STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
			B. WING			05/16/2017	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5401 VOGEL RD, STE 110 EVANSVILLE, IN 47715				
(X4) ID	STIMMADV S	FATEMENT OF DEFICIENCIES	I	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
N 0000				1.10			5.112
14 0000							
Bldg. 00	initial survey.	r a state home health  May 15th and May 16th	N 00	000			
	Medicaid Vendor						
	Skilled Unduplic	eated Admissions: 2					
	Current Census:	4					
N 0446 Bldg. 00	also be the superv registered nurse re shall do the follow (3) Employ qualifi	nagement 7-12-1(c)(3) administrator, who may vising physician or equired by subsection (d),					
	Based on observe record review the ensure personnel	ation and personnel e Administrator failed to received adequate staff of 4 personnel files	N 04	146	1. Employee B received re-education about hand hygie during PICC dressing change 6/12/17. Employee B had PICC line education on 3/16/17, but evidence of this education was not in their personnel file during the survey. It was placed into the personnel file on 6/12/17. Route	on C S g heir	06/12/2017

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			ETED	
			B. WING 05/16/2017			2017	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8	5401 VOGEL RD, STE 110				
EDIC HE	ALTH SERVICES				VILLE, IN 47715		
	ALTITOLITYIOLO			LVANO			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					hand hygiene will be added to		
	Findings Include:				Agency onboarding process by	У	
					6/30/17 and evidence of		
	1 Darsonnal rac	cord B, date of hire			education to all field nurses		
					working with IV clients will be placed in each personnel file.		
	2/26/1/, was rev	viewed on 5/16/17.			The Director of Nursing will be	ı	
					responsible for completion and		
	A. During a hor	me visit on 5/15/17 at			ongoing compliance by verifying		
	5:30pm, employ	ee B was observed while			completion for any and all nurs		
	providing care to patient #3. Employee B who is a registered nurse applied and removed gloves but failed to perform				who work with infusion cases		
					2. A PICC line dressing chang	ge	
					checklist process has been pu		
					place as of 6/12/17. Checklist	is	
	hygiene while performing a PICC (				to be completed every time a		
	1 ^ ^	erted central-line)			PICC dressing change is	:11	
	dressing change.				provided. 10% of check lists w	111	
					be reviewed each quarter or completeness of hand hygic	ono	
	B. A document	titled Annual Clinical			during PICC dressing	SI IC	
		ecklist contained in			changes. A process of reviewi	na	
	1 1	sonnel record dated			all nursing files, prior to	3	
					placement with a patient for th	е	
	2/26/17 failed to				appropriate competencies was	3	
	skill/technique/e				initiated on 6/12/17 and will be		
	(intravenous) Ac	ecess on			ongoing. 10% of actively work	ing	
	PICC/Central/Pe	eripheral was provided.			nursing personnel files will be		
		_			reviewed each quarter		
	C. In an intervie	ew with the Director of			for appropriate nursing competencies based on the		
		ecutive Director on			patients they care for. Audits v	vill	
					last for a period of 2 quarters.	<b>*</b> 111	
		ployees acknowledge			The Director of Nursing and/or	-	
		ducation was not			Executive director will oversee		
	provided for stat	ff prior to providing care			the task as listed going forwar		
	for the patient.				3. Re-education to employee	В	
					was provided by the Regional		
					Nursing Director. Review of		
					nursing files for competencies	1	
					prior to placement with a patie		
					will be conducted by the ED. T Executive Director will be	пe	
					Executive Director will be		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	(X2) MULTIPLE CONSTRUCTION (X3) I A. BUILDING 00 C B. WING 0		
NAME OF PROVIDER OR SU		STREET ADDRESS, CITY, STATE, ZIP CODE 5401 VOGEL RD, STE 110 EVANSVILLE, IN 47715			
PREFIX (EACH DE	ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
			responsible for review of all competencies prior to employ placement with a patient. 10% files will be reviewed each qua for completeness by the ED o designated person for a minim of 2 quarters.  4. 6/12/16	o of arter r	
Rule 12 Sec may also be registered no shall do the so (6) Ensure to meets all rule Based on clareview, obsorbed Administration direct the against the	agency n/management 1(c)(6) The administrator, who the supervising physician or urse required by subsection (d), following: nat the home health agency es and regulations for licensure. inical record review, policy ervation and interview the for failed to organize and gency's ongoing functions and sure state rules and were followed for 1 of 1	N 0449	1. A PICC line process was in place at the time of the survey but was not provided in writing the surveyors at that time. The process was made available freview, within the office, on 6/12/17.  Employee B had PICC line education on 3/16/17, but evidence of this education wa not in their personnel file durir the survey. It was placed into personnel file on 6/12/17. The Executive Director or designar person will be responsible for review of all competencies pri to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED o designated person for a minim of 2 quarters.	g to e or s ng their ted or	

