STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CO A. BUILDING B. WING	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD DGWOOD CT IO, IN 46902	<b>-</b>
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE COMPLETION
TAG G 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE
Bldg. 00	survey with three (3) This survey was an	nounced as fully extended on	G 0000		
	IN00212618; substa IN00277902; substa	antiated with findings antiated with findings antiated with findings			
	Facility #: 012928 Provider #: 15K09				
	Medicaid #: 20109	1400			
	Survey dates: Febr 26; 2019	uary 15, 18, 19, 20, 21, 22, 25,			
	Skilled Services: 2 Home Health Aide Unduplicated Censo	-			
	Record reviews with Record review with Discharged record reviews Focused record reviews Total clinical record	nout home visits: 14 reviews: 6 iews: 10			
	providing its own h competency evalua years beginning Fel 2021 for being four	neare, LLC is precluded from some health aide training and tion program for a period of 2 bruary 26, 2019 to February 26, and out of compliance with the cipation 484.55 Comprehensive			

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 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/26/2019			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION		
	Assessment of Patie coordination, qualit	ents, and 484.60 Careplanning, y of care.					
G 0372							
Bldg. 00	failed to submit OA information set) wit completion for 3 of OASIS submissions  Findings include:  1. An agency policy "Completing the Costated "Once OASIS accurately and refle of assessment, the Completed form to the (ACM) for review. complete ACM will the administrative be electronically transmedicare and medic completion of the policy of the polic	y dated 1/14/19, titled omprehensive assessment," S assessment is completed ct the patient's status at time CM [case manager] will turn in he assistant clinical manager After review and approval is deliver completed OASIS to iilling specialist to encode and mit to CMS [centers for raid] within 30 days of atient assessment"  and of patient #2 was reviewed ed a start of care date of d failed to evidence that OASIS d within 30 days of competion  recertification was completed ASIS submission was not	G 0372	Agency CM will complete the patient OASIS assessment a submit to the Assistant Clinic Manager (ACM) for review. The ACM has approved the completed OASIS, the ACM submit the OASIS to the CM print the verification report. The ACM will be kept in the OA report binder in the ACM offer The ACM will ensure the OA submitted within 30 days of completing the assessment beneficiary. The Administrate ensure the completion and submission of OASIS per the agency policy by reviewing to OASIS report binder weekly verifying the completion and submission of OASIS was done appropriate timeline.	and cal After  will IS and The SIS ice. ASIS is of the tor will e the and		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MUL' A. BUIL B. WINC	DING	NSTRUCTION  00	(X3) DATE ( COMPL <b>02/26</b> /	ETED
	PROVIDER OR SUPPLIER			1817 DC	DDRESS, CITY, STATE, ZIP COD OGWOOD CT O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	completed until 7/2	5/18.					
		recertification was completed ASIS submission was not 0/19.					
		DASIS submission was not /19.					
	2/22/19 and indicat The record failed to	ord of patient #8 was reviewed ed a start of care date of 3/9/18. evidence that OASIS d within 30 days of competion					
		start of care was completed on IS submission was not 5/18.					
		recertification was completed ASIS submission was not 5/18.					
		ord of patient #9 was reviewed ed a start of care date of 9/2/18.					
		start of care was completed on IS submission was not 0/19.					
		recertification was completed ASIS submission was not /19.					
	employee B, billing agency should be so	riew on 2/26/19 at 1:56 PM, g specialist, stated that the abmitting OASIS data within stered nurse completing the					

