STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/11/2018	
	PROVIDER OR SUPPLIER			1135 BI	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET		
KIGHT A	T HOME, INC			ANDER	RSON, IN 46012		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG G 0000	REGULATORY OF	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENC!)		DATE
Bldg. 00	This was a state survey.	and federal initial licensure	G 0	000			
	Facility #: 0142	55					
	Survey Dates: J	anuary 4, 5, 8, 9; 2018					
	Skilled unduplicated census for provisional license period = 11 patients						
		record review = 4 vithout home visits = 7					
G 0102 Bldg. 00	written notice of the advance of furnish	ovide the patient with a ne patient's rights in ning care to the patient or valuation visit before the		100			
			G 0	102	o:p>		01/17/2018
		review, interview, and			/span>		
	policy review the	e agency failed to obtain			o:p>		
	proper consent f	or treatment before the			1. On <b>1-15-18</b> , clarification	1	
	initiation of care	for 1 out of 11 records			order was written and faxed to patient #8's physician (copy	)	

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

TITLE

(X6) DATE

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	ETED
			B. WI	NG		01/11	/2018
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			ROADWAY STREET		
RIGHT A	T HOME, INC		ANDERSON, IN 46012				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPRO		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG			DATE
	reviewed (# 8).				included).  2. On <b>1-16-18</b> the clarificat	tion	
					order was signed by patient #8		
	Findings include	e:			physician.	55	
					3. On <b>1-17-18</b> , patient #8 v	was	
	1. The clinical record of patient #8 was				notified of the clerical error, a		
		/18 and indicated a start of			home visit was made and pati	ent	
		2/17. The record contained			#8 was given a copy of the sig	ıned	
					physician clarification order.		
	*	ated 11/21/17-1/19/18.			Patient #8 verbalized		
The record failed to evidence signed				understanding that the conser	nt		
consents prior to the initiation of care.			was reviewed and signed on 9-22-17 along with the				
					comprehensive assessment.		
	A. The age	ncy document titled			Patient #8 co-signed physiciar	า	
	"Comprehensive	<del>.</del>		order, retained a copy, and original			
	•	as completed and dated			was place on patient #8's chart.		
	9/22/17.	us completed and dated					
	9/22/17.						
					The Agency will prevent the deficiency from recurring by:		
		ncy consent document titled			deficiency from recurring by.		
	" Emergency Pla	an," was completed and					
	dated 9/23/17.						
					The Administrator, Director of		
	C. The age	ncy consent document titled			Nursing, Quality Improvement		
	_	e, Inc.," stated " Home care			Coordinator or designee will	mit	
	_	een initiated on 9/23/17."			complete 100% audit of all add		
		was signed by the patient			These audits will be completed within 48 hours of submission		
					admission documents. The	OI .	
	and employee B	on 9/23/1/.			documentation audit is to ensu	ure	
					dates of admission and conse		
	D. The age	ncy consents document titled			which includes the patients' rig	ghts	
	" Admission Ser	rvice Agreement Home			correlate and date errors do n		
	Health," was ini	tialed and signed by the			recur. Audits will be ongoing t	to	
	patient and that employee B on 9/23/17.				ensure compliance and		
	1	1 -3			consistency of all medical	will	
	E During o	in interview on 1/5/18 at			records. All registered nurses be oriented upon hire regarding		
	т туптини и				, SS SHOHIGA APOH HILL ICABIAN		•