State Form Event ID: EF8U11 Facility ID: 014086 If continuation sheet Page 3 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. WING 05/16/2017			2017		
		l .		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹			OGEL RD, STE 110			
EDIC HE	ALTH SERVICES				VILLE, IN 47715			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
	education to mai	nage a PICC-line for 1 of			Administrator, director of nursi	ng		
	5 personnel files reviewed (employee B).				and executive director all	n		
	A document	titled Annual Clinical			received job specific orientation on 1/4/17, but documentation			
	Competency Ch	ecklist contained in			not in their personal files durin			
		sonnel record dated			time of survey. Evidence of su			
	2/26/17 failed to				orientation was placed into ea			
					personal file on 6/16/17. The			
	skill/technique/e				Executive Director or designat	ed		
	(intravenous) Access on				person will be responsible for			
	PICC/Central/Pe	eripheral was provided.			review of all competencies price	or		
					to employee placement with a			
	3. The administ	rator failed to ensure			patient. 10% of files will be reviewed each quarter			
	documentation of adequate orientation to the job for 3 out of 5 (employees A, B,				for completeness by the ED fo	ra		
					minimum of 2 quarters.	ı a		
					Reeducation was provided to			
	and E) personne	i illes reviewed			executive director regarding th	ie		
					need for physical examination	for		
		rator failed to ensure			all direct care staff to be prese	nt		
	personnel files in	ncluded a physical			in the personal file, dated no			
	examination not	more than 180 days prior			more than 180 days prior to di			
	to direct patient	contact for 1 of 2 direct			patient contact, before providir	ng		
	_	se personnel records were			patient care. (Regardless of transfer from parent agency to			
		oyee B). Personnel file			the independent agency). Curi			
					employee files will be audited	0.11		
		was reviewed and			and, if no physical is present, t	the		
		dividual had been hired			employee will obtain a physica	ıl.		
		RN, Director of Nursing,			The Executive Director will be			
	first date of patie	ent contact 3/1/17. The			responsible for this going			
	file evidenced a	physical examination by			forward. Outstanding physical			
	a physician date	d 2/4/15, 2 years before			will be completed by Septemb 9, 2017. Moving forward, all n			
	the date of first				employees will have a qualifying			
	]				physical prior to providing care			
	5. The administrator failed to ensure staff complied with the agency's policy for handwashing for 1 of 2 (#3) home				The Executive Director or			
					designated person will be			
					responsible for review of			
	_	, ,			completion prior to employee			
		s. During a home visit			placement with a patient. 10%			
	(#3 of 2) on 5/15/17 at 5:30pm, employee				files will be reviewed each qua	ırter		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
			B. WING			05/16/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OGEL RD, STE 110		
EPIC HE	ALTH SERVICES				VILLE, IN 47715		
					VILLE, IIV 477 13		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	B was observed	while providing care to			for completeness by the ED fo	ra	
	patient #3. Employee B who is a RN				minimum of 2 quarters. Employee B received		
	(registered nurse	e) applied and removed			re-education about hand hygie	ne	
	gloves but failed	I to perform hygiene			during PICC dressing change		
	~	g a PICC-line dressing			6/12/17. Routine hand hygien		
		g a rree mie aressing			will be added to the Agency		
	change.  6. The administrator failed to ensure the agency discharge policy included a 15 day notice before services are stopped. A policy titled Termination of Services Against the Family's Wishes 3-22, Rev.				onboarding process by 6/30/17		
					and evidence of education to a	all	
					field nurses working with IV		
					clients will be placed in each personnel file. The Director of		
					Nursing will be responsible for		
					completion and ongoing		
					compliance by verifying		
	_	hat notification will be			completion for any and all nurs	ses	
	nrovided to the t	family in writing not less			who work with infusion cases		
	_	ior to discontinuation of			Policy titled Termination of		
	service, exempt				Services against the Family's		
					Wishes 3-22, will be revised to		
		ardy or the physician			include a 15-day notice before services are stopped. Revisior		
	refuses orders to	continue care.			will be in place by 6/16/17. The		
					Director of Nursing will be		
	7. The administ	rator failed to ensure that			responsible for compliance.		
	all pertinent info	ormation was included on			On 5/19/16, the care plans of		
	the plan of care	in 4 out of 4			patients #1, 2 and 4 were		
	(#1,#2,#3,#4) red				updated by obtaining orders from		
	, , ,,,				their physicians, clarifying that		
	A The clini	cal record #1 included a			duration of ordered care indication on the plans of care was for 60		
					days. On 5/19/17, the care pla		
	1 ^	blished by the physician			of patients #1, 2, 3 and 4 were		
		ion period 4/21/17			updated by obtaining orders from		
		with orders to provide			their physicians, clarifying pati	ent	
	`	alth aide) services 2-4			specific vital sign parameters.	All	
	hours a day for 2	2-4 days a week of			applicable clinicians will be		
	unskilled care ar	nd provide skilled nursing			educated as to how to properly	/	
		a week ongoing per MD			complete a Plan of Care to include vital sign parameters a	ınd	
		r) orders. The plan of			discipline frequency and	ıı ıu	
	`	ecify a specific duration			duration. This will be complete	ed	
	care raneu to spe	cerry a specific duration			Table 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 05/16/2017	
	PROVIDER OR SUPPLIEF		5401	T ADDRESS, CITY, STATE, ZIP CODE VOGEL RD, STE 110 NSVILLE, IN 47715	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	B. The clinic included orders included orders included orders included orders included orders included, and R (rulse), and R (rulse), and R (rulsed parameters included orders	cal record #1 plan of care for "vital sign for SN (skilled nurse) to or RN (registered nurse) T (temperature), P espiration) outside of s greater than 30-60 an of care failed to fic vital sign parameters.  cal record #2 included a blished by the physician fron period 5/3/17 through rs to provide HHA rs a day for 2-4 days a d care. The plan of care a specific duration for		by September 9, 2017. The Director of Nursing or designar person will ensure compliance Plans of Care will be reviewed 100% for compliance x 2 morand then at 10% per quarter thereafter.  Policy titled Monitoring Patient Care 3-14, will be revised to sthat non-skilled supervisory will be conducted every 30 dainstead of every 60 days.  Revision will be in place by 6/16/17. The Director of Nursion designated person will ensure compliance.  On 5/15/17, evidence of home health aide supervision every weeks was placed into clinical record #1. The supervisory vinad been completed on 5/2/1 but the documentation was not found during the survey. The Director of Nursing or designar person will ensure compliance 2. Starting 6/12/17, all process involving patient care, will be available for immediate review all times, and will be ongoing. Quarterly, 5 patient-care-relating processes will be selected, and an audit will be conducted to ensure the written processes available for immediate review and the will be conducted to ensure the written processes available for immediate review and the direction of ED and/or designee A process of reviewing all nurfiles, prior to placement with a patient for the appropriate competencies was initiated on 6/12/17 and will be ongoing.	ated e. d at oths  It state disits state disits rys, sing ure e 2 I sit 7, ot ated e. ses v, at red are v. f the rsing a

