasks completed absent of a re nursing assessment, vital and rasks completed absent of a re nursing assessment, vital and rasks completed absent of a re nursing assessment, vital and rasks completed absent of a re nursing assessment, vital	GS	968		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	l \ /	ATE SURVEY DMPLETED
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		50/10/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 968	included orders for the order of absorptive secteanses two times a conducted during this. A review of a skilled of 7/27/18, 7/30/18, evicting the patient for 2 hour of a physician's order vital signs, the wound measured, and suprawas completed. The dressing changes had a review of a physicial signed by the adminited evidenced HHA was day, 7 days a week, with ADLs' and IADLs' grocery shopping, er skilled nurse was to week for wound care medication monitoring changes and coordinance and coo	an order dated 7/23/18, he right sacrum for dressing filver and mepilex border with a week. Only 1 visit was a week (7/22/18 to 7/28/18). Inurse visit note dated denced Employee B visited absent a were nursing assessment, and on the sacral area was apubic catheter monitoring note failed to evidence if denced been conducted. In order dated 7/31/18, strator / director of nursing, to visit the patient 5 hours a for 26 weeks for assistance and meal prep. The visit 2 hours daily, 3 days a nursing assessment, g, catheter care and ation of care. In order dated 7/31/18, strator / director of nursing, to visit the patient 5 hours a for 26 weeks for assistance and meal prep. The visit 2 hours daily, 3 days a nursing assessment, g, catheter care and ation of care. In order dated 7/31/18, and completed by the or of nursing on 7/31/18. In order dated 7/31/18, and completed by the or of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18. In order dated 7/31/18, and completed by the order of nursing on 7/31/18.	G 96	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K070	B. WING			C 08/16/2018	
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	ı	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 968	Continued From pag	e 168	G 9	68			
	care 12/13/17, and p essential hypertensionurse conducted care physician's order as a Review of the plan of period of 6/11/18 - 8/ agency was to set unchecking blood sugar Review of A skilled in by Employee B dated nurse set up the patic	on, evidenced the skilled e and services absent of a evidenced by: f care for the certification 9/18, failed to evidence the p the patient's medications or					
	by Employee B dated evidenced the nurse medications for the n During an interview of administrator / direct medication set up was						
	care 11/16/17, and p Quadriplegia, failed to visits were provided plan of care and the conducted care and a physician's order as a A review of the Home Plan of Care for the of - 9/11/18 evidenced to 5 hours day, for 7 day	rincipal diagnosis of o evidence skilled nurse per the physician ordered record evidenced SN services absent of a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		` IDENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING			C 08/16/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		0.710,2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
G 968	irrigation. A review of an Adult I Sheet dated 7/14/18 M, RN, indicated task a physician's order: including vital signs, neurological assessment, respirat gastrointestinal asses assessment including assessment and irrig hours, pain assessment care, and trach chang uncuffed trach, woun measured and cleans patted dry, and dress education with discus medications were addications were addicated tasks were addicated t	Extended Hour Nursing Flow and completed by Employee as were completed absent of A physical assessment nutritional assessment, nent, cardiovascular ory assessment, sement, genitourinary applied, patient sion about proper hydration, ministered, bladder irrigation iven, suprapubic and trach denivourinary genitourinary genitourinary genitourinary pubic catheter and irrigation, hours, pain assessment, care, patient education to proper nutrition and promote wound healing,	G 96	88				
	medications were set completed, shower g	t up, bladder irrigation iven, trach care, trach collar ng placed and suprapubic						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 8/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 968	dressing care completed A review of an Adult I Sheet dated 7/16/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment, respirat gastrointestinal asses assessment of supra repositioning every 2 skin assessment and patient education saf wheelchair, and med A review of an Adult I Sheet dated 7/17/18 M, indicated tasks we physician's order: A including vital signs, neurological assessment, respirat gastrointestinal asses assessment of supra pain assessment, ski care, trach care, and A review of an Adult I Sheet dated 7/18/18 M, indicated tasks we physician's order: A including vital signs, incurological assessment, respirat gastrointestinal asses assessment, respirat gastrointestinal asses assessment of supra	Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment nutritional assessment, sement, genitourinary pubic catheter and irrigation, hours, pain assessment, wound care, trach care, ety while sitting in ications provided. Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment, nent, cardiovascular ory assessment, sement, genitourinary pubic catheter and irrigation, in assessment, sement, genitourinary pubic catheter and irrigation, in assessment and wound if medications provided. Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment and wound if medications provided.	G 9	168			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			08/1) 16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