PRINTED: 02/06/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 01/11/2018			
	ROVIDER OR SUPPLIER T HOME, INC		STREET ADDRESS, CITY, STATE, ZIP COD  1135 BROADWAY STREET  ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	2:15 PM, the assistant director of nursing stated that the start of care date is the date that consents are signed.		assessment date and consent date correlating.		t		
				The Administrator, Director or Nursing, Quality Improvement Coordinator or designee are responsible for correcting the deficiency and preventing it from recurring.			
				The deficiency will be corrected by (date):			
G 0121	484.12(c)			1-17-18			
Bldg. 00	COMPLIANCE W/PROFESSIONAL The HHA and its saccepted profession	STD staff must comply with conal standards and sly to professionals					
	Based on record interview the age	review, observation, and ency failed to ensure that owed infection control	G 0121	o:p=""> G121: What is the agency's p to ensure that this deficiency onto occur with the entire clinic staff?	will		
	policies for 1 of Findings include	4 home visits (#4).		The agency has corrected the deficiency: On 1.11.18, All clinical staff completed in-services consist			
	-	ecord of patient #4 was		of Hand Hygiene and Infection Control videos, as well as, in service tests. The Director of	ו		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<sup>3</sup> <u>00</u>		COMPLETED	
			B. WING			01/11/2018	8
NAME OF F	PROVIDER OR SUPPLIER				CITY, STATE, ZIP COD		
					AY STREET		
KIGHT A	T HOME, INC		ANI	DERSON, IN	1 400 12		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	P	ROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-	I CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)		MPLETION DATE
TAG			IAG	Nursin	g educated all clinical s		DATE
	reviewed on 1/4/18 and indicated a start of				cy 5010-Standard	iuii	
care date of 11/2/17. The record contained				itions, Policy 5011 Han	d		
a plan of care dated 11/2/17-12/31/17.				e and N131 Glove			
					que. All staff was		
		observation on 1/9/18 at			tency checked on Hand		
	_	oyee D, HHA (Home			ne and Glove Technique of all clinical staff passe		
	Health Aide) wa	s observed providing			ice tests and proper ha		
	personal care. T	The HHA assisted the			e and glove technique.		
	patient in the sho	ower. With gloved hands,		_	ency will prevent the		
	the HHA rubbed	l soap all over the			ency from recurring by		
	washcloth with h	nands. The HHA then			nire and annually, all cli	nical	
	washed the patie	ent's back. While patient			ill complete in-services ting of Hand Hygiene,		
	_	wer alone, the HHA stood			ard Precautions, and Gl	ove	
		ower. HHA then dried		Techni	que. All clinical staff wi	ll be	
		d assisted with applying			tency checked upon hir		
	_	assisted with applying brief		1	evaluation, annually ar	nd as	
		ent to room using rollator		needed	u. 0.18 and Ongoing: All		
		IA failed to remove gloves,			staff will be educated of	n	
		•			Hygiene, Standard		
	^	ygiene, and apply new			itions, Glove Technique		
	gloves in betwee	en paulent tasks.			sage, and Infection Cor	ntrol	
	<b>.</b>	1.0 4.777			s with videos, return estration, upon hire, at 9	o	
		d of care the HHA cleaned			aluation, annually and a		
		eked up dirty linen and		needed			
		The HHA failed to			dministrator and Directo	r of	
	complete hand h	ygiene after care was			g are responsible for		
	completed and g	loves were removed.			ng that this deficiency oot recur.		
					eficiency was corrected	,	
	2. During an int	erview on 1/9/18 at 2:22		by 1.11			
	PM, the director	of nursing stated that glove					
		occur anytime gloves are					
	soiled or in betw	_					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		01/11/	2018
NAME OF A			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	(		1135 BF	ROADWAY STREET		
RIGHT A	T HOME, INC		ANDERSON, IN 46012				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCIT		DATE
	1	terview on 1/9/18 at 2:21					
	PM, the director of nursing stated that hand						
	1	be completed before care,					
	during care, anytime gloves are changed,						
	when gloves are soiled and after care.						
	4. The agency p	policy dated 7/24/17, titled					
	"STANDARD PRECAUTION," Reference						
	#5010 stated "POLICY: Standard						
	Precautions are designed for care of all						
	patients in facilities, regardless of diagnosis						
	or presumed infe	ection status, to reduce the					
	_	sion from both recognized					
		ed sources of infection					
	_	tions include: Gloves: To					
		ouching blood, body fluids,					
		etions, mucous membranes,					
	•	and other contaminated					
		ment. Gloves do NOT take					
	_	d hygiene. Hands are to be					
		noving gloves. Gloves					
	ı	ed between tasks and					
		ne same patient after contact					
	with material that	at may contain a high					
	concentration of	microorganisms."					
	5. The agency p	policy dated 7/24/17, titled					
	"HAND HYGIE	ENE - CDC [Centers for					
	Disease Control	] GUIDELINES,"					
	·	1 stated "Purpose: To					
		es for effective hand					
	1 ^	r to prevent the transmission					
	inglicine, in orde	to prevent the transmission					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 01/11/2018	
	PROVIDER OR SUPPLIER T HOME, INC		STREET ADDRESS, CITY, STATE, ZIP COD 1135 BROADWAY STREET ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
G 0225	CDC has recommend to use non-antime and antimicrobia alcohol-based has contact with patient a patient's blood lifting/moving the	-					
G 0225 Bldg. 00	HEALTH AIDE The home health are ordered by the	DUTIES OF HOME aide provides services that e physician in the plan of aide is permitted to perform					
	interview the age home health aide on the aide care reviewed (#4).  Findings include  1. The clinical reviewed on 1/4, care date of 11/2 a plan of care date.  A. The agen	review, observation, and ency failed to ensure that the e (HHA) followed the tasks plan for 1 of 11 records  ecord of patient #4 was /18 and indicated a start of /17. The record contained ted 11/2/17-12/31/17.  here document titled " Aide eated " shower every visit	G 0	225	o:p> /span>  On 1-10-18, the Director of Nursing in-serviced the home health aide, Employee D, on following the patient's care pla documenting each completed and reviewed patient's care pla with home health aide, Employe D. The home health aide, Employee D, was instructed on how to complete the visit note sample visit note was provided the home health aide, Employe D. The home health aide, Employee D, was instructed to document if the patient refuses have task performed, the home	task an yee n . A d to ee o s to	01/11/2018

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  01/11/2018			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1135 BROADWAY STREET ANDERSON, IN 46012				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	BE COMPLETION		
TAG	B. During of 10:30 AM employ observed provided HHA assisted the patient removed washed the patient finished the bath outside of the sh failed to complete washing the back shampoo or check that failed to as could be completed every tasks on the aided completed every the country of the country of the complete tasks on the aided completed every the country of the cou	n interview on 1/9/18 at 2: tor of nursing stated that all care plan should be visit ( if they are marked to	TAG	health aide, Employee D, n document the patient's refunctify case manager.  On 1-11-18, the Director of Nursing made visit with the health aide, Employee D, to patient's home to observe the performing and documenting tasks on the patient's care. The home health aide, Employee The home health aide's, Employee The home health aide's, Employeist note to ensure all tasks offered then completed or documented as refused. The home health aide's, Employeist note was compliant actor patient #4's care plan. The Agency will prevent the deficiency from recurring by:	shome to the the aide ng all plan. ployee sks on e ed the yee D, s were the yee D, scording		
	be completed every visit) unless the patient refuses.			Administrator, Director of Nor designee will perform a ongoing audits on all home aides visit notes and will ed	100% health		
	PM, the director	of nursing stated that it condition of the patient to ompleted.		home health aides upon his with every new patient on f the patient's care plan and documenting all tasks on the patient's care plan. If the v	re and following ne risit		
	2. The undated a "HOME HEALT DESCRIPTION			note does not match the caplan, the RN Case Manage complete a joint visit with the home health aide and the p	er will ne		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/11/2018			
	ROVIDER OR SUPPLIER T HOME, INC		STREET ADDRESS, CITY, STATE, ZIP COD 1135 BROADWAY STREET ANDERSON, IN 46012				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	personal care act assignment by the 3. The agency purple "PLAN OF CAR stated "All Clinic implemented on the state of the s	2/4 stated "Performs tivities contained in a written he Nursing Supervisor."  colicy dated 7/24/17, titled RE," Reference #10004 cal services shall be ly in accordance with a planed by a physician's written			to review the patient's care platarevised care plan is necessathe Case Manager will update educate the home health aide patient.  Upon review of the care plan ano revision is needed, the home health aide will be in-serviced proper completion of the visit mand proper documentation of the visit note.  The Administrator, Director of Nursing or designee are responsible for correcting the deficiency and preventing it from recurring.  The deficiency will be corrected by (date):	ry, and and ind ie on iote	
G 0236 Bldg. 00	and current finding accepted profession maintained for even health services. In care, the record co- identifying informated drug, dietary, treat signed and dated copies of summar	ontaining pertinent past gs in accordance with	G 02	236	o:p=""> ="" span="">G236 Initial		01/18/2018