State Form Event ID: EF8U11 Facility ID: 014086 If continuation sheet Page 6 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>			COMPLETED	
			B. W	ING		05/16/	2017	
			•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	C		5401 V	OGEL RD, STE 110			
EPIC HE	ALTH SERVICES			EVANS	VILLE, IN 47715			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF COL			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	*	ervention that are not			Executive Director or designat	ed		
	resolved. The pl	an of care failed to			person will be responsible for review of completion prior to			
	specify specific	vital sign parameters.			employee placement with a			
					patient. 10% of files will be			
	F. The cl	inical record #4 included			reviewed each quarter			
	a plan of care es				for completeness by the ED or	-		
	*	e certification period			designee for a minimum of 2			
	* *	•			quarters.			
4/28/17 through 6/26/17 with orders to provide HHA services 2-4 hours a day for				10% of all new administrative staff personal files will be audi	tad			
	2-4 days a week of unskilled care. The plan of care failed to specify a duration for services.				for evidence of documented jo			
					specific orientation. The			
					Executive Director or designat	ed		
					person will be responsible for			
					review of completion prior to			
	G. The plan	of care for clinical record			employee placement with a			
	#4 included orde	ers/goals for the patient to			patient. 10% of files will be reviewed each quarter			
	maintain adequa	te cardiac output as			for completeness by the ED for	ra		
	•	R (heart rate) within			minimum of 2 quarters.			
	1	ers and no s/s (signs or			A process of reviewing all dire	ct		
	•	ardiac failure. The plan of			care staff files, prior to placem	ent		
		ecify specific vital sign			with a patient for the	:		
	_	cerry specific vital sign			appropriate physical examinat dated within 180 days is prese			
	parameters				in the personal file before			
	0 771 1				providing patient care was			
		rator failed to ensure			initiated on 6/15/17 and will be			
		es were supervised by a			ongoing. 10% of actively work	ing		
	health care profe	essional to ensure			direct care staff personal files			
	competent provi	sion of care in 1 out of 4			be reviewed each quarter for t	ne		
	(#1) records revi	iewed. Clinical record #1			presence of a physical examination dated within 180			
	failed to evidence	ee home health aide			days of direct patient care. Au	dits		
	supervisory visits were conducted every 2 weeks.				will be conducted for 2 quarter			
					Current employee files will be			
					audited and, if no physical is			
	9 The agency f	ailed to evidence an			present, the employee will obt	ain		
		hat supervisor visits will			a physical. The Executive Director will be responsible for	•		
		_			this going forward. Outstandir			
be done every 30 days, either when the				and going forward. Odistalluli	·9			

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PRINTED: 07/18/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 05/16/2017		
	PROVIDER OR SUPPLIER EALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 5401 VOGEL RD, STE 110 EVANSVILLE, IN 47715				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
	HHA is present or absent. The agency's policy titled Monitoring Patient Care 3-14, Rev. 10/2009, stated the frequency of care supervision is as follows: Frequency of on-site patient monitoring visits are conducted every 60 days for personal care aide/HHA services (provided in conjunction with skilled services) ** an aide must be present during the supervisory visit.		physicals will be completed by September 9, 2017. Moving forward, all new employees we have a qualifying physical priproviding care. The Executive Director or designated person be responsible for review of completion prior to employee placement with a patient. 10% files will be reviewed each quering for completeness by the ED forminimum of 2 quarters. A PICC line dressing change checklist process has been personated as of 6/12/17. Checklist to be completed every time at PICC dressing change is provided. 10% of check lists were be reviewed each quarter for completeness of hand hydrough pick will last for a period of quarters The Director of Nurwill be responsible for compliance through audit as mentioned above Administrator or Nursing Director will work with Regional to ensith that corporate compliance is aware of any law changes that require policy revision going forward.  Beginning 5/19/17, all new stresponsible for the developm of patient care plans, will received education regarding the need orders indicating duration of care and patient specific vital signs on every plan of care. Education will be provided during job specific orientation. 10% of all patient corientation. 10% of all patient	vill or to e n will % of earter for a  ut in t is  will giene es. 2 rsing  ctor sure at  aff, ent eive I for		