G 968	Sheet dated 7/19/18 at M, indicated tasks we physician's order: A pincluding vital signs, representation assessment, respirate gastrointestinal assessment of suprapain assessment, skiicare, trach care, medicollar replaced. A review of an Adult E Sheet dated 7/20/18 at M, indicated tasks we physician's order: A pincluding vital signs, reproving assessment, respirate gastrointestinal assessment, respirate gastrointestinal assessment, skii and medication admir A review of an Adult E Sheet dated 7/21/18 at B, evidenced the nursapproximately 3 hour Tasks completed abswere a physical assessment, gastroing assessment, gastroing genitourinary assessment genitourinary assessment genitourinary assessment genitourinary assessment genitourinary assessment.	Extended Hour Nursing Flow and completed absent of a physical assessment nutritional assessment, sement, genitourinary public catheter and irrigation, in assessment and wound ications set up, and trach Extended Hour Nursing Flow and completed by Employee are completed absent of a physical assessment nutritional assessment and wound ications assessment assessment, genitourinary public catheter and irrigation, in assessment, genitourinary public catheter and irrigation, in assessment, trach care, instration. Extended Hour Nursing Flow and completed by Employee are had completed by Employee and completed by Employee and completed by Employee and completed by Employee are had completed by	GS	968			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING		08/16/2018	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	1 00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORREST TO THE APPOEFICIENCY)	OULD BE COMPLETION	
G 968	Sheet dated 7/21/18 B, evidenced the nur visit from 6:41 PM - 7 absent of a physiciar assessment including assessment, neurolo cardiovascular asses assessment, gastroir genitourinary assess pain assessment, sk and medication admi A review of an Adult Sheet dated 7/22/18 B, evidenced the nur hour visit from 7 AM absent of a physiciar assessment including assessment, neurolo cardiovascular asses assessment, gastroir genitourinary assess pain assessment, sk medication administr A review of an Adult Sheet dated 7/22/18 B, indicated tasks we physician's order: A including vital signs,	Extended Hour Nursing Flow and completed by Employee se had completed a 1 hour 7:51 PM. Tasks completed a's order were a physical g vital signs, nutritional gical assessment, respiratory ntestinal assessment, ment of suprapubic catheter, in assessment, trach care, inistration. Extended Hour Nursing Flow and completed by Employee se had completed a 1:45 - 8:45 AM. Tasks completed a's order were a physical g vital signs, nutritional gical assessment, respiratory ntestinal assessment, ment of suprapubic catheter, in assessment, trach care, ation, and digital stimulation. Extended Hour Nursing Flow and completed by Employee are completed absent of a physical assessment, nutritional assessment, utritional assessment nutritional assessment,	G 96	,		
	neurological assessr assessment, respirat gastrointestinal asse assessment of supra assessment, skin ass	nent, cardiovascular cory assessment, ssment, genitourinary pubic catheter, pain sessment, and trach care.				
	A review of an Adult	Extended Hour Nursing Flow				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K070	B. WING				C / 16/2018
	ROVIDER OR SUPPLIER			224	EET ADDRESS, CITY, STATE, ZIP CODE W JEFFERSON BLVD STE 200 UTH BEND, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
G 968	Sheet dated 7/23/18 M, indicated tasks we physician's order: A including vital signs, in neurological assessmassessment, respirate gastrointestinal asses assessment of suprapain assessment, ski care, trach care, and administration. A review of an Adult E Sheet dated 7/27/18 M, indicated tasks we physician's order: A including vital signs, ineurological assessment, respirate gastrointestinal asses assessment of suprapain assessment, ski care, trach care, med collar replaced. A review of an Adult E Sheet dated 7/28/18 M, evidenced the nur visit from 8 am - 1:30 absent of a physician Suprapubic catheter oc catheter, and track During an interview of administrator / director record lacked a comprecord was lacking or	and completed by Employee ere completed absent of a physical assessment nutritional assessment, nent, cardiovascular ory assessment, genitourinary pubic catheter and irrigation, in assessment and wound medications set up and Extended Hour Nursing Flow and completed by Employee ere completed absent of a physical assessment nutritional assessment, nent, cardiovascular ory assessment, genitourinary pubic catheter and irrigation, in assessment and wound lications set up, and trach Extended Hour Nursing Flow and completed by Employee se completed a 5 1 / 2 hour PM. Tasks completed 's order: Assessments, change with a 26 French 10	G	968			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		33, 13, 23 13	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
G 968	be in a hospital bed administrator / direct to assess the patient then give the patient albuterol. The CPT approximately 9:25 A completed at approximately 9:25 A completed was a net medication albuterol, tracheostomy with a cough assist. A review of clinical refe/27/18, and principal failed to evidence skilled nursing provior of a physician's orde. A review of the Home Plan of Care for the 6-8/25/18, evidenced 60 hours a month. The written on this docum. A review of the Compevidenced a start of document evidenced administrator / direct indicated the patient catheter, and a feedi indicated orders for the boluses 240 CC ever family. Tasks perform order were: A physic site was washed with	catient #9 was observed to with an air mattress. The or of nursing was observed by taking vital signs and a nebulizer treatment with exest treatment was started at M. The CPT treatment was imately 9:50 AM. Also culizer treatment with the suctioning of the 14 French suction tube and exercised with the suction of Quadriplegia, and the record evidenced led care and services absent as evidenced by: The Health Certification and certification period of 6/27/18 the skilled nurse was to visit there were no additional tasks ment.	G	968			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING				C 16/2018
	ROVIDER OR SUPPLIER			224	EET ADDRESS, CITY, STATE, ZIP CODE W JEFFERSON BLVD STE 200 UTH BEND, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