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  01/11/2018			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1135 BROADWAY STREET ANDERSON, IN 46012				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	Based on record	review and interview the		assessment documentation	ı		
	agency failed to ensure that an initial			needs to be clarified:			
	" "	was documented for 11 of		How will the agency ensure t			
	11 records revie			is documentation that the init			
				assessments were completed same day/same visit as the	a the		
	(#1,2,3,4,5,6,7,8	,9,10,11).		comprehensive assessments			
				versus only indicating on the			
	Findings include	e:		referral sheet?			
The clinical record of patient #1 was				The agency has corrected the	he		
				deficiency by:			
reviewed on 1/5/18 and indicated a start of			This deficiency was corrected	d on			
care date of 9/25/17. The record contained			2.2.18. Page 2 of the referra				
				includes the initial assessmen			
	a plan of care dated 11/24/17-1/22/18.			visit note. This form was revi			
		d to evidence an initial		to reflect that page 2 is the in assessment visit note. The			
	assessment was	documented.		performs the initial assessme			
				visit, signs and dates when the			
	A. The age	ncy document titled		initial assessment visit note has			
	"Comprehensive	e Adult Nursing		been completed on page 2. The			
	•	ted 9/25/17 was the only		RN then completes the			
	· ·	pleted upon start of care.		comprehensive assessment which			
		pieted upon start of eare.		includes a signature and date.			
	2 771 1: : 1	1 6 6 49		The RN will also document o			
		record of patient #2 was		page 24 of the comprehensive assessment that "The Initial	' <del>C</del>		
		/18 and indicated a start of		Assessment was performed of	on		
	care date of 10/1	6/17. The record		(date) and (time). Please see			
	contained a plan	of care dated		attachment.			
	12/16/17-2/12/1	8. The record failed to		The agency will prevent the			
	evidence an initi	al assessment was		deficiency from recurring by			
	documented.			All RN staff will be in-serviced	· ·		
	documentou.			2.5.18 and all new RN's will be			
	A 701			in-serviced upon hire regarding	ng me		
	_	ncy document titled		initial assessment visit to be completed the same day as t	he		
	"Comprehensive			comprehensive assessment.			
	Assessment," da	ted 10/16/17 was the only		Also, all RN's will be in-servi	ced		
assessment completed upon start of care.			on documentation of the initia				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY	7
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
			B. W	ING		01/11/2018	
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
		<b>L</b>			ROADWAY STREET		
RIGHT A	T HOME, INC			ANDERSON, IN 46012			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(	(X5)
PREFIX	`	CH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMP	LETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	assessment visit date/time on	DA	ATE
		1 0 1 1 1 10			page 24 of the comprehensive		
	3. The clinical record of patient #3 was				assessment visit.		
		/18 and indicated a start of			Effective 2.5.18 and ongoing,	he	
	care date of 10/3	31/17. The record			DON/ADON/QI Coordinator or		
	contained a plan	of care dated			designee will complete 100%		
	10/31/17-12/29/	17. The record failed to			ongoing audits on all admits to		
	evidence an initi	al assessment was			verify that the initial assessme and the comprehensive	IL	
	documented.				assessments were completed	on	
					the same day/same visit.		
A. The agency document titled					The administrator, Director of		
"Comprehensive Adult Nursing				Nursing, Assistant Director of			
	Assessment," dated 10/31/17 was the only				Nursing/Quality Improvement		
	•	•			Coordinator or designee are responsible for correcting the		
	assessment com	pleted upon start of care.			deficiency and preventing it	-	
	4 751 1: : 1	1 6			from recurring and will ensure	,	
		record of patient #4 was			the agency's ongoing compliance		
		/18 and indicated a start of			with performance and		
		2/17. The record contained	documentation of the initial				
	_	ted 11/2/17-12/31/17.			assessment visits and the comprehensive assessment vi	site	
	The record failed	d to evidence an initial			on the same day/visit.	3113	
	assessment was	documented.			The deficiency will be		
					corrected by 2.2.18		
	A. The age	ncy document titled					
	"Comprehensive	e Adult Nursing			="" span="">		
	•	ted 11/2/17 was the only			– span– /		
		pleted upon start of care.					
	5. The clinical r	record of patient #5 was					
		/18 and indicated a start of					
		0/17. The record contained					
		ted 11/18/17-1/6/18. The					
	_						
		evidence an initial					
	assessment was	documented.					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	
			B. W	ING		01/11/	2018
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	DDRESS, CITY, STATE, ZIP COD		
					ROADWAY STREET		
RIGHT A	T HOME, INC			ANDER	SON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEPICIENCY)		TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	A The						
	_	ncy document titled					
	"Comprehensive	•					
	· ·	ted 9/19/17 was the only					
	assessment comp	oleted upon start of care.					
	( m)	1 0 2 2 2 2					
		ecord of patient #6 was					
		18 and indicated a start of					
	care date of 10/6/17. The record contained						
a plan of care dated 12/5/17-2/2/18. The							
	record failed to evidence an initial						
	assessment was	documented.					
	A. The ager	ncy document titled					
	"Comprehensive	Adult Nursing					
	Assessment," da	ted 10/6/17 was the only					
	assessment comp	pleted upon start of care.					
	7. The clinical r	ecord of patient #4 was					
	reviewed on 1/5/	18 and indicated a start of					
	care date of 9/22	/17. The record contained					
	a plan of care da	ted 11/21/17-1/19/18.					
	^	d to evidence an initial					
	assessment was						
	A. The ager	ncy document titled					
	"Comprehensive						
	^	ted 9/22/17 was the only					
	· ·	pleted upon start of care.					
	assessment comp	sieted apoir suit of oure.					
	8 The clinical r	ecord of patient #8 was					
		18 and indicated a start of					
	reviewed on 1/5/	10 and mulcated a start of					