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PRINTED: 07/18/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING B. WING		00	COMPLETED 05/16/2017			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
EPIC HE	ALTH SERVICES			OGEL RD, STE 110 SVILLE, IN 47715		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X COMPLI	ETION
				charts will be audited quarterly the presence of duration and patient specific v/s. All applications will be educated as a how to properly complete a Plant of Care to include vital sign parameters and discipline frequency and duration. This be completed by September 92017. The Director of Nursing designated person will ensure compliance. Plans of Care wireviewed at 100% for complianx 2 months and then at 10% parameter thereafter. Administrator or Nursing Direct will work with Regional to ensuthat corporate compliance is aware of any law changes that require policy revision going forward. Any clinical team member responsible for supervisory viswill be required to have documentation of such supervision placed into the clinical file within 72 hours of completion. 10% off all patients' charts, receiving both skilled and unskilled care will be audited quarterly for quarters. The Director of Nursor designee will be responsible for completion. Results of all audits will be communicated to the Administrator ongoing upon the completion by the individual responsible for conducting the audit.  3. The Director of Nursing will	r for able to to the total	

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PRINTED: 07/18/2017 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 05/16/2017			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  5401 VOGEL RD, STE 110					
EPIC HE	ALTH SERVICES		EVANSVILLE, IN 47715					
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
				responsible for ensuring that a patient care related processes use are available for immediat review. Audits will be conducted by the Director of Nursing or designated clinician weekly of 10% of weekly charting per nur for a period no less than 2 quarters Review of nursing files for competencies prior to placemed with a patient will be conducted by the ED. The Executive Director will be responsible for review of all competencies prior to employee placement with a patient. 10% of files will be reviewed each quarter for completeness by the ED or designated person for a minimor of 2 quarters.  The regional nursing director vinsure that documentation for all administrator staff is place in personal files upon completion orientation. The executive direction will audit 10% of all new administrative staff personal files upon completion orientation. The executive direction will audit 10% of all new administrative staff personal files upon completion orientation. The executive direction administrative staff personal files upon to the designed will review files of director provided re-education. The ED designed will review files of director provided re-education. The ED designed will review files of director provided re-education. The ED designed will review files of director provided re-education apparent to employee placement of a patient. 10% of files will be responsible for review of all file prior to employee placement of a patient. 10% of files will be reviewed each quarter	s in te ed			

State Form Event ID: EF8U11 Facility ID: 014086 If continuation sheet Page 10 of 25

PRINTED: 07/18/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COMPLETED 05/16/2017				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  5401 VOGEL RD, STE 110					
EPIC HE	ALTH SERVICES		EVANSVILLE, IN 47715					
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE			
N 0460	410 IAC 17-12-1(g			for completeness by the ED of designated person for a minim of 2 quarters. ED will conduct audits. Re-education to employee B was provided by the Regional Nursing Director. Administator and Nursing Director and audits will be provided by the Director of Nursing. Administator and Nursing Director of Nursing. Administator and Nursing Director of Nursing. ND will also complete audits. The administrator will be responsible for review of all audits and the initiation of fur process implementation for less than compliant results 4. 6/16/17	ector ector the so			
Bldg. 00	Home health agen administration/mar	су						
	records of the supunder subsection (1) Be kept currer (2) Include a copy (A) Limited crimir 16-27-2.  (B) Nursing licens (C) Annual performance of the supunder subsection (C)	ervising nurse, appointed d) of this rule, shall: tt. of the following: all history pursuant to IC						

State Form Event ID: EF8U11 Facility ID: 014086 If continuation sheet Page 11 of 25

