PRINTED: 12/10/2019

DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FOI	RM APPROVED	
CENTERS FOR	MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPL	ETED		
15K065			B. W	B. WING			11/04/2019	
NAME OF PROVIDER OR SUPPLIER HELP AT HOME SKILLED CARE			<u> </u>	3347 N	ADDRESS, CITY, STATE, ZIP COD GREEN RIVER RD VILLE, IN 47715			
TIELF AT HOWE SKILLED CARE				LVANO	· · · · · · · · · · · · · · · · · · ·			
(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	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
G 0000								
Bldg. 00	This visit was for a Federal Recertification and State Licensure survey.  Survey Dates: October 30, 31, and November 1, and 4, 2019  Facility ID: 012482 Provider #: 15K065 Medicaid #: 201010780  12 Month Unduplicated Admissions: 229  Active Skilled: 57 Active Unskilled: 80		G 0	000				
	28 OASIS patients/ Reports	eviewed / 3 home visits 12 months OASIS Validation reflect State Findings cited in 0 IAC 17.						
G 0372								
Bldg. 00			G 0	372	1.Nursing Supervisors will be	<b>:</b>	12/03/2019	

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

Based on record review and interview the agency

failed to ensure Outcome Assessment and

Information Set (OASIS) data were submitted

10, 13, 15, 11) and 11 of 15 patients from the

22, 23, 24)

within 30 days of collection for 5 of 13 patients

reviewed from the Evansville Branch (Patients 9,

Vincennes Branch who qualified for OASIS data collection. (Patients 12, 14, 16, 18, 19, 17, 20, 21,

TITLE

in-serviced by the Administrator on

the Agency policy "Reporting of

OASIS Information" that requires

2. To prevent the deficient practice

OASIS assessments to be

completion.

transmitted within 30 days of

(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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			LETED
		15K065	B. W	ING		11/04/2019	
NAME OF PROVIDER OR SUPPLIER  HELP AT HOME SKILLED CARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG REGULATORY OR LSC IDENTIFYING INFORMATION			3347 N	ADDRESS, CITY, STATE, ZIP COD GREEN RIVER RD SVILLE, IN 47715  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	Information," was p Nursing Supervisor policy indicated, bu Agency must encode transmitting OASIS thirty (30) days of of data set assessment 2. The 2019 OASIS Reports from Evans 10/30/19 at 11:19 at Patient 9's OASIS, on 7/1/19. Patient 10's OASIS on 6/10/19. Patient 13's OASIS on 3/18/19. Patient 15's OASIS on 3/18/19. Patient 11's OASIS on 3/7/19. 3. The 2019 OASIS Reports from Vince at 2:10 p.m., and in	cy, titled, "Reporting of OASIS provided by the Evansville on 11/4/19 at 10:00 a.m. The at was not limited to, "2. He and have the capability of 3 data for each patient within completing any required OASIS."  S Agency Final Validation swille were reviewed on .m., and indicated the following: dated 5/30/19, was submitted dated 5/4/19, was submitted , dated 1/7/19, was submitted , dated 1/16/19, was submitted S Agency Final Validation ennes were reviewed on 11/1/19 dicated the following: , dated 4/15/19, was submitted			from reoccurring, the Adminis will audit the OASIS validation reports monthly to ensure the transmissions are within 30 d of the date the assessments completed.  3. The Administrator will be responsible for ensuring compliance with agency police.	n e ays were	

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on 6/25/19.

Patient 14's OASIS, dated 5/22/19, was submitted

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CENTERS FOR	R MEDICARE & MEDIC		OMB NO. 0938-039						
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED				
		15K065	B. WING		11/04/2019				
	PROVIDER OR SUPPLIER		3347 N	STREET ADDRESS, CITY, STATE, ZIP COD  3347 N GREEN RIVER RD					
HELP AT	HOME SKILLED C	CARE	EVAN	SVILLE, IN 47715					
(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 APPROPRIAT	COMPLETION				
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE				
	Patient 16's OASIS, on 9/12/19.	, dated 8/9/19, was submitted							
	Patient 18's OASIS on 9/12/19.	, dated 8/5/19, was submitted							
	Patient 19's OASIS on 9/12/19.	, dated 8/8/19, was submitted							
	Patient 17's OASIS, dated 8/9/19, was submitted on 9/12/19.								
	Patient 20's OASIS on 9/12/19.	, dated 8/12/19, was submitted							
	Patient 21's OASIS, on 9/5/19.	, dated 7/26/19, was submitted							
	Patient 22's OASIS, on 9/5/19.	, dated 8/1/19, was submitted							
	Patient 23's OASIS, on 9/5/19.	, dated 7/31/19, was submitted							
	Patient 24's OASIS on 9/5/19.	, dated 7/29/19, was submitted							
	Administrator indic	iew on 11/1/19 at 11:25 a.m., the ated OASIS submissions are mitted within 30 days.							
G 0536									
Bldg. 00									
	interview, the agend	on, record review, and by failed to ensure medications the medication profile updated	G 0536	All Nurses will be in-serviced the Nursing Supervisor on the Agency policy "Medication Preparation" regarding the	12/02/2019				