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Event ID:

G1YO11 Facility ID: 014255

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NAME OF PROVIDER OR SUPPLIER  RIGHT AT HOME, INC  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL AGE of 9/22/17. The record contained a plan of care dated 11/21/17-1/19/18. The record failed to evidence an initial assessment was documented.  A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care.  9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained a plan of care dated 9/25/17. The record contained a plan of care dated 9/25/17. The record contained a plan of care dated 9/25/17. The record contained a plan of care dated 9/25/17. The record contained a plan of care dated 9/25/17-11/23/17.	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  01/11/2018				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  care date of 9/22/17. The record contained a plan of care dated 11/21/17-1/19/18. The record failed to evidence an initial assessment was documented.  A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care.  9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained				1135 BROADWAY STREET					
care date of 9/22/17. The record contained a plan of care dated 11/21/17-1/19/18. The record failed to evidence an initial assessment was documented.  A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care.  9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained					(EACH CORRECTIVE ACTION SHOUL)	D BE COMPLETION			
a plan of care dated 11/21/17-1/19/18.  The record failed to evidence an initial assessment was documented.  A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care.  9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained	TAG			TAG	DEFICIENCY)	DATE			
The record failed to evidence an initial assessment was documented.  A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care.  9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained									
A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care.  9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained		_							
A. The agency document titled "Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care.  9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained									
"Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care.  9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained		assessment was	documented.						
"Comprehensive Adult Nursing Assessment," dated 9/22/17 was the only assessment completed upon start of care.  9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained		A The agency document titled							
Assessment," dated 9/22/17 was the only assessment completed upon start of care.  9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained		1							
9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained		1							
9. The clinical record of patient #9 was reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained		· ·	· · · · · · · · · · · · · · · · · · ·						
reviewed on 1/5/18 and indicated a start of care date of 9/25/17. The record contained		,	•						
care date of 9/25/17. The record contained		9. The clinical record of patient #9 was							
		reviewed on 1/5/18 and indicated a start of							
a plan of care dated 9/25/17-11/23/17.		care date of 9/25/17. The record contained							
1 *		a plan of care da	ted 9/25/17-11/23/17.						
The record failed to evidence an initial		The record failed	d to evidence an initial						
assessment was documented.		assessment was	documented.						
A. The agency document titled		_	•						
"Comprehensive Adult Nursing		•	•						
Assessment," dated 9/25/17 was the only		· ·	· · · · · · · · · · · · · · · · · · ·						
assessment completed upon start of care.		assessment comp	pleted upon start of care.						
10. The disirely would find #10.		10 771 11 1							
10. The clinical record of patient #10 was reviewed on 1/5/18 and indicated a start of			*						
care date of 9/22/17. The record contained									
a plan of care dated 9/22/17-11/20/18.  The record failed to evidence an initial		-							
assessment was documented.									
assessment was documented.		assessment was	documentou.						
A. The agency document titled		A. The age	ncv document titled						
"Comprehensive Adult Nursing		_	- <del>-</del>						
Assessment," dated 9/22/17 was the only		•	· ·						