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING OO			(X3) DATE SURVEY  COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00  B. WING			COMPLETED 05/16/2017	
			B. W			05/16/	2017
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
					OGEL RD, STE 110		
EPIC HE	ALTH SERVICES			EVANS	SVILLE, IN 47715		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		uations required by this					
	subsection must be performed every nine (9) to fifteen (15) months of active						
	employment.	nontris of active					
			N <sub>0</sub>	460			06/16/2017
	Based on person	nel record review and					
	•	ency failed to include					
	_	of orientation to the job			1. Administrator, director of nursin	g	
		•			and executive director all received		
	`	mployees A, B, and E)			job specific orientation on 1/4/17,		
	personnel files reviewed.				but documentation was not in personal file during time of survey.		
					Evidence of such orientation was		
	Findings include:				placed into each personal file on		
					6/16/17. Moving forward, the ED		
	1. Personnel re	cord A was reviewed on			and/ or ND will ensure that all		
	5/16/17 and faile	ed to evidence job			positions receive proper job specifi	С	
	orientation docu	mentation for the			orientation. 10% of all files will be		
	Executive Direc	tor.			audited quarterly for a minimum o	f	
					2 quarters		
	2. Personnel rec	ord B was reviewed on			2. 10% of all new administrative sta	off	
	5/16/17 and faile	ed to evidence job			personal files will be audited for th		
		mentation for the			documentation evidencing job		
	Director of Nurs	ing.			specific orientation upon its		
		<u>~</u>			completion. the ED and/ or ND will		
	3. Personnel red	ord E was reviewed on			ensure that all positions receive		
		ed to evidence job			proper job specific orientation. 10		
		mentation for the			of all files will be audited quarterly		
	Administrator.	invitation for the			for a minimum of 2 quarters		
	Administrator.				3. The regional nursing director wil	I	
	1 In an intervie	yy with amployee A and			insure that documentation of job		
		w with employee A and			specific orientation for the		
	employee B on 3				Administrator and Director of		
	employees was able to provide additional				Nursing is placed in their personne	l	
		arding job orientation			files upon completion of orientatio	n.	
		for employee (A, B, and			The Director of Nursing and/or		
	E) personnel rec	ords.			Executive Director will ensure that		
					all other administrative staff will		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED		
			B. WING		05/16/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
				OGEL RD, STE 110	
EPIC HE	ALTH SERVICES		EVAN	SVILLE, IN 47715	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEPICIENCY)		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	<u> </u>	DATE
				receive job specific orientation and evidence of this orientation will be	
				placed in their personnel file. The	
				executive director will audit 10% of	
				all new administrative staff persona	
				files within 30 days of hire for the	
				documentation evidencing job	
				specific orientation upon its	
				completion	
				4. 6/16/17	
N 0462	410 IAC 17-12-1(h	1)			
	Home health agen				
Bldg. 00	administration/mai	•			
		Each employee who will			
		contact shall have a			
		ion by a physician or nurse re than one hundred			
	•	before the date that the			
		ct patient contact. The			
		ion shall be of sufficient			
	•	at the employee will not			
	spread infectious of to patients.	or communicable diseases			
	•	review and interview,	N 0462	1. Reeducation was provided to	06/15/2017
		to ensure personnel files	110102	executive director regarding the	00/10/2017
	• •	cal examination not more		need for physical examination for al	ı
		ior to direct patient		direct care staff to be present in the	1
		2 direct care givers		personal file, dated no more than	
		•		180 days prior to direct patient	
	-	records were reviewed		contact, before providing paitent	
	(Employee B).			care. (Regardless of transfer from parent agency to	
	P. J. J. J.			the independent agency). This	
	Findings include	•		education was provided on	
	1 D 100	CF 1 D		6/15/17. Current employee file	<b> </b>
	Personnel file	of Employee B was		will be audited and, if no physi	cal

State Form Event ID: EF8U11 Facility ID: 014086 If continuation sheet Page 13 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>			COMPLETED	
			B. Wl	NG		05/16/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OGEL RD, STE 110		
EDIC DE	ALTH SERVICES				VILLE, IN 47715		
EPIC HE	ALTH SERVICES			EVANS	VILLE, IN 477 15		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed and ev	idenced the individual			is present, the employee will		
	had been hired o	n 2/26/17 as a RN,			obtain a physical. The Execut		
		ing, first date of patient			Director will be responsible for		
		The file evidenced a			this going forward. Outstandir	•	
					physicals will be completed by	'	
		ation by a physician			September 9, 2017. Moving forward, all new employees wi	11	
	dated 2/4/15, 2 y	rears before the date of			have a qualifying physical prio		
	first patient cont	act.			providing care. The Executive		
					Director or designated person		
	2. In an intervie	w with the Executive			be responsible for review of		
		/17 s/he stated the			completion prior to employee		
					placement with a patient. 10%	of	
		ation provided was from			files will be reviewed each qua	arter	
	previous employ	ment at the parent			for completeness by the ED fo	r a	
	agency and no en	mployee physical had			minimum of 2 quarters.		
	been completed	for this agency.					
	•	5 3			2. A process of reviewing all direct		
					care staff files, prior to placement		
					with a patient for the		
					appropriate physical examination		
					dated within 180 days is present in		
					the personal file before providing		
					patient care was initiated on		
					6/15/17 and will be ongoing.		
					10% of actively working direct care		
					staff personal files will be		
					reviewed each quarter for the		
					presence of a physical examination		
					dated within 180 days of direct		
					patient care. Audits will be		
					conducted for 2 quarters. Current employee files will be audited		
					and, if no physical is present,	the	
					employee will obtain a physica		
					The Executive Director will be	41.	
					responsible for this going		
					forward. Outstanding physical	ls	
					will be completed by Septemb		
					9, 2017. Moving forward, all n		
					employees will have a qualifyi		
			1				