G 968	water, rinsed well, and A review of an Adult E Sheet dated 7/2/18 and administrator / director nurse had completed PM. Tasks completed order were: A physical assessment (the patie mouth); neurological assessment, respirate humidification, CPT of gastrointestinal assessment; genito - usuprapubic catheter is soapy H20 (Catheter balloon); reposition evassessment; skin assechanged and inner catracheal suctioning correcorded. A review of an Adult E Sheet dated 7/9/18 and administrator / director nurse had completed PM. Tasks completed PM. Tasks completed order were: A physical assessment (the patie mouth); neurological assessment, respirate concerning humidificated Gastrointestinal assessment.	Extended Hour Nursing Flow and completed by the profit of nursing, evidenced the a 8 hour visit from 8 AM - 4 disabsent of a physician's all assessment, nutritional cent receives nothing by assessment with a note: present reatment completed, assent (patient has a rinary assessment with a site cleansed with warm site is 24 French, 10 covery 2 hours; pain essment; trach ties annula changed; oral and ampleted; and intake extended Hour Nursing Flow and completed by the profit of nursing, evidenced the a 8 hour visit from 8 AM - 4 disabsent of a physician's all assessment, nutritional cent receives nothing by assessment, cardiovascular pry assessment with note ation, CPT vest X 1/2 hour; assessment and appliance	G	968			
	assessment with suprocleansed with warms 24 French, 10 cc ballo hours; pain assessme	colostomy); genito - urinary rapubic catheter site coapy H20, Catheter site is con; reposition every 2 ent; skin assessment; trach er cannula changed; full and					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		15K070	B. WING			C 8/16/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	0/10/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
G 968	lower extremities; leg catheter draining urin suctioning; and positi minutes. A review of an Adult I Sheet dated 7/16/18 administrator / directonurse had completed PM. Tasks complete order were: A physicassessment (the patimouth); neurological assessment, respirat concerning humidificagastrointestinal assescolostomy); genito - usurapubic catheter soapy H20; reposition assessment; skin assesment; skin assended and inner cahumidification removes Shiley, uncuffed trackstraps; pacimuir valves peaking; CPT vest pintervals at 14 pressuupper and lower extra Isosource 240 cc folloflush. A review of an Adult I Sheet dated 7/30/18 administrator / directonurse had completed Tasks completed abswere: A trach ties chenge, cough assist	ion completed on upper and bag applied to suprapubic be; cough assist with tracheal on changes every 15 Extended Hour Nursing Flow and completed by the per of nursing, evidenced the a 6 hour visit from 8 AM - 2 dealers and assessment, nutritional ent receives nothing by assessment, cardiovascular ory assessment with note ation, CPT vest X 1/2 hour; assment (patient has a purinary assessment with site cleansed with warm the every 2 hours; pain sessment; trach ties annula changed; ed from tracheotomy #6 ho, midline secured with Dale	G 96	68				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	DDE	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
G 968	flushed with 240 cc w A review of an Adult I Sheet dated 8/6/18 a administrator / director nurse had completed Tasks completed abswere: Trach ties charchanged; suctioned trace given bolused as ord partial bed bath given bolused as ord partial bed bath given During an interview of administrator / director plan of care was not In regards to the Plan required elements 9. A review of clinicate for the certification per to evidence home he of visits specific to the failed to evidence the home health aide. The following: A review of a docume Follow - up assessments with Plan of dated 6/1/18, with tim 10 AM, was complete signed on 6/5/18 by the nursing. The docume be provided were suppresentification, and the visits 7 days a week to the state of the suppresent of	Extended Hour Nursing Flow and completed by the period of nursing, evidenced the a visit from 8 AM - 4 PM, and of a physician's orderinged and inner cannula rach, gastric tube feeding ered, flushed with water; and	GS	968			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBED:		2) MULTIPLE CONSTRUCTION BUILDING			
		15K070	B. WING_			00/		
NAME OF PR	ROVIDER OR SUPPLIER	Tortoro	1	STREET ADDRESS, CIT	Y, STATE, ZIP CODE	08/	16/2018	
TMG HOM	E HEALTH CARE INC		224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		(EACH COI	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 968	administrator / director order for only RN dutifrequency and duration as well as the tasks to the plan of care for the 6/6/18 - 8/4/18, failed and duration of home the certification period provided by the home care was electronically administrator / director Review of HHA visit in 6/13, 6/14, 6/15, 6/18 7/16, 7/17, 7/18, 7/19 indicated specific ADI assistance with media washing clothes were practical nurse and he hours on these days. 10. A review of clinication period, and the certification period, and the certification period, and the certification period, and the skilled nursing and was evidenced by the A physician order date by the physician, evid cleanse all wounds, put with absorptive silver border; the peri anal as	or of nursing, evidenced an es and did not evidence on of home health aide visits to be provided. The certification period of to evidence the frequency health aide visits specific to d and the tasks to be health aide. This plan of the y signed by the period of nursing on 6/5/18. The dated 6/7, 6/9, 6/11, 6/20, 7/6, 7/9, 7/12, 7/13, 7/27, 7/31, and 8/2/18 The personal care including cations, meal preps, and the provided by a licensed to me health aide from 4 to 8. The personal care including cations, meal preps, and the provided by a licensed to me health aide from 4 to 8. The personal care including cations, meal preps, and the provided by a licensed to me health aide from 4 to 8. The personal care including cations, meal preps, and the provided by a licensed to me health aide from 4 to 8.	G	68				
	A verbal order dated	5/30/18, evidenced the						

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE			15K070	B. WING				
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DV DV					22	4 W JEFFERSON BLVD STE 200	1 001	10/2010
	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO			(X5) COMPLETION DATE