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04/03/2019 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15K094 B. WING 02/26/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1817 DOGWOOD CT SCOTT'S HOME HEALTHCARE LLC **KOKOMO. IN 46902** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE G 0438 Bldg. 00 G 0438 The agency will ensure all patient 03/28/2019 Based on observation, record review and clinical records are kept interview, the agency administrator failed to confidential. For field employees ensure a confidential clinical record was specifically, the agency will maintained for 1 of 1 home visits observed enforce the policy titled "Computer utilizing electronic documentation (#1). Terminals/Workstations/Hand Held Devices," specifically #3 of Findings include: said policy stating "A user may not leave his/her workstation, An agency policy dated 1/10/19, titled "HIPAA terminal or hand held device [health insurance portability and accountability unattended for periods of time (e.g. act] Administrative Policies and Procedures." breaks, lunch, meetings, etc) Policy # 113.00 stated "...Purpose: To ensure unless the terminal or device compliance with HIPAA regulations and screen is cleared and the user is guidelines and to provide protection for protected logged off." #4 A user must clear patient information ...." the terminal and device screen if the workstation or terminal is left During an observation on 2/18/19 at 8:00 AM, unattended. All field staff will be in employee D, home health aide (HHA), was serviced by 3/28/19 on confidential observed assisting with personal care with patient clinical records. The agency's #1. After completion of care employee D swiped field staff will be required to lock the screen on her cell phone (no lock on her cell their hand held device per the phone) and went into the agency's software above mentioned policy and program to begin charting and the visit note was specifically #8 Hand held devices observed. A username and password was must have a security pass required to get into the agency's software code/word, screen lock or finger program. Employee D went in and out of the print lock enabled on the lock agency's software program three times. Each time screen. The field staff is to lock employee D would go back into the app, the app their screen any time their device did not have her re-enter the username and is not actively in use by the field password, but rather took her back to the same staff. The field staff will complete screen that it had been left on. The agency failed the home health aide note by to ensure staff protected the electronic clinical marking the completed tasks, record against unauthorized use by documenting receive the patients signature for on unlocked personal cell phones and the system verification of tasks and depart did not require username and passwords to be from the electronic home health re-entered when leaving the agency software aide note. The field staff will only

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PRINTED: 04/03/2019 FORM APPROVED OMB NO. 0938-039