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		IDENTIFICATION NUMBER:	A. BUILDING 00  B. WING		COMPLETED 05/16/2017		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  5401 VOGEL RD, STE 110				
EPIC HE	ALTH SERVICES		EVANSVILLE, IN 47715				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тЕ	(X5) COMPLETION DATE	
				physical prior to providing care The Executive Director or designated person will be responsible for review of completion prior to employee placement with a patient. 10% files will be reviewed each qua for completeness by the ED for minimum of 2 quarters. 3. Regional nursing director provided re-education to the E and ND. The ED will review fi of direct care staff, prior to the staff member providing patient care. ED will conduct audits on every newly on boarded staff member, random monthly aud on current staff members as w as quarterly audits by the inter compliance team 4. 6/15/17	of arter or a ID des t n		
N 0470 Bldg. 00	shall be written an control of commun	cy nagement Policies and procedures d implemented for the					
	Based on observation interview the age complied with the	ation, policy review, and ency failed to ensure staff e agency's policy for 1 of 2 (#3) home visit	N 0470	1. Employee B received re-education about hand hygie during PICC dressing change 6/12/17. Routine hand hygiene will be added to the Agency onboarding process by 6/30/1 and evidence of education to a field nurses working with IV clients will be placed in each personnel file. The Director of	ene on e 7 all	06/12/2017	

State Form Event ID: EF8U11 Facility ID: 014086 If continuation sheet Page 15 of 25

	OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/16/2017
	PROVIDER OR SUPPLIER ALTH SERVICES	5401 V	ADDRESS, CITY, STATE, ZIP CODE OGEL RD, STE 110 SVILLE, IN 47715	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1. During a home visit on 5/15/17 at 5:30pm, employee B, an RN was	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Nursing will be responsible fo completion and ongoing compliance by verifying	DATE
	observed while providing care to patient #3. The RN applied and removed gloves but failed to perform hygiene while performing a peripherally inserted central catherter (PICC) dressing change.  2. An undated agency policy titled, Hand Washing N-130 stated that the CDC (Center for Disease Control) recommends hand washing before and after handling dressings or touching open wounds.  3. In an interview with the Director of		completion for any and all nur who work with infusion cases 2. A PICC line dressing chang checklist process has been propleted as of 6/12/17. Checklist to be completed every time a PICC dressing change is provided. 10% of checklists who be reviewed each quarter for completeness of hand hygoduring PICC dressing change Audits will be conducted for 2 quarters. A process of review all nursing files, prior to placement with a patient for the	ge ut in is ill iene s.
	Nursing on 5/16/17 at 11am s/he a policy on hand hygiene that is utilized by the agency which indicated that hand hygiene is done prior to and after any contact with tubing, ports, dressings, infusion fluids, and the patient. The policy on Infection Prevention and Control the agency utilized stated gloves do not replace the need for hand washing or alcohol gel use.		appropriate competencies wa initiated on 6/12/17 and will be ongoing. 10% of actively work nursing personnel files will be reviewed each quarter for appropriate nursing competencies based on the patients they care for. Audits last for a period of 2 quarters. The Director of Nurs will be responsible for compliance through audit as mentioned above.  3. Re-education to employee was provided by the Regional Nursing Director. Audits will be completed by the ED.  4. 6/12/16	e king will sing B

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COMPLETED 05/16/2017	
	PROVIDER OR SUPPLIEF		5401 V	ADDRESS, CITY, STATE, ZIP CODE OGEL RD, STE 110 SVILLE, IN 47715	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
N 0488 Bldg. 00	must develop and requiring a notice the patient, the partient, the partient's care at least before the services (j) The five (5) das subsection (i) of the following circus (1) The health, see home health agent at immediate and health agency corto the patient. (2) The patient reagency's services (3) The patient reagency's services (3) The patient's reimbursable base reimbursement rehealth agency inforcommunity resour following discharg (4) The patient no regulatory criteria, physician's order,	nce improvement A home health agency implement a policy of discharge of service to tient's legal representative, responsible for the east five (5) calendar days is are stopped.  y period described in his rule does not apply in mstances: Ifety, and/or welfare of the cy's employees would be significant risk if the home tinued to provide services  fuses the home health  services are no longer ed on applicable quirements and the home forms the patient of ces to assist the patient e; or longer meets applicable			
	discharge.  Based on policy agency failed to discharge policy before services a Findings Include		N 0488	1. Policy titled Termination of Services Against the Family's Wishes 3-22, will be revised to include a 15 day notice before services are stopped. Revisio will be in place by 6/16/17.  2. Administrator or Nursing Director will work with Region ensure that corporate compliatis aware of any law changes to	al to