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG		01/11/	2018
NAME OF PRO	OVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					ROADWAY STREET		
RIGHT AT H	HOME, INC			ANDER	SON, IN 46012		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	1	TAG	BEIGHALI		DATE
a	issessment comp	pleted upon start of care.					
	11 701 1:: 1	1 6 7 111					
		record of patient #11 was					
		18 and indicated a start of					
		/17. The record contained					
		ted 111/8/17-1/6/18. The					
		vidence an initial					
a	assessment was d	documented.					
	A. The agen	cy document titled					
",	'Comprehensive	Adult Nursing					
A	Assessment," dat	ted 11/8/17 was the only					
a	assessment comp	pleted upon start of care.					
	•	•					
1	12. During an in	terview on 1/5/17 at 2:14					
	_	director of nursing stated					
	hat the initial ass	•					
		ssessment are combined					
	-	ent form when completing					
	the start of care.	ent form when completing					
"	ile start of care.						
1	12 During on in	terview on 1/5/17 at 2:15					
	•						
		of nursing stated that both					
		ment and comprehensive					
		ompleted in the home on					
S	start of care.						
		policy dated 7/24/17, titled					
"	'COMPLIANCE	E WITH FEDERAL,					
S	STATE, AND LO	OCAL LAWS," Reference					
#	#7011 stated "Rig	ght at Home complies with					
a	all applicable fed	leral, state, and local laws					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURV COMPLETED 01/11/201	)			
	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD  1135 BROADWAY STREET  ANDERSON, IN 46012					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	D BE CO	(X5) MPLETION DATE		
	and regulations in home health bus	regarding all aspects of iness practices."						
	"ACCEPTANCE PATIENTS," Re patient meets HI criteria, an initia is performed by including drug r The agency pol "PLAN OF CAR stated "All Clini implemented on	policy dated 7/24/17, titled E/ADMISSION OF eference #10001 stated "If HA [Home Health Agency] al comprehensive assessment a Registered Nurse, egime review." icy dated 7/24/17, titled RE," Reference #10004 cal services shall be ly in accordance with a plan ed by a physician's written						
	"ASSESSMENT #10008 stated "I HHA [Home He with a comprehe services within a outlined by Fede Admission as performed by a hours of referral Registered Nurs comprehensive a needs for care, to within the time to	policy dated 7/24/17, titled F - NURSING," Reference Purpose: To provide each ealth Agency] patient ensive assessment and/or an appropriate time frame, as eral regulatory requirements. sessments shall be Registered Nurse within: 48 Procedure: A e shall complete an initial assessment of the patient's reatment and/or services frame specified in the above itial comprehensive						

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	LDING	nstruction 00	(X3) DATE : COMPL <b>01/11</b> /	ETED
	ROVIDER OR SUPPLIER T HOME, INC			1135 BF	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET SON, IN 46012		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		with all areas being					
	"INTERDISCIPANSESEMENTS REASSESSMENT Stated "A Registe initial evaluation instances where only therapy service Evaluates the paresidence for approximate treatment and/or 48 hours of referming 18. The undated titled "ADMINIS #4014 stated "Jo and directs the HAgency's] day-to-compliance with regulations."  19. The undated titled "DIRECTO DESCRIPTION, #4HRDJD004-11 compliance to al requirements."	NTS," Reference #10010 ered Nurse completes all assessments except in those the physician has ordered vices Skilled Nursing: tient in his/her place of propriateness of care, services requested within: tral."  I agency job description STRATOR," Reference b Summary: Organizes IHA's [Home Health p-day operations, ensuring State and Federal  I agency job description OR OF NURSING JOB ," Reference 2/4 stated "Maintains 1 regulatory					
	20. The undated	agency job description					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
			B. W	ING		01/11/	2018
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1135 BROADWAY STREET ANDERSON, IN 46012				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDER'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	titled "ALTERN	ATE DIRECTOR OF					
	NURSING JOB	DESCRIPTION,"					
	Reference #4HRDJD004-12/4 stated						
	"Maintains comp	oliance to all regulatory					
	requirements."						
	requirements.						
N 0470	410 IAC 17-12-1(r	-					
DI-I 00	Home health agen	-					
Bldg. 00	administration/mai						
		Policies and procedures dimplemented for the					
control of communicable disease in compliance with applicable federal and state							
	laws.						
			N 0	470	o:p="">		01/11/2018
	Based on record	review, observation, and			N470: What is the agency's p		
	interview the age	ency failed to ensure that			to ensure that this deficiency will		
		owed infection control			not occur with the entire clinical staff?	al	
		4 home visits (#4).			The agency has corrected th	is	
	policies for 1 of	Thome visits (#1).			deficiency:		
	Findings in stude				On 1.11.18, All clinical staff		
	Findings include	·			completed in-services consisti	-	
	1 00 1 1	1 0			of Hand Hygiene and Infection	1	
		ecord of patient #4 was			Control videos, as well as, in service tests. The Director of		
		18 and indicated a start of			Nursing educated all clinical s	taff	
	care date of 11/2	/17. The record contained			on policy 5010-Standard		
	a plan of care da	ted 11/2/17-12/31/17.			Precautions, Policy 5011 Hand	d	
					Hygiene and N131 Glove		
	A. During o	observation on 1/9/18 at			Technique. All staff was		
		oyee D, HHA (Home			competency checked on Hand		
	•	s observed providing			Hygiene and Glove Technique 100% of all clinical staff passe		
	, , , , , , , , , , , , , , , , , , ,	The HHA assisted the			in-service tests and proper ha		
	•				hygiene and glove technique.		
	-	ower. With gloved hands,			The agency will prevent the		
	the HHA rubbed	soap all over the			deficiency from recurring by	:	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  01/11/2018	
	ROVIDER OR SUPPLIER T HOME, INC		1135 B		
	SUMMARY:  (EACH DEFICIEN REGULATORY OR  washcloth with It washed the patie finished the show outside of the sh patients' back an robe. HHA then and pushed patie walker. The HH complete hand h gloves in between  B. At the en- work station, pic removed gloves. complete hand h completed and g  2. During an int PM, the director changes should of soiled or in between  3. During an int PM, the director hygiene should it during care, any when gloves are	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION  nands. The HHA then ent's back. While patient wer alone, the HHA stood ower. HHA then dried d assisted with applying assisted with applying brief ent to room using rollator IA failed to remove gloves, ygiene, and apply new en patient tasks.  d of care the HHA cleaned eked up dirty linen and The HHA failed to ygiene after care was loves were removed.  erview on 1/9/18 at 2:22 of nursing stated that glove occur anytime gloves are even tasks.  erview on 1/9/18 at 2:21 of nursing stated that hand be completed before care, time gloves are changed, soiled and after care.	1135 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET RSON, IN 46012  PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIL DEFICIENCY)  Upon hire and annually, all cl staff will complete in-services consisting of Hand Hygiene, Standard Precautions, and G Technique. All clinical staff w competency checked upon hi 90 day evaluation, annually a needed. On 1.10.18 and Ongoing: All clinical staff will be educated Hand Hygiene, Standard Precautions, Glove Technique PPE Usage, and Infection Co Policies with videos, return demonstration, upon hire, at 9 day evaluation, annually and needed. The Administrator and Director Nursing are responsible for ensuring that this deficiency does not recur. The deficiency was corrected by 1.11.18	inical love fill be re, at nd as on e, ntrol 90 as or of
	"STANDARD P #5010 stated "PO	olicy dated 7/24/17, titled RECAUTION," Reference DLICY: Standard designed for care of all			