gatient was to have skilled nursing and aide services. There was no frequency and duration of the visits or tasks for the staff to complete. A physician order dated 5/31/18, and completed by the administrator / director of nursing, evidenced the skilled nurse was to visit 3 hours a day, 3 days a week, for 26 weeks for wound care, medication monitoring, health monitoring, suprapubic catheter changes and care and bowel program 3 times a week by digital disimpaction. The home health aide was to visit for assistance with Alba and IADLs, supervision, meal preparation, housekeeping, laundry, grocery shopping, errands, assistance with appointments, and arranging specialized transportation. The order failed to include a duration and frequency of skilled nursing and home health aide visits specific to the 6/2/18 to 7/31/18 certification period. A review of a Home Health Certification and Plan of Care for the certification period of 6/2/18 - 7/31/18, evidenced skilled nursing orders for 3 hours a day, 3 days a week, for 26 weeks and HHA orders 6 hours a day, 7 days a week, 9 weeks. The plan of care failed to evidence the tasks that would be completed by the staff as indicated on the 5/31/18 physician's order and failed to evidence goals, rehabilitation potential, and discharge plans, and the mental status, DME (durable medical equipment) and supplies, safety measures, activities permitted, and allergies sections were all blank. This document was electronically signed by the administrator / director of nursing on 5/31/18 and electronically signed by the physician on 6/71/18. A review of home health aide visit notes dated	G 968	patient was to have a services. There was of the visits or tasks or the administrator of evidenced the skilled day, 3 days a week, or medication monitorin suprapubic catheter of program 3 times a weare the home health aid with ADLs and IADLs preparation, houseke shopping, errands, as and arranging special order failed to include skilled nursing and he specific to the 6/2/18 period. A review of a Home of the certification of the certification of the certification of the tasks that would be condicated on the 5/31 failed to evidence go and discharge plans, (durable medical equipmeasures, activities processed of the physicial or the visits of the physicial or the visits of the physicial or the visits of the vi	skilled nursing and aide no frequency and duration for the staff to complete. Ited 5/31/18, and completed director of nursing, nurse was to visit 3 hours a for 26 weeks for wound care, g, health monitoring, changes and care and bowel eek by digital disimpaction. Ite was to visit for assistance as supervision, meal reping, laundry, grocery sesistance with appointments, alized transportation. The readuration and frequency of ome health aide visits to 7/31/18 certification Health Certification and Plan cation period of 6/2/18 - killed nursing orders for 3 as week, for 26 weeks and a day, 7 days a week, 9 care failed to evidence the completed by the staff as and the mental status, DME injement) and supplies, safety permitted, and allergies nk. This document was by the administrator / na 5/31/18 and electronically an on 6/7/18.	G	968			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT 224 W JEFFERSON B SOUTH BEND, IN	BLVD STE 200	1 00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY)		
G 968	6/2, 6/3, 6/4, 6/5, 6/6 6/14, 6/15, 6/16, 6/17 6/23, 7/13, 7/18, 7/20 indicated HHAs compersonal care, hair coutput / input, inspectambulation assist and A review of skilled not visits occurred on 6/5 6/27, 6/29, 7/2, 7/6, 7 and 7/30/18, and indivital signs, dressing of coccyx area and right measurements, supragusing a 26 French / 3 A review of the "Receassessment" including of care / 485 dated 7 administrator / directed indicated the wounds A review of a Home of Care for the certification of care / 485 dated 7 administrator / directed indicated the wounds A review of a Home of Care for the certification of care / 485 dated 7 administrator / directed indicated the wounds A review of a Home of Care for the certification of care / 485 dated 7 administrator / directed indicated the wounds A review of a Home of Care for the certification of care of the certification of the certification of care of the cert	g, 6/7, 6/8, 6/9, 6/10, 6/13, 7, 6/18, 6/19, 6/21, 6/22, 0, 7/25, and 7/27/18, oleted tasks such as bathing, are, catheter care, record to the residence of the	G	968			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			1	C 16/2018
	ROVIDER OR SUPPLIER			22	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 968	area, wound measure assessments, and ca cc of normal saline. 11. A review of clinication of 6/11/18 - 8/8 skilled nurse was to smedications. This was following: Review of A skilled in by Employee B dated evidenced the nurse medications for the following ordered." During an interview of administrator / director medication set up was administrator of 7/14/18 - 91 tasks to be completed was evidenced by the A review of the Home Plan of Care for the construction of 1/14/18 evidenced to 5 hours day/ 7 days and additional tasks writte under Medications: Firrigation.	ements, suprapubic catheter theter was irrigated with 60 all record #3 with a start of incipal diagnosis of essential of care for the certification 2/18 failed to evidence the set up the patient's as evidenced by the ursing visit notes, completed 16/16, 6/23, and 6/3018, set up the patient's following week. A note on cations dispensed as n 8/16/18 at 12 noon, the for of nursing indicated the set not on the plan of care. all record #4 with a start of incipal diagnosis of in of care for the certification 1/18 failed to evidence the diby the skilled nurse. This	G	968			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER	,	1	STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 968	7/20, 7/21 (x2 visits), and 7/28/18, indicate including vital signs, neurological assessmassessment, respirat gastrointestinal assessment including assessment and irrig hours, pain assessment and irrig hours, pain assessment and cleans patted dry, with dresseducation with discus administered, bladde suprapubic and trach and new dressings peing completed and with a 26 French 10 cleans administrator / directorecord lacked a comprecord was lacking or 13. During an observation of the patient then give the patient then give the patient albuterol. The CPT approximately 9:25 A completed was a net medication albuterol.	15, 7/16, 7/17, 7/18, 7/19, 7/22 (x2 visits), 7/23, 7/27, d physical assessment nutritional assessment, nent, cardiovascular ory assessment, sement, genitourinary g suprapubic catheter ation, repositioning every 2 ent, skin assessment, trach ge with fenestrated size 4 d care on right buttock was sed with soap and water, sing applied, patient ssion, medications were r irrigated, shower given, care, trach collar changed laced, bowel program was suprapubic catheter change cc catheter was completed. In 8/16/18 at 12:05 PM, the proof of nursing indicated the collete plan of care. The reders for the care received. In a station of the home visit on continuity was observed to with an air mattress. The proof of nursing was observed to with an air mattress. The proof nursing was observed by taking vital signs and an ebulizer treatment with rest treatment was mately 9:50 AM. Also pulizer treatment with the	GS	968		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER E HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	' E	33, 13, 23 13