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLE			ETED	
			B. WI	NG		05/16/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OGEL RD, STE 110		
EDIC HE	ALTH SERVICES				VILLE, IN 47715		
LFICTIL/	ALTIT SERVICES			EVANS	VILLE, IN 477 15		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Services Against	the Family's Wishes			require policy revision going		
	3-22, Rev. 10/20	09 stated that			forward.		
	notification will	be provided to the family			3.Administator and Nursing Director 4. 6/16/17		
		ss than 72 hours prior to					
	<del>-</del>	of service, exempt when			4. 0/10/17		
		•					
		liate jeopardy or the					
	physician refuses	s orders to continue care.					
	2. In an interview	w with the Executive					
	Director and Dire	ector of					
	Nursing/alternate administrator on						
	•	m, neither was able to					
	•	t discharge policy stating					
	•						
	the 15 day notice	e before services were .					
N 0524	410 IAC 17-13-1(a	a)(1)					
	Patient Care						
Bldg. 00		1) As follows, the medical					
	plan of care shall:						
		in consultation with the					
	home health agen						
	skilled service is b	vices to be provided if a					
	(B) Cover all perti						
	(C) Include the fol						
	(i) Mental statu						
		vices and equipment					
	required.						
		nd duration of visits.					
	(iv) Prognosis.						
	(v) Rehabilitatio	•					
	<ul><li>(vi) Functional lir</li><li>(vii) Activities per</li></ul>						
	(viii) Nutritional re						
		and treatments.					
		neasures to protect					
		•					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u>		COMPLETED	
			B. W	ING		05/16/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIEF	R			OGEL RD, STE 110		
EDIC HE	ALTH SERVICES				VILLE, IN 47715		
	ALITIOLITYICLO			LVANS			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	referral.	for timely discharge or dalities specifying length of					
		onronriate items					
	review, and interensure that all poincluded on the pincluded on the pincluded.  1. Clinical recordate 4/21/17, certhrough 6/19/17 and included a hand assignment registered nurse,  A. The clinit of care establish the certification 6/19/17 with ord (home health aid day for 2-4 days and provide skill times a week on	al record review, policy rview the agency failed to ertinent information was plan of care in 4 out of 4 cords reviewed.  e:  d #1, SOC (start of care) rtification period 4/21/17 was reviewed on 5/15/17 ome health plan of care completed by the	N 0	524	1. On 5/19/16, the care plans of patients #1, 2 and 4 were updated by obtaining orders for their physicians, clarifying that duration of ordered care indicated on the plans of care was for 60 days. On 5/19/17, the care plated of patients #1, 2, 3 and 4 were updated by obtaining orders for their physicians, clarifying patis specific vital sign parameters. applicable clinicians will be educated as to how to properly complete a Plan of Care to include vital sign parameters adiscipline frequency and duration. This will be complete by September 9, 2017 with oversight by the Director of Nursing.  2.Beginning 5/19/17, all applicable clinicians will be educated as thow to properly complete a Plate of Care to include vital sign parameters and discipline frequency and duration. This will be completed by September 9 2017. The Director of Nursing designated person will ensure compliance. Plans of Care will reviewed at 100% for compliant x 2 months and then at 10% properly control of the properly and duration.	om the ated ons ens ent All y and ed es to an will for libe ance er	05/19/2017

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PRINTED: 07/18/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00  B. WING			COMPLETED 05/16/2017	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE OGEL RD, STE 110		
EPIC HE	ALTH SERVICES			EVANS			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	for "vital sign parageter (skilled nurse) to (registered nurse) (temperature), P (respiration) outsigneater than 30-6 failed to specify parameters.  C. In an intenursing on 5/16/provide addition vital sign parameter by the physician and was unaward services need to of care.  2. Clinical record certification periods was reviewed on home health plan completed by the 5/3/17.  A. The clinical force established the certification of care established the certification of 7/1/17 with order services 2-4 hour week of unskilled.	of care included orders rameters" and for SN onotify MD and/or RN onotify MD and/or RN of supervisor for a T (pulse), and R side of listed parameters on minutes. The agency the specific vital sign rview with the director of 17, s/he was unable to al information as to why eters was not established on the start of care date especific duration for be included on the plan of 5/3/17 through 7/1/17 of 5/15/17 and included a n of care and assignment especial record included a plan ed by the physician for period 5/3/17 through rs to provide HHA rs a day for 2-4 days a d care. The agency failed iffic duration for services.			4, 5/19/17		

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		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 05/16/2017
	ROVIDER OR SUPPLIER		5401 V	ADDRESS, CITY, STATE, ZIP CODE OGEL RD, STE 110 SVILLE, IN 47715	
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	for "vital sign pa	of care included orders rameters" (patient ency failed to specify parameters.			
	nursing on 5/16/2 provide additional vital sign parametry by the physician The director of n	rview with the director of 17, s/he was unable to all information as to why eters was not established at the start of care date. ursing was unaware of services need to be blan of care.			
	certification period 5/28/17 was revi- included a home	1 #3, SOC date 3/30/17, od 3/30/17 through ewed on 5/15/17 and health plan of care and pleted by the registered 17.			
	of care established the certification process of the certification process of the certification parameters. It is parameters of the certification patient of the certification of	•			
	B. In an inte	rview with the director of			