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	A. BUILDING B. WING	<u>00</u>	COMPLETED 02/26/2019		
	OVIDER OR SUPPLIER	ARE LLC	STREET ADDRESS, CITY, STATE, ZIP COD  1817 DOGWOOD CT  KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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)	TE	(X5) COMPLETION DATE	
	During an interview employee D was ask could pick her phone clinical record and sididn't know it did the During an interview administrator stated main agency softwar	on 2/18/19 at 9:00 AM, ted if she realized that anyone to up and get into the patient's the stated, "That's not good, I at."  on 2/18/19 at 1:59 PM, the that she would have to call the program company about supposed to have staff		be on their hand held device of this time and will lock their device when they are not actively completing their home health anote. The in service record wikept in the employees file to ensure completion. The Administrator will ensure all file staff were in serviced by nursi staff by reviewing the complete service log. All new field employees will be trained on proper HIPAA procedures and the above mentioned policy proper to FPC. The agency will not reconsure employee electronic decises cured and will utilize this process to guarantee patient medical information is kept confidential. The case manage will monitor compliance by checking aide phone and if it is locked when not in use at supervisory visit. CM will also educate about hand held devices needed and at supervisory concerning locking screen and HIPAA. This will be added as of the supervisory visits will be audit by ACM or other RN delegate compliance.	vice aide aide aide aide aide aide aide aid		
		iew and interview, the agency to investigate and document	G 0480	The Client/Grievance Incident recreated to show the details of the grievance process from		03/28/2019	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMP	E SURVEY PLETED 6/2019	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD  1817 DOGWOOD CT  KOKOMO, IN 46902				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF complete complaint complaint investiga  Findings include:  1. An agency polic Grievance / Inciden Family Grievance reviewing and resol concerns is based o rights and responsit evidence that the co- investigated.  2. The clinical reco- on 02/20/19 and inc 9/12/18. An agency Incident Form" data employee report of The "Resolution / O 10/20/16 indicated from the employee possible bed bugs in up with patient" Th	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION investigations for 2 of 2 tions reviewed (#9, 12).  y dated 1/10/18, titled Client t Process," stated " Client / Incident Policy for receiving, ving complaints and / or in the premises of the patient's polities" The policy failed to	ID PREFIX TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  initiation to resolution will be as follows: Dat Grievance/Incident re Grievance Filed by, Ir complaint pertains to, grievance, Employee investigating complain investigation, Time fra investigation, patient resolution and follow resolution was comple Administrator to revie complaints and deleg resolution. The Admi review completed cor in its entirety to ensur is acceptable and all correctly completed a The Administrative Bi Specialist to keep all Grievance/Incident fo in the Administrative I All agency staff will be by 3/28/19 to educate updated Client/Grieva	E APPROPRIATE  The format te eceived, adividual, Details of (s) ame of notification of up to ensure eted. The ew all late inistrator to implaint form re resolution sections and resolved. Elling completed orms in a log Billing office. e in serviced e on the	(X5) COMPLETION DATE	
	2/25/19 and indicat agency document ti Form" dated 6/18/1 phoned in a concern another HHA signe a visit. The "Resol- incident dated 6/19/ resources employee sign for a client. If Immediately! Aide / incident failed to 6	ord of patient #12 was reviewed ed a start date of 10/4/16. An tled "Grievance / Incident 8 indicated an employee of for patient #12 that regarded d patient #12's signature after ation / Counseling" of the (18 indicated "HR [human et W] counseled aide to never can't sign to call the office. understood" The grievance evidence a through patient follow up in regards to		form process.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		` ′	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED	
		15K094	B. Wl	NG		02/26/	2019
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
	incident.						
	administrator stated /counseling" area of	the complaint was the ated it "could be more					
G 0510							
Bldg. 00	Registered Nurse (Rassessment within 4 G514); failed to ens comprehensive asse G526); failed to ensidentified in the contag G530); failed to interactions were id indications for PRN tag G536); failed to was updated and incassessment (see tag Resumption of Care performed after hos.  The cumulative efferesulted in the agency with the Condition of	riew and interview, the RN) failed to complete the inital 8 hours of referral (see tag ure contents of the ssment was accurate (see tag ure patient goals were aprehensive assessment (see ensure all drug to drug entified and failed to specify (as needed medication) (see to ensure all current information cluded in the comprehensive G544) and failed to ensure a cassessment (ROC) was pitalization (see tag G548).  The sect of this systemic problem be being out of compliance of Participation 42 CFR 484.55 tessment of Patients.	G 0	510	The agency will ensure the init assessment is completed within 48 hours of the referral date at the comprehensive assessment completed within 5 days of the referral. The ACM will receive patient referral, assign the CM ensure the patient was contact and the initial assessment is stup and completed within 48 hours. The CM will document the clinical note the date and to the patient was contacted and date and time the initial assessment meeting is scheduled. The ACM reviews documentation by the CM and we review the clinical note and utilithis system as a tracking resource and timeline for the referral to admission process. CM will receive an order from MD if the patient is appropriate services and the Comprehensing Assessment will be completed within 5 days of the referral.	in and the and ted et on ime the all will lize  The effor ive	03/28/2019
					within 5 days of the referral. T ACM will ensure the timeline is executed and oversee the process. The Administrator wi	3	

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

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15K094	B. W	ING		02/26/2019	
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				OGWOOD CT		
SCOTTIC	S HOME HEALTHC	ADELLO			MO, IN 46902		
300113	TIOWE HEALING			KOKON			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					meet daily with the ACM to rev	view	
					the status of referrals to ensur	e	
					the initial assessment and		
					admission of patients is		
					completed in the regulated tim	ne	
					frame. All clinical staff to be		
					retrained on patient referral		
					timelines by 3/28/19. Once th	е	
					comprehensive assessment is	3	
					completed upon admission, th	е	
					ACM will review for content ar	nd	
					accuracy. The CM will review	the	
					medical diagnosis of the patie	nt	
					and create goals for the medic	cal	
					diagnosis to support the		
					assessment findings. The CM	1 will	
					also ensure the patient		
					participates in creating a goal(	(s)	
					that they want to achieve. The	е	
					CM will run drug to drug		
					interactions on all patient iden	tified	
					medications. The CM will use		
					drugs.com to ensure the		
					interactions are properly		
					identified. Any interactions wi	ll be	
					reported to the MD with follow		
					instructions requested. All		
					instructions to be documented	l in	
					the clinical chart and medication	ons	
					updated per MD order if		
					applicable. The patient educa	ition	
					will be documented in the nurs	se	
					assessment and any follow up	)	
					education and or instructions t	to be	
					documented in a clinical note	in	
					the medical chart. The ACM to	)	
					review all assessments includ	ing	
					the medication interactions an	_	
					ensure interactions are reporte	ed	