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PRINTED: 02/06/2018 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER			-			ETED 2018	
	ROVIDER OR SUPPLIER		1	135 BR	DDRESS, CITY, STATE, ZIP COD ROADWAY STREET SON IN 46012		
	SUMMARY:  (EACH DEFICIEN  REGULATORY OR  patients in facility or presumed inferisk of transmiss and unrecognize Standard Precauth be worn when to secretions, excree non-intact skin a items, i.e. equipment the place of hand washed after remshould be changed procedures on the with material that concentration of  5. The agency period "HAND HYGIE Disease Control Reference #5011 provide guidelin hygiene, in order of bacteria, germ CDC has recomment to use non-antimal antimicrobia alcohol-based has	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION ties, regardless of diagnosis ection status, to reduce the ion from both recognized d sources of infection tions include: Gloves: To buching blood, body fluids, tions, mucous membranes, and other contaminated ment. Gloves do NOT take d hygiene. Hands are to be noving gloves. Gloves ed between tasks and e same patient after contact at may contain a high microorganisms."  olicy dated 7/24/17, titled INE - CDC [Centers for GUIDELINES," I stated "Purpose: To es for effective hand or to prevent the transmission as and infections The mended guidelines on when aicrobial soap and water, al soap and water or an and rub After coming in ent's intact skin, i.e., taking pressure, pulse,	A II PRE	NDER	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRIA' DEFICIENCY)	TE .	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/11/2018	
	PROVIDER OR SUPPLIEF		1135	T ADDRESS, CITY, STATE, ZIP COD BROADWAY STREET ERSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
N 0494 Bldg. 00	legal representativinformed of the pareffective means of health agency mulexercise of these following:  (1) Provide the positive for the patient's right (A) in advance of patient; or  (B) during the initiation of tree (2) Maintain dochas complied with section.  Based on record policy review the proper consent from the initiation of care reviewed (# 8).  Findings included 1. The clinical reviewed on 1/5 care date of 9/22 a plan of care date.	The patient or the patient's we has the right to be atient's rights through of communication. The home st protect and promote the rights and shall do the rights and	N 0494	o:p> o:p> 1. On 1-15-18, clarification order was written and faxed to patient #8's physician (copy included). 2. On 1-16-18 the clarification order was signed by patient #9 physician. 3. On 1-17-18, patient #8 notified of the clerical error, a home visit was made and pati #8 was given a copy of the sign physician clarification order. Patient #8 verbalized understanding that the conservas reviewed and signed on	tion 8's was ent gned