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
G 968	6/27/18 and principal evidenced the Comport dated 6/27/18. The coadministrator / director admission and indical was completed, the purpose suprapubic catheter, document indicated of feedings was a bolust performed by family. Site was washed with dry and the suprapubic soap and water, rinse Review of the plan of period of 6/27/18 - 8/2 nurse was to visit 60 care failed to contain such a as safety mean nutritional requirement potential / discharge to include size of supcare, gastric tube cartasks to be provided evidenced by the follow. A review of an Adult If Sheet dated 7/2,7/9, the administrator/ direphysical assessment patient receives noth assessment, cardiovarespiratory assessment.	cord #9 with a start of care diagnosis of Quadriplegia, rehensive Adult Assessment locument indicated the or of nursing conducted the ted a physical assessment latient had colostomy, and a feeding tube. The orders for the enteral 240 CC every 4 hours to be The document indicated the soap and water and patted ic catheter was washed with ed well, patted dry. care for the certification 25/18, evidenced the skilled hours a month. The plan of all the required elements sures, DME and supplies, hts, and goals/ rehabilitation plans box were blank, failed rapubic catheter, colostomy e and failed to evidence the by skilled nursing. This was owing: Extended Hour Nursing Flow 7/30, and 8/6/18, evidenced ector of nursing conducted a nutritional assessment (the ing by mouth); neurological ascular assessment, ent with a note: rest treatment completed,	G	968		
	colostomy); genito - ι	rinary assessment with site cleansed with warm				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			1	C 16/2018
	ROVIDER OR SUPPLIER		,	22	TREET ADDRESS, CITY, STATE, ZIP CODE 24 W JEFFERSON BLVD STE 200 OUTH BEND, IN 46601	, 50.	10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 968	soapy H20; reposition assessment; skin assessment; skin assessment; skin assessment; skin assessment; skin assessment applied to supurine; full and passive on upper and lower each administrator of director physical assessment, patient receives nothing assessment, cardiovarespiratory assessment humidification, CPT v. Gastrointestinal assessolostomy); genito - usuprapubic catheter assoapy H20; reposition assessment; skin assechanged and inner cathumidification removes Shiley, uncuffed trach straps; Pacimuir valve speaking; CPT vest printervals at 14 pressurupper and lower extrements.	every 2 hours; pain essment; trach ties innula changed; oral and impleted; intake recorded; orapubic catheter draining erange of motion completed atremities; bed bath given; extended Hour Nursing Flow and completed by the interest of nursing, indicated a nutritional assessment (the ing by mouth); neurological inscular assessment, int with note concerning est X 1/2 hour; issment (patient has a rinary assessment with ite cleansed with warm in every 2 hours; pain essment; Trach ties innula changed; end from tracheotomy #6 in place to aid with laced on for 15 minute in e. Range of motion on	G	968			
G1008	administrator / director plan of care was not of		G10	800			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING		C 09/46/2049	
	ROVIDER OR SUPPLIER E HEALTH CARE INC	151070		STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	08/16/2018	
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
G1008	patient accepted by the health services. Informal clinical record must be current clinical record of practice, and be avissuing orders for the and appropriate HHA be maintained electron. This CONDITION is Based on record revifailed to ensure the grand based on the confindings (see G1016; Registered Nurse confindings (see G1022); and failed to ensure clinical failed to ensure clin	ain a clinical record urrent information for every ne HHA and receiving home mation contained in the e accurate, adhere to documentation standards railable to the physician(s) home health plan of care, staff. This information may nically. not met as evidenced by: ew, the home health agency coals were patient specific inprehensive assessment failed to ensure the	G100	08		
G1016	The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation: 484: 110 Condition: Clinical Records. 6 Goals in the patient's plans of care CFR(s): 484.110(a)(3) Goals in the patient's plans of care and the patient's progress toward achieving them; This ELEMENT is not met as evidenced by: Based on record review, the home health agency failed to ensure the goals were patient specific		G10 ⁻	16		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	'	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G1016	Continued From page	Continued From page 186		116		
		mprehensive assessment ve clinical records reviewed				
	The findings include:					
	Assessment" dated 7 will be developed from assessment plan with family, and physician 2. The agency policy	titled "Comprehensive 7/11/18 stated, "Plan of care in the comprehensive in information from client, ." titled "2.8 Care Plan" dated fermine of the nature of the				
	home care services r	needed. To determine this s to be achieved, what				
	for patient #2, start or document titled "Hom Plan of Care" with a pressure ulcer of sac certification period of by administrator / dire The physician signed This document had a Rehabilitation potenti was blank. The asses comprehensive asse	riew on 8/13/18 and 8/16/18 If care 12/4/17, evidenced a ne Health Certification and primary diagnosis of ral region stage 2, for the 16/2/18 - 7/31/18, and signed ector of nursing on 5/31/18. If this document on 6/7/18. In area subtitled "Goals / Ital / discharge plans that essment below evidenced essment findings that did not f goals on the plan of care.				