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with MD orders received and

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039	
	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/26/2019	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD			
SCOTT'S	HOME HEALTHO	ARE LLC	KOKOI	MO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY 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)	NTE .	(X5) COMPLETION DATE	
G 0514				patient education conducted. ACM will utilize the admission recertification audit checklist the ensure all mandatory requirer are completed by CM. All PR medications will be reviewed a must have documented indications for use in patient understood verbiage. The CM to review a findings from the current certification period in the clinic chart and address each item to occurred in the comprehensive assessment along with the resolution. A patient that has been hospitalized for 24 hours be placed on hold per MD ord. The CM will complete a resumption of care assessment the patient before resuming agency services. The ACM will meet daily with the clinical state and review the status of each patient in order to ensure proper procedures are followed regains resumption of care.	a and o ments N and ations all cal that re s will der. nt on vill		
Bldg. 00							
Siag. 00	Registered Nurse ( initial admission as	view and interview, the RN) failed to complete the ssessment within 48 hours of records reviewed (#1).	G 0514	The agency will ensure the initial assessment is completed with 48 hours of the referral date at the comprehensive assessment completed within 5 days of the referral. The ACM will receive patient referral, assign the CM	nin and ent e e the	03/28/2019	

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An agency policy dated 1/13/18, titled

"Admission Policy and Procedure," stated "... The

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ensure the patient was contacted

and the initial assessment is set

up and completed within 48

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/26/2019				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	DATE			
	assessment within 4	igned to complete initial 8 hours in order to evaluate		hours. The CM will document the clinical note the date and the patient was contacted and date and time the initial	time			
	2/18/19 and indicate 3/21/18.	of patient #1 was reviewed ed a start of care date of		assessment meeting is scheduled. The ACM reviews documentation by the CM an review the clinical note and ut	will			
	on 3/7/18 by an unk	/ intake form was completed mown employee. assessment," was completed		this system as a tracking resource and timeline for the referral to admission process.  CM will receive an order from				
	the initial assessmen	N. The RN failed to complete nt within 48 hours of referral.		MD if the patient is appropriat services and the Comprehens Assessment will be completed within 5 days of the referral.	ive I			
	administrator stated admission within 48 to admit a patient and initial and the comp	the agency would set up the 8 hours, but the RN had 5 days and they would complete the rehensive assessments on the		ACM will ensure the timeline in executed and oversee the process. The Administrator with meet daily with the ACM to re	s ill view			
	same day.			the status of referrals to ensure the initial assessment and admission of patients is completed in the regulated time frame. All clinical staff to be				
				retrained on patient referral timelines by 3/28/19. Once the comprehensive assessment is completed upon admission, the	S .			
				ACM will review for content ar accuracy. The CM will review medical diagnosis of the patie and create goals for the medic	nd the nt			
				diagnosis to support the assessment findings. The CN also ensure the patient participates in creating a goal	1 will			
				that they want to achieve. The CM will run drug to drug interactions on all patient iden	e			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			
		15K094	B. WING		02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
SCOTT'S	S HOME HEALTHC	ARE LLC		1O, IN 46902		
(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	
TAU	REGULATORY OF	RESC IDEN HEY ING INFORMATION	IAG	medications. The CM will use drugs.com to ensure the interactions are properly identified. Any interactions wi reported to the MD with follow instructions requested. All instructions to be documented the clinical chart and medication updated per MD order if applicable. The patient educawill be documented in the nursus assessment and any follow upeducation and or instructions to documented in a clinical note the medical chart. The ACM to review all assessments include the medication interactions and ensure interactions are reported with MD orders received and patient education conducted. ACM will utilize the admission recertification audit checklist to ensure all mandatory requirem are completed by CM. All PR medications will be reviewed a must have documented indication use in patient understood verbiage. The CM to review as	Il be up l in ons ation se to be in o ing d ed The and o nents N and tions	
				findings from the current certification period in the clinic chart and address each item t		
				occurred in the comprehensive		
				assessment along with the	-	
				resolution. A patient that has		
				been hospitalized for 24 hours	s will	
				be placed on hold per MD ord		
				The CM will complete a		
				resumption of care assessme	nt on	
				the natient before resuming		