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prior to filling the medication planner in the home

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requirement to compare

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
		15K065	B. WING			11/04/2019	
				CEDEE	A D D D D G G G G G G G G G G G G G G G		
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
LIELD AT LIGHT OWN ED CADE				3347 N GREEN RIVER RD			
HELP AT HOME SKILLED CARE				EVANSVILLE, IN 47715			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	for 1 of 2 medication	on management home visits.			medication orders with the		
	(Patient 6)				medication container and upda	ate	
					medication profile prior to		
	Findings include:			preparing medications.			
	An undated policy,	titled, "Medication					
	Preparation," was p	provided by the Administrator			2. To prevent the deficient pra	ctice	
	on 11/4/19 at 1:11 j	p.m. The policy indicated, but			from reoccurring, the Nursing		
	was not limited to,	"2. Staff will utilize appropriate			Supervisor or designee will		
	techniques during r	nedication			conduct on-going competency	,	
	administrationUs	ing appropriate techniques to			assessments for nurses during	9	
	ensure accuracy, e.g., comparing the medication				their annual review to ensure		
	order with the medication container."				compliance with agency policy	<i>/</i> .	
	During a home visit on 10/31/19 at 11:00 a.m.,				The Administrator will be		
	Employee 2 was observed to fill Patient 6's				responsible for ensuring		
		on planner. Employee 2 was			compliance with the corrective	;	
	observed to place the following pill twice per day				action. The Administrator will		
		ups: Calcium 600 mg			audit 10% of the competency		
		n D3 800 mg. The medication			assessments quarterly of nurs	e's	
		d to have a fill date of 10/17/19.			due for annual review.		
		served to place a week's					
		ll medication cups into the					
	electronic medication	on planner.					
		ent medication profile, dated					
		Calcium 600 mg/ Vitamin D3 400					
	mg by mouth two t	imes daily.					
	A 01:11 137 :	57 1 N 1 140/17/10					
	A Skilled Nursing Visit Note, dated 10/17/19, and						
		e 3, indicated no medication					
	changes.						
	A Skilled Nursing Visit Note, dated 10/24/19, and signed by Employee 2, indicated no medication						
	changes.						
	During an interview	v on 10/31/19 immediately					
	_	observation, Employee 2					
		unaware of the medication					
	muicated they were	unaware or the medication	1		1		

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STATEMENT OF DEFICIENCIES X1) I		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		15K065	B. WING 11/04/2019			2019	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  3347 N GREEN RIVER RD  EVANSVILLE, IN 47715				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDERS DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	from the medication when there was a net the home, they show medication profile, and bring an update the patient's home.  During a record rev	notice the pill bottle differed in profile. Employee 2 indicated ew or changed medication in ald update the plan of care and send an order to the doctor, in different medication profile back to sew on 10/31/19 at 2:55 p.m., Jursing Visit Notes indicated					
0.000							
G 0682							
Bldg. 00	interview, the agency followed infection of agency's policy relator 1 of 3 home visits. Findings include:  An undated policy, Technique," was pronounced in the surface paper towels to create a clean are items which will be items on one of the		G 0	682	1. The Nursing Supervisor will in-service nurses on agency p "Exposure Control Plan" which specifies that nursing bag sho be placed on a clean surface obarrier created with paper tow or a plastic bag and items removed from the bag placed the barrier.  2. To prevent the deficient prafrom reoccurring, the Nursing Supervisor or designee will conduct on-going competency assessments for nurses during their annual review to ensure compliance with agency policy  3. The Administrator will be	olicy n uld or a els on ctice	12/02/2019
	12:27 p.m., Employ	ee 6 was observed to perform a ient 5. Employee 6 was			responsible for ensuring compliance with the corrective action. The Administrator will a		

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

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K065	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/04/2019		
NAME OF PROVIDER OR SUPPLIER HELP AT HOME SKILLED CARE			STREET ADDRESS, CITY, STATE, ZIP COD  3347 N GREEN RIVER RD  EVANSVILLE, IN 47715				
(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	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	observed to remove the vital sign equipment from				10% of the competency		
	the bag and place directly on Patient 5's kitchen		assessments quarterly of nurses		ses		
	table with no barrier. Employee 6 was observed to				due for annual review.		
	use the equipment to assess Patient 5's						
		pressure, and listened to					
	lungs, heart, and abdominal sounds with the						
	stethoscope.						
	During an interview on 11/1/19 at 2:07 p.m., the Administrator indicated staff were supposed to utilize a barrier in the home between the bag/supplies/equipment and the home.  410 IAC 17-12-1(m)						

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