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. WI	NG _		01/11/	2018
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹			ROADWAY STREET		
RIGHT A	T HOME, INC				SON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					9-22-17 along with the		
	A. The ager	ncy document titled			comprehensive assessment.		
	"Comprehensive	-			Patient #8 co-signed physician		
	•	· ·			order, retained a copy, and ori	-	
		as completed and dated			was place on patient #8's char	t.	
	9/22/17.						
	R The ager	ncy consent document titled		The agency will prevent the			
	B. The agency consent document titled "Emergency Plan," was completed and		deficiency from recurring by:				
		in, was completed and					
	dated 9/23/17.						
					The Administrator, Director of		
	C. The agency consent document titled				Nursing, Quality Improvement		
	" Right At Home	e, Inc.," stated " Home care			Coordinator or designee will		
	•	en initiated on 9/23/17."			complete 100% audit of all adr	nit.	
		vas signed by the patient			These audits will be completed	b	
					within 48 hours of submission	of	
	and employee B	on 9/23/1/.			admission documents. The documentation audit is to ensu	ır≙	
	D. The age	ncy consents document titled			dates of admission and conse		
	_	-			which includes the patients' rig	ghts	
		vice Agreement Home			correlate and date errors do no		
	*	tialed and signed by the			recur. Audits will be ongoing t	0	
	patient and that	employee B on 9/23/17.			ensure compliance and		
					consistency of all medical		
	E. During a	n interview on 1/5/18 at			records. All registered nurses		
		sistant director of nursing			be oriented upon hire regardin assessment date and consent		
	-	art of care date is the date			date correlating.		
					date contolating.		
	that consents are	e signea.					
					The Administrator, Director of		
					Nursing, Quality Improvement		
					Coordinator or designee are		
					responsible for correcting the deficiency and preventing it from		
					recurring.		
					<b>,</b>		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING 00 COMPLET					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED  B. WING 01/11/2018				
			D. WI			01/11/2	0.10
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET		
RIGHT A	T HOME, INC		ANDERSON, IN 46012				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DETCIENCT		DATE
					The deficiency will be corrected by (date):		
					1-17-18		
N 0540	410 IAC 17-14-1(a Scope of Services						
Bldg. 00	Rule 14 Sec. 1(a) services are limite purposes of practi setting, the register following:	(1)(A) Except where Id to therapy only, for Ice in the home health Ired nurse shall do the Itial evaluation visit.					
			N 0	540	o:p="">	1	01/18/2018
	Based on record	review and interview the			N540 Initial assessment		
	agency failed to	ensure that an initial			documentation needs to be clarified:		
	assessment visit	was documented for 11 of			How will the agency ensure th	iere	
	11 records revie	wed			is documentation that the initia	I	
	(#1,2,3,4,5,6,7,8	,9,10,11).			assessments were completed	the	
					same day/same visit as the comprehensive assessments		
	Findings include	): :			versus only indicating on the		
	C				referral sheet?		
	1. The clinical r	ecord of patient #1 was			The agency has corrected th	e	
		18 and indicated a start of			deficiency by:		
		/17. The record contained			This deficiency was corrected 2.2.18. Page 2 of the referral		
		ted 11/24/17-1/22/18.			includes the initial assessmen	I	
	-	d to evidence an initial			visit note. This form was revis		
	assessment was				to reflect that page 2 is the ini		
	assessificing was				assessment visit note. The f	I	
	Δ The ager	ncy document titled			performs the initial assessmer visit, signs and dates when the		
	"Comprehensive	<del>-</del>			initial assessment visit note ha		
	•	•			been completed on page 2. T	he	
	•	ted 9/25/17 was the only			RN then completes the		
	assessment comp	pleted upon start of care.			comprehensive assessment w	/hich	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	NSTRUCTION (X3) DATE S		SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
			B. Wl	ING	_	01/11/	/2018
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	· ·		1135 BI	ROADWAY STREET		
RIGHT A	T HOME, INC			ANDER	RSON, IN 46012		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					includes a signature and date.		
	2. The clinical i	record of patient #2 was			The RN will also document on		
	reviewed on 1/4/18 and indicated a start of				page 24 of the comprehensive	;	
	care date of 10/1	6/17. The record			assessment that "The Initial Assessment was performed or	<b>n</b>	
					(date) and (time). Please see		
	contained a plan				attachment.	uic	
		8. The record failed to			The agency will prevent the		
	evidence an init	ial assessment was			deficiency from recurring by	:	
	documented.				All RN staff will be in-serviced		
					2.5.18 and all new RN's will be	Э	
	A The age	ncy document titled			in-serviced upon hire regardin	g the	
	"Comprehensive	<del>-</del>			initial assessment visit to be		
	•				completed the same day as th	е	
	•	ted 10/16/17 was the only			comprehensive assessment.		
	assessment com	pleted upon start of care.			Also, all RN's will be in-servic		
					on documentation of the initial		
	3. The clinical i	record of patient #3 was			assessment visit date/time on		
		/18 and indicated a start of			page 24 of the comprehensive assessment visit.	;	
		31/17. The record			Effective 2.5.18 and ongoing,	the	
					DON/ADON/QI Coordinator or		
	contained a plan				designee will complete 100%		
	10/31/17-12/29/	17. The record failed to			ongoing audits on all admits to	)	
	evidence an init	ial assessment was			verify that the initial assessme		
	documented.			and the comprehensive			
					assessments were completed	on	
	A The age	ncy document titled			the same day/same visit.		
		•			The administrator, Director of		
	"Comprehensive				Nursing, Assistant Director of		
	•	ted 10/31/17 was the only			Nursing/Quality Improvement		
	assessment com	pleted upon start of care.			Coordinator or designee are responsible for correcting th	Δ.	
					deficiency and preventing it	C	
	4. The clinical i	record of patient #4 was			from recurring and will ensure	е	
		/18 and indicated a start of			the agency's ongoing complia		
		2/17. The record contained			with performance and		
					documentation of the initial		
	•	ated 11/2/17-12/31/17.			assessment visits and the		
	The record faile	d to evidence an initial			comprehensive assessment v	isits	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. W	ING		01/11/	/2018
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	R			ROADWAY STREET		
RIGHT A	T HOME, INC			1	SON, IN 46012		
	Г	CTATEMENT OF DEFICIENCIE	1	ID.			(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	ì ·	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
	assessment was				on the same day/visit.		
	assessment was	documented.			The deficiency will be		
	A 773	1		corrected by 2.2.18			
	_	ncy document titled					
	"Comprehensive	•			="" span="">		
	Assessment," da	ted $11/2/17$ was the only					
	assessment comp	pleted upon start of care.					
	5. The clinical r	record of patient #5 was					
		/18 and indicated a start of					
		9/17. The record contained					
	a plan of care dated 11/18/17-1/6/18. The						
		evidence an initial					
	assessment was	documented.					
	A. The age	ncy document titled					
	"Comprehensive	e Adult Nursing					
	Assessment," da	ted 9/19/17 was the only					
	· ·	pleted upon start of care.					
	6 The clinical r	record of patient #6 was					
		•					
		/18 and indicated a start of					
		5/17. The record contained					
		ted 12/5/17-2/2/18. The					
	record failed to	evidence an initial					
	assessment was	documented.					
	A. The age	ncy document titled					
	"Comprehensive	-					
	-	ted 10/6/17 was the only					
	· ·	•					
	assessment comp	pleted upon start of care.					
	7. The clinical r	record of patient #4 was					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 01/11/2018
	PROVIDER OR SUPPLIER		1135 B	ADDRESS, CITY, STATE, ZIP COD ROADWAY STREET RSON, IN 46012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
IAU	reviewed on 1/5/care date of 9/22 a plan of care da The record failed assessment was of the A. The ager "Comprehensive Assessment," da assessment comp	/18 and indicated a start of //17. The record contained ted 11/21/17-1/19/18. It to evidence an initial documented.  Incy document titled and Adult Nursing ted 9/22/17 was the only poleted upon start of care.	TAU		DATE
	reviewed on 1/5/ care date of 9/22 a plan of care da	ecord of patient #8 was /18 and indicated a start of /17. The record contained ted 11/21/17-1/19/18. It to evidence an initial documented.			
	"Comprehensive Assessment," da	Adult Nursing ted 9/22/17 was the only pleted upon start of care.			
	reviewed on 1/5/ care date of 9/25 a plan of care da	ecord of patient #9 was /18 and indicated a start of /17. The record contained ted 9/25/17-11/23/17. It to evidence an initial documented.			
	A. The ager	ncy document titled Adult Nursing			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED			
			B. W.	B. WING			01/11/2018	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
DICHT AT HOME INC				1135 BROADWAY STREET ANDERSON, IN 46012				
RIGHT AT HOME, INC				<u> </u>	3011, III <del>1</del> 0012		1	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)	(X5) COMPLETION	
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
	Assessment," dated 9/25/17 was the only							
		pleted upon start of care.						
	assessment completed upon start of care.							
	10. The clinical record of patient #10 was							
	reviewed on 1/5	/18 and indicated a start of						
	care date of 9/22/17. The record contained							
	a plan of care dated 9/22/17-11/20/18.							
	The record faile	d to evidence an initial						
	assessment was	documented.						
	A. The agency document titled							
	"Comprehensive Adult Nursing							
	Assessment," dated 9/22/17 was the only							
	assessment completed upon start of care.							
	11. The clinical	record of patient #11 was						
	reviewed on 1/9/18 and indicated a start of							
	care date of 11/8/17. The record contained							
	a plan of care dated 111/8/17-1/6/18. The							
	record failed to evidence an initial							
	assessment was documented.							
	A. The agency document titled							
	"Comprehensive Adult Nursing							
		ated 11/8/17 was the only						
	assessment completed upon start of care.							
	12 5	1/5/15 . 3.1.						
	12. During an interview on 1/5/17 at 2:14							
		t director of nursing stated						
	that the initial as							
	into one assessment form when completing							