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agency services. The ACM will

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	R/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15K094	B. W	ING		02/26/2019	
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8					
COSTIC	S HOME HEALTHC	ADELLO		1817 DOGWOOD CT KOKOMO, IN 46902			
300113	S HOIVIE HEALTHG	ARE LLC		KUKUK	WO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	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 APPROPR		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
					meet daily with the clinical sta	ff	
					and review the status of each		
					patient in order to ensure prop	er	
					procedures are followed regar	ding	
					resumption of care.		
G 0526							
Bldg. 00							
			G 0	526	The CM will provide a		03/28/2019
	Based on observation	on, record review and			comprehensive assessment the	nat	
	interview, the Regis	stered Nurse (RN) failed to			accurately reflects the patient		
	ensure contents of t				status. The agency will ensur	е	
	assessment was acc	urate for 1 of 7 full records			consistency of this regulation	by	
	reviewed in a sample	le of 17 (#3).			requiring all CM to follow and		
					complete an approved checkli	st	
	Findings include:				form of tasks at each		
					comprehensive assessment v	isit	
	An agency policy d	ated 1/14/19, titled "			titled comprehensive assessm	ient	
	Completing the Cor	nprehensive assessment"			checklist. This form includes		
	stated "Once OASIS	S assessment is completed			review of all medications, their	ruse	
	accurately and refle	ct the patient's status "			and indication, any education		
					regarding initial diagnosis requ	uiring	
	The clinical record	of patient #3 was reviewed on			prescribed medication need a	nd	
	02/18/19 and indica	ted a start of care date of			systems review including skin		
	8/23/17. The record	d contained a plan of care			assessment to address all		
	(POC) for the certif	ication period of			medical diagnosis in plan of ca	are.	
	2/14/19-4/14/19, wh	nich indicated a medication			Care plan items will be review	ed	
	"Nitoruranton" [sic]	(an antibiotic used to treat			with patient at each nurse visi	t to	
	urinary tract infection	ons) 100 milligrams 1 tablet by			ensure no changes in patient	have	
	mouth three times d	laily for 3 days that began			occurred during current		
		osis of Type 2 diabetes. The			certification period. Care plan	to	
		lence information regarding an			be customized and updated if		
	infection or the use	of an antibiotic, and accurate			patient status change occurs t	iO	
		he patient's ability to			reflect patients current needs.		
	independently reach	feet to apply socks and			ACM to ensure all checklist ite	ems	
	shoes as evidenced	by:			for patient visit have been		
					completed by nurse by review	ing	
	During a home visit	observation on 2/18/19 at			all visit documentation for		
	12:00 PM, at patien	t #3's home, employee E, a			accuracy. The ACM will utilize	9	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/26/2019		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  1817 DOGWOOD CT  KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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		
	personal care. After complete, the HHA legs and feet. The pand placed it over the pointed out a thick, right great toe. The been present for "a patient had pulled patient then pulled patient then pulled and repeated the The patient bent own on shoes independent A Recertification conducted 2/12/19 indicated 2/12/19 indicated to perform diashe is unable to reach assessment failed to calloused, build-up to evidenced genitor evidence the patient required antibiotic u 2/25/19 at 2:27 PM,	omprehensive assessment ated " No diabetes tient] is diabetic and requires abetic foot care at each visit as the her feet" The evidence the presence of a to the soles of the feet, failed urinary problems, and failed to 's recent infection that use. During an interview on the administrator stated that assessment should have		the CM checklist in auditing the skilled nurse documentation. Clinica staff will be in serviced and re educated on comprehensive assessment procedure by 3/28/19. The Administrator or delegate will audit at least 10% all comprehensive assessmen visits to ensure this regulation upheld.	her % of nt		
G 0530							
Bldg. 00	Registered Nurse (Regoals were identified assessment for 7 of sample of 17 (#1, 2). Findings include:	riew and interview, the RN) failed to ensure patient d in the comprehensive 7 full record reviews in a , 3, 4, 5, 9, 15).	G 0530	Every admitted patient to have patient centered goals in their comprehensive assessment completed by the RN at the patient visit. The RN will inquivant goals the patient has for themselves then write specific patient centered goals in the assessment. These goals to	ire		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	COMP	E SURVEY LETED 5/2019