	of care / 485 informa Integumentary Status Stage II sacrum / coo turgor poor. Measure	ertification Follow up g OASIS elements with plan tion evidenced the following: s evidenced the patient had a ccyx pressure ulcer, skin ements of the pressure ulcer eters, width 5 centimeters,				

<u> </u>	C . C	MEDIO/ ND OLIVIOLO				<u> </u>	7. 0000 000 I
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 50.25	_		، ا	c
		15K070	B. WING				16/2018
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	10.2010
				2	24 W JEFFERSON BLVD STE 200		
IMG HOM	IE HEALTH CARE INC			s	SOUTH BEND, IN 46601		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
G1016	Continued From page	e 187	G1	016			
	and depth 4.5 centim	eters. This assessment					
	evidenced the patient	t had chronic pain issues					
	with above knee amp	outation sites that were					
	presently at a "3" leve	el (0 -10), with aching,					
	throbbing and with the	e back with present level "2"					
	and worst pain gets a	at a "9". This pain was					
	shooting, aching. The	e patient had a chronic					
		scribed as a smoker's cough					
	and COPD (chronic o	bstructive pulmonary					
	disease) due to smok	king. Patient last smoked					
	5/31/18. Elimination status evidenced the patient						
		r due to neurogenic bladder					
		w the waist level. The					
		ed as a Suprapubic catheter					
		cubic centimeter milliliter)					
		rine with sediment. The					
		s one to three times weekly					
		nce and removal of feces					
	_	n and digital removal of					
		nt stated, "Laxative reglan,					
		ncontinence products Mental status awake and					
	· ·	Needs prompting when					
		r in the situation. Paranoid					
		tes trusts no one to set up					
	medications but [him	•					
		videnced by trying to do self					
		without assistance Neuro					
	Spasms: abdomer						
		sist with transfers, ADLs					
		ng], IADLs [instrumental					
		g]; needs assistance with					
	· ·	ecialized transportation.					
		us: bilateral amputations					
		atient is wheel chair bound,					
	needs assistance for	transfers from bed to chair,					
	uses regular w / c [wh	neelchair] in apartment and					
	-	ut in the community with					
		ifety Fall Risk assessment					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 224 W JEFFERSON BLVD STE SOUTH BEND, IN 46601		33.13.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
G1016	the patient able to co Yes was checked. T about the patient's re towards their person measurable goals. SN (skilled nurse) ga genitourinary goals: symptoms) of UTI (u Integumentary Goals and safe effective we education / understa 3. Clinical record rev #9, start of care 6/27 titled "Home Health of Care" with a primary 5 - C-7, for the certifit 8/25/18, and signed nursing on 6/28/18. document on 7/11/18 area subtitled "Goals discharge plans that below evidenced cor findings that did not on the plan of care: A review of the "Com Assessment includin elements with plan of dated 6/27/18 and si director of nursing and date evidenced the for Cardiac pacemaker in with history of adult in syndrome. Intermitti updrafts; Enteral fee Gastrostomy, bolus,	sk for falls Psychosocial Is immunicate their needs?" he sections were blank eport about their progress al goals and the HHA Potential goals were listed as astrointestinal goals, SN will be free of S / S (signs / rinary tract infection) SN including healing of wounds bund care teaching / nding of patient. View on 8/16/18 for patient //18, evidenced a document Certification and Plan of diagnosis of quadriplegia C - cation period of 6/2718 - by administrator / director of The physician signed this B. This document had an a / Rehabilitation potential / it was blank. The assessment ead to the addition of goals apprehensive Adult g SOC / ROC OASIS for care / 485 information gned by administrator / nd patient caregiver on this following: Cardiopulmonary: in left chest. Tracheostomy	G10	016		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· ,	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 224 W JEFFERSON BLVD STE SOUTH BEND, IN 46601	E, ZIP CODE	0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
G1016	with soap and water incontinence: supra to urinary incontiner Type 26 French / 10 changed 6/7/18, discolostomy and supra soap and water, rins emotional / behavior spasticity, history of 12/6/16 - needs full daily living, all IADLs Quadriplegia , fractugrips weak; How do affect their functiona assistance with all a ADLs and IADLs? gastrostomy feeding "Potential Goals: SI Maintain current hea 6/27/18; SN Respira caregiver] will demo technique proper demonstrate tracl 6/27/18, SN Cardiov state understanding manage disease and Gastrointestinal goawill remain intact wite effective: 6/27/18, pfeedings without cordate 6/27/18."	pubic catheter placement due ce and past skin issues CC balloon date last ease management problems: apubic catheter - wash with ee well, pat dry; neuro/ ral status, quadriplegia with a traumatic brain injury date eassistance with all activities of s; Musculoskeletal: are C 5 neck fracture, hand es the patient's condition all activity and safety? Needs ctivities. Full assistance with fransfers, toileting, ss. The document stated, N Patient Centered Goal: alth status start effective date: attory Goals: Pt / Pcg [patient instrate proper suction use of respiratory treatments in care start effective date asscular goals: Pt / PCG will of measures to manage to didentify S / S to report; SN ls: Enteral feeding tube site hout S / S infection. Start att. will be able to tolerate inplications. Start effective	G10	016			
G1022	the primary care pra		G10	022			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(
		15K070	B. WING			08/	16/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TMG HON	IE HEALTH CARE INC			2	24 W JEFFERSON BLVD STE 200		