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	OF CORRECTION	IDENTIFICATION NUMBER:	ì í	JILDING ING	<u>00</u>	COMPI 05/16.	LETED	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5401 VOGEL RD, STE 110					
EPIC HE	ALTH SERVICES				VILLE, IN 47715			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
TAG	nursing on 5/16/2 provide additional vital sign parametric by the physician  4. Clinical record certification period/26/17 was revisincluded a home assignment compourse, dated 4/28  A. The clinical of care established the certification period/26/17 with ord services 2-4 hour week of unskilled to specify a specific specify a specific vital sign of the certification period/26/17 with ord services 2-4 hour week of unskilled to specify a specific vital sign orders/goals for the adequate cardiace that the certification period/26/17 with ord services 2-4 hour week of unskilled to specify a specific vital sign orders/goals for the adequate cardiace that the certification of the certification period/26/17 with orders/goals for the certification period/26/17 with orders/go	17, s/he was unable to al information as to why eters were not established at the start of care date.  1 #4, SOC date 4/28/17, od 4/28/17 through ewed on 5/15/17 and health plan of care and oleted by the registered 6/17.  cal record included a plan ed by the physician for period 4/28/17 through ers to provide HHA as a day for 2-4 days a d care. The agency failed iffic duration for services.  of care included the patient to maintain output as evidenced by within ordered parameters or symptoms) of cardiac cry failed to specify		TAG	DEFICIENCY)		DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING <u>00</u> CO		COMPL	ETED
			B. WI	NG		05/16/2017	
NAME OF B	DOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		5401 VOGEL RD, STE 110				
	ALTH SERVICES		EVANSVILLE, IN 47715				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG	DLI ICILIACI )		DATE
N 0584	410 IAC 17-14-1(g						
Pida 00	Scope of Services	Home health aides shall					
Bldg. 00	\ <b>O</b> /	a health care professional					
		ent provision of care.					
	•	vices must be within the					
	scope of practice of						
		ding the supervision.	N 05	501	1. On 5/15/17, evidence of hor	me	05/16/2017
		l record review, policy	14 03	J <b>04</b>	health aide supervision every		03/10/2017
	· ·	view the agency failed to			weeks was placed into clinical		
	ensure home hea				record #1. The supervisory vis		
	-	nealth care professional			had been completed on 5/2/17	-	
	•	tent provision of care in			but the documentation was no found during the survey. Movin		
	1 out of 4 (#1) re	ecords reviewed.			forward, 10% of applicable cha	arts	
	Findings include	:			will be audited each quarter to ensure compliance. The Direct of Nursing or designee will be		
	Clinical recor	d #1 was reviewed on			responsible for the audits		
		ed to evidence home			2. Any clinical team member	vito	
		visory visits were			responsible for supervisory vis will be required to have	sitS,	
	conducted every	-			documentation of such		
					supervision placed into the		
	B A policy title	d Monitoring Patient			clinical file within 72 hours of		
		the frequency of care			completion. 10% off all		
		follows: Frequency of			patients' charts, receiving both skilled and unskilled care		
	-	onitoring visits is every			will be audited quarterly for q 2		
	•	onal care aide/HHA			week supervisory visits, x 2		
	•	ed in conjunction with			quarters. The Director of Nurs		
	-	tu in conjunction with			or designee will be responsible	Э	
	skilled services.				for the audits		
	C. In an intent	5/1//17 -/ 120 DM			3. Education will be provided to	ру	
		ew on 5/16/17 at 130 PM,			the Director of Nursing. 10% o	-	
	the Executive Di	rector and Director of			all patients' charts, receiving		

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AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 05/16/2017			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 5401 VOGEL RD, STE 110 EVANSVILLE, IN 47715				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	unable to eviden supervisory visit	te administrator were ce documentation that s were conducted every 2 ance agency policy.		both skilled and unskilled care will be audited quarterly for q week supervisory visits, x 2 quarters. The Director of Nursor designee will be responsib for the audits 4. 5/16/17	2 sing		
N 0606 Bldg. 00	therapist in therap the initial visit to the make a supervisor (30) days, either w is present or abse assess relationshi whether goals are Based on policy agency failed to supervisory visit days, either where absent.  Findings include  1. The policy tit Care 3-14, Rev. frequency of care follows: Frequency monitoring visits days for persona (provided in con	A registered nurse, or y only cases, shall make be patient's residence and ry visit at least every thirty when the home health aide not, to observe the care, to ps, and to determine being met.  Treview and interview the evidence a policy that is will be done every 30 in the HHA is present or  Eled Monitoring Patient 10/2009, stated the expervision is as a pacy of on-site patient are conducted every 60 in care aide/HHA services igunction with skilled ide must be present	N 0606	1. Policy titled Monitoring Pat Care 3-14, will be revised to sthat non-skilled supervisory will be conducted every 30 dainstead of every 60 days. Revision will be in place by 6/16/17.  2. Administrator or Nursing Director will work with Region ensure that corporate complia is aware of any law changes require policy revision going forward.  3. Administator and Nursing Director  4. 6/16/17	state isits ays, all to ance		
	2. Indiana Law s	states "a registered nurse					

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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>		00	COMPLETED		
			B. WING			05/16	/2017	
NAME OF T		STF	EET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
NAME OF PROVIDER OR SUPPLIER			54	5401 VOGEL RD, STE 110				
EPIC HEALTH SERVICES			EV	EVANSVILLE, IN 47715				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE	
	, or therapist only cases, shall make the							
	initial visit to the							
	make a supervisory visit at least every							
	thirty (30) days, either when the home							
	health aide is present or absent, to							
	observe the care, to assess relationships,							
	and to determine whether goals are being							
	met. (Indiana State Department of							
	Health; 410 IAC 17-14-1)."							
	3. In an interview with the Executive							
	Director and Director of Nursing on							
	5/16/17 at 1:30pm, both were unaware							
	the agency policy stated that non-skilled							
	supervisory visits are to be conducted							
	every 60 days in	stead of 30 days.						
l			1				1	

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