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
			B. WI	NG		01/11/	/2018
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
RIGHT AT HOME, INC					ROADWAY STREET SON, IN 46012		
	· T			L	.3011, 111 40012		1
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX TAG			COMPLETION DATE
	the start of care.			-			
	13. During an i	nterview on 1/5/17 at 2:15					
		of nursing stated that both					
		ment and comprehensive					
		completed in the home on					
	start of care.						
	14. The agency	policy dated 7/24/17, titled					
	"COMPLIANCE WITH FEDERAL,						
	STATE, AND LOCAL LAWS," Reference						
	#7011 stated "Right at Home complies with						
	all applicable federal, state, and local laws						
	and regulations regarding all aspects of						
	home health business practices."						
	nome nearm ousmess practices.						
	15. The agency	policy dated 7/24/17, titled					
		E/ADMISSION OF					
	PATIENTS," Reference #10001 stated "If						
	patient meets HHA [Home Health Agency]						
	criteria, an initial comprehensive assessment						
	is performed by a Registered Nurse,						
	including drug r						
	The agency policy dated 7/24/17, titled						
	" " "	RE," Reference #10004					
		ical services shall be					
	implemented on	ly in accordance with a plan					
	of care established by a physician's written						
	orders."						
	16. The agency policy dated 7/24/17, titled "ASSESSMENT - NURSING," Reference						
			1				I

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		СОМРІ	(X3) DATE SURVEY COMPLETED 01/11/2018			
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC			STREET ADDRESS, CITY, STATE, ZIP COD 1135 BROADWAY STREET ANDERSON, IN 46012					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE			
IAU	#10008 stated "FI HHA [Home He with a comprehe services within a outlined by Fede Admission assign performed by a linear hours of referral Registered Nurse comprehensive a needs for care, the within the time of policy The initial assessment form addressed and do 17. The agency "INTERDISCIP ASSESEMENT REASSESSMENT REASSESSMENT stated "A Regist initial evaluation instances where only therapy services and the paresidence for apprenent and the services of the paresidence of the services within a comprehensive and the services and the services are services within the time of policy The agency "INTERDISCIP ASSESEMENT REASSESSMENT REASSESSM	Purpose: To provide each alth Agency] patient ensive assessment and/or an appropriate time frame, as eral regulatory requirements. sessments shall be Registered Nurse within: 48 Procedure: A e shall complete an initial assessment of the patient's reatment and/or services frame specified in the above tial comprehensive with all areas being ocumented".  policy dated 7/24/17, titled LINARY PATIENT S AND NTS," Reference #10010 ered Nurse completes all assessments except in those the physician has ordered vices Skilled Nursing: tient in his/her place of propriateness of care, a services requested within:	IAG			DATE		
	titled "ADMINI	l agency job description STRATOR," Reference b Summary: Organizes						

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Í		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/11/2018		
NAME OF PROVIDER OR SUPPLIER RIGHT AT HOME, INC			STREET ADDRESS, CITY, STATE, ZIP COD 1135 BROADWAY STREET ANDERSON, IN 46012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
MG	and directs the Hagency's] day-to compliance with regulations."  19. The undated titled "DIRECTO DESCRIPTION #4HRDJD004-1 compliance to all requirements."  20. The undated titled "ALTERN NURSING JOB Reference #4HR	HA's [Home Health oday operations, ensuring state and Federal dagency job description OR OF NURSING JOB "Reference 2/4 stated "Maintains					

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