TWG HON	IE HEALTH CARE INC			S	OUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G1022	the patient's discharg (ii) A completed trans- within 2 business day the patient's care will a health care facility; (iii) A completed trans- within 2 business day unplanned transfer, if care in a health care if HHA becomes aware This ELEMENT is no Based on record reviagency failed to ensu completed a discharg discharge summary w meeting the care plan records reviewed (#8) The findings include: The policy titled "2.17 dated 2015 stated, "T process for the ongoin patient's continuing can needs at the visit b patient and the physic discharge all patier instructions regarding prior to discharge the physician shall be not summary which shall of discharge will be m physician with a copy The discharge summar reason for discharge and psychosocial stat C. A summary of the	within 5 business days of e; or fer summary that is sent s of a planned transfer, if be immediately continued in or sfer summary that is sent s of becoming aware of an the patient is still receiving facility at the time when the of the transfer. It met as evidenced by: we wand interview, the re the Registered Nurse e assessment and with the patient's progress in a goals for 1 of 3 closed by: If Discharge / Transfer Policy he agency will maintain a ng assessment of each are and discharge planning efore this discharge, the cian will be notified of the nts will receive discharge his / her ongoing care patient, the attending tified. A written discharge be prepared within 30 days	G1	022			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	'	567 167 2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G1022	A review of clinical re 4/25/16, for the certifical 10/16/17, diagnosis of complicating pregnar discharge assessment had been completed requested by the age refusal to sign staff viplans on the plan of of the patient was to providenced by the follow. A review of the record Comprehensive Adult This note evidenced Employee H, RN, and discharge plans, Employee H, RN, and discharge	cord #8, start of care ication period of 8/18/17 - of physical abuse and and discharge summary after a discharge was ancy due to the caregiver's isit notes. The discharge care did not evidence goals are did not evidence goals are start was completed by disgned on this date. Under cloyee H checked box when services are no longer ovided by another source." The alth certification and plantation period of 8/18/17 - ander the goals / rehabilitation plans this statement, "When are needed or can be provided There were no other goals devidenced home health //18/17, 8/25/17, 8/26/17, 0/17, 8/31/17, 9/11/17, 9/2/17, 1/17, 9/8/17, 9/9/17, 9/18/17, 1/17, 9/2/17. A supervisory	G102	22		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED C			
		15K070	B. WING)8/16/2018		
	NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
G1022	A review of the recovisit with no tasks conote was signed by Aide. A note on this signature stated, "Pi [illegible words after signed by Employed During record review about the discharge 9/28/17 from Emplo "Please complete not that note to discharge review occurred 8/1." During an interview owner of the agency representative for pavisit notes. The patiof the records that his sign without receiving grabbing aides in apstated, "[Patient #8] aides." The owner administrator and to the patient representative] we wishe would not sign the the agency refused complaining to the and the agency disconfered in the representation of the patient representation of the	or devidenced a home health completed on 10/2/17. The Employee K, Home Health is note under patient's ower of attorney verbalized this.]" This was electronically is K on 10/19/17. In the only communication in the notes was dated yee L, RN, which stated, on 8/14/17. Need to use ge patient as of 9/23/17." This 4/18 - 8/16/18. In the notes was dated yee L, RN, which stated, on 8/14/18 at 3:20 PM, the representative wanted all the state of the patient was groppiately. The patient was propriately. The owner was abusive and would grab er indicated talking to the past ld the past administrator that the transport of the patient would not service [him / her] if	G102	22				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _			C 08/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	<u> </u>	00/10/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
G1022	called in sick. A new was assigned after th representative recalled and administrator due and the smell of the sign of the smell of the	aide, Employee K, HHA, e complaint. The patient of complaining to the owner of to Employee K's smoking moke in the home. In 8/15/18 at 10:18 AM, lanager for patient #8, erns with the agency. She complaint filed and the mer of the agency were not. This pertained to the low the agency. In the agency were not the agency were not. This pertained to the low the agency. In the agency. In the agency were not the low the low the agency. In the agency were not the low t	G10	022			
G1024	administrator / director patient went to a groudirector of nursing included and summary were not Authentication CFR(s): 484.110(b) Standard: Authentication	n 8/14/18 at 3:45 PM, the or of nursing indicated the up home. The administrator/licated the discharge oasis of found in the record.	G10	024			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		15K070	B. WING _			C 8/16/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	•	0/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
G1024	Authentication must i (occupation), or a sec unique identifier, of a reviewed and approv This STANDARD is a Based on record revagency failed to ensucompleted and signerendered for 7 of 9 rea timely manner. The findings include: 1. A review of a polic "Policy for Charting CHHA, ATTC" stated, 'charting by nursing paides. Charting must computer and turned be checked by billing accuracy, misspelling appropriate actions whack to the staff memappropriate. This was administrator / directors. 2. A review of a polic "Entering Late Charting is to provide information on clients to provide document to provider. Special insidocument current data narrative area - [late of the control	cicated, dated, and timed. Include a signature and a title cured computer entry by a primary author who has ed the entry. Inot met as evidenced by: It is and interview, the are clinical records were decords reviewed (#1 - #7) in The sy dated 8/16/18 and titled corrections for Nursing, Daily observations of the ersonnel and home health are completed on the in. When submitted it will and skilled nurse for a sy, accurate wording and will be monitored and sent obsers for corrections if a signed by the or of nursing on 8/16/18. The sy dated 7/12/18 and titled and revised 7/12/18 stated, growth be completed ted. Purpose: entering late accurate and up to date accurate and up to date accurate and enter in the state, and enter in	G10	24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING			C 08/16/2018	
	NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP COD 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		3.10,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
G1024	Health Aides are to d provided on the visit concurrence with card documentation of car the home health aide documentation of the observations during to client's progress or documentation of the observations during to client's progress or documentation of the observations during the observations during the supervising nurse not limited to a). Incressin, foul smelling uring the original documentant diled in the chart. 4. A review of a policy Clinical Record Visits initial assessments of the complete and filed with their time sheets completed and filed with their time sheets completed and filed with the complete of skilled nurse following: A review of skilled nurse following: A review of skilled nurse following: A review of skilled nurse following: During an interview of the completion date of 8/	ntation" stated, "Home ocument care / services record and be in e plan. Purpose 1. Provides e / services provided during visit. 2. Provides home health aide's he visits and evidence of emise. Special instruction: aide is responsible for is in the client's condition to e, such as the following but eased pain, reddened area to ene, falls, fatigue, edema. 2. Intation is to be completed within 14 days of the visit." By titled "2.10 Submission of "dated 2015 stated, "All enust be submitted within 48 sits must be submitted within 48 sits must be filed in the 14 days of the visit. Home is the submitted once weekly is all discharges must be within 30 days of discharge." I record #1 evidenced and a not completed by the or of nursing evidenced a	G102	2.4			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K070	B. WING _				C / 16/2018	
	ROVIDER OR SUPPLIER			224 W	T ADDRESS, CITY, STATE, ZIP CODE JEFFERSON BLVD STE 200 TH BEND, IN 46601	1 00/	10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
G1024	record. She also indidown that day. 6. A review of clinical notes not completed was further evidence. A review of a Compressive Assessment including (resumption of care) 485 Information evide 12/4/17 and a visit dat 12/26/17. The admin electronically signed and 12/29/17. Also semployee F, billing e A review of AM HHA with a date of 6/6/200 and Employee E, HH A review of HHA visit was signed by patien 6/18/18. A review of HHA visit and signed by patien 6/18/18. A review of AM HHA visit and signed by patien 6/18/18. A review of AM HHA visit and signed by patien 6/18/18. A review of AM HHA visit and signed by patien 6/18/18.	I record #2 evidenced visit in a timely manner. This d by the following: The ensive Adult Nursing g SOC (start of care)/ ROC OASIS elements with CMS enced a start of care date of the on this document of distrator / director of nursing this document on 12/28/17 digning this document was mployee on 1/10/18. (home health aide) visit note 17, was signed by patient #2	G10	024				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING				C 16/2018
	ROVIDER OR SUPPLIER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 124 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G1024	E on 8/13/18. A review of a skilled rof 6/29/18, and complicensed Practical Nunote was not completemployee. A review of a skilled rof 7/13/18, evidenced thrompleted until 8/7/18 by the administrator / A review of a skilled rof 7/18/18, and completed the note wordenced in the supervision, with a review of skilled nuthe supervision, with a completed by the administration of the supervision, with a completed by the administration of the supervision, with a completed by the administration of the supervision, with a completed by the administration of the supervision, with a completed by the administration of the supervision, with a completed by the administration of the supervision, with a completed by the administration of the supervision, with a completed by the administration of the supervision, with a completed by the administration of the supervision of	nursing visit note with a date leted by Employee B, urse (LPN), evidenced the red until 7/10/18 by this nurse supervisory visit dated his supervisory visit was not 8. This form was completed director of nursing. nursing visit note with a date leted by Employee B, ras not completed until	G1	024			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
15K070		B. WING _			C 08/16/2018	
NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC				DE .	00/10/2010	
PREFIX (EACH DEFICIENCY M	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
of visit of 11/16/17 and sevidenced this document administrator / director of the vision of an adult extended and a signed on 8/7/18. A review of an adult extended and a signed on 8/7/18. A review of an adult extended and a signed this document are signed on 8/9/18. 9. A review of clinical retimely documentation. To following: A review of a skilled nument and a signed until 8/7/18. By the administrator / director of the neighborhood."	titled "Comprehensive h included SOC / ROC MS 485 Information, date start date of 11/16/17, at was signed by the of nursing on 11/28/17. The ended hour nursing flow dompleted by Employee ment on 8/8/18 and the coord #5 failed to evidence was evidenced by the se supervisory visit dated supervisory visit was not This form was completed rector of nursing. This form was completed rector of nursing.	G10	024			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K070	B. WING_			C 08/16/2018
	NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP 224 W JEFFERSON BLVD STE 200 SOUTH BEND, IN 46601	CODE	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G1024	11. A review of clinica 2/23/18, failed to evid This was evidenced but A review of a Compression with a visit date of 2/2 administrator / director 12. During an intervience administrator / director home health aides an	al record #7, start of care ence timely documentation.	G10	024		