	PROVIDER OR SUPPLIER		1817 🛭	ADDRESS, CITY, STATE, ZIP ( DOGWOOD CT MO, IN 46902	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
TAG	on 02/18/19 and inc 8/23/17. The record (POC) for the certification of dated 2/12/19 failed goals.  2. The clinical record on 2/20/19 and indicated 10/2/18. The record certification period The recertification period ated 10/2/18 failed goals.  3. The clinical record on 2/20/19 and indicated 10/2/18. The record certification period The recertification period ated 1/10/19 failed goals.  4. The clinical record on 02/21/19 and indicated 01/21/19 failed goals.  5. The clinical record the certification period dated 01/21/19 failed goals.  5. The clinical record dated 01/21/19 failed goals.  5. The clinical record dated 01/21/19 failed goals.	licated a start of care date of d contained a plan of care	TAG	reviewed at each asses visit, along with all diagnosis centered go updated with the curre goals, specifically documentative section of go educate patient at every assessment visit on his can be met. ACM to repatient documentation accuracy and to ensure documenting updated goal and any education patient regarding goal Administrator to ensure requirement is complete auditing 10% of assess documentation month compliance with this reresult in disciplinary as agency policy.	essment  pals, and ent status of cumented in pal. RN to ery ow goals review all in for re RN is l status of on given to els. re eted by essment ely. Non egulation will	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		JILDING	00	COMPL	
		15K094	B. W	NG		02/26/	2019
	ROVIDER OR SUPPLIER		<u>,                                     </u>	1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT IO, IN 46902		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	1	ID	DROWINED'S DLAN OF CODDECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
	A recertification ass to evidence patient-	specific goals.					
	2/19/19 and indicate 5/26/17. The record	rd of patient #2 was reviewed ed a start of care date of d contained a plan of care for iod of 1/22/19-3/22/19.					
	A recertification ass to evidence patient-	sessment dated 1/21/19 failed driven goals.					
	2/21/19 and indicate	rd of patient #5 was reviewed ed a start of care date of 3/2/18. d a plan of care for the of 6/30/18-8/28/18,					
	A recertification ass to evidence patient-	sessment dated, 6/27/18 failed specific goals.					
	administrator stated	iew on 2/25/19 at 1:47 PM, the that the plan of care should be patient has made for					
G 0536							
Bldg. 00							
	Registered Nurse (R drug interactions we regimen review and for as needed (PRN) records reviewed (# of 17.  Findings include:  1. An agency policy	riew and interview, the RN) failed to ensure all drug to ere identified in the drug failed to specify indications) medications for 7 of 7 full 1, 2, 3, 4, 5, 9, 15), in a sample by, dated 1/14/19 titled ciliation," stated "Purpose: To	G 0	536	Nursing staff to review all paties medications patient is using to identify any potential adverse effects and drug interactions, including ineffective drug thera significant side effects, significating interactions, duplicate drug therapy, and non compliance of drug therapy. The RN will utilist the comprehensive assessment checklist to ensure each step is completed. The RN will write a medications in layman's terms	apy, ant ug vith ze nt s	03/28/2019

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	ETED
		15K094	B. W	ING		02/26/	2019
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t			OGWOOD CT		
SCOTT'S	HOME HEALTHC	ARFIIC			MO, IN 46902		
			_		T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		reconciliation is up to date and			that is easy for patient to		
	•	ent's medical chart and in the			understand and document rev		
	home"				was completed with patient, th	ie	
					acknowledgment that patient		
		ord of patient #3 was reviewed			understands medications, side		
	on 2/18/19 and indicated a start date of 8/28/17.				effects, interactions, duplicate		
	The record contained a plan of care for the				therapy and risks associated v		
	certification period of 12/16/18-2/13/19.				non compliance. The nurse w	ıll	
	TEI 1	1			utilize drugs.com to run drug		
		ed a current Medication profile			interactions and note that		
	effective 2/14/19 with the following medications:				interactions were reviewed wit		
	"ASA 1 PO QDCetirizine 1 PO QHS PRN				patient. The MD will be notified		
	AllergyCyclobenzaprine 1 PO BID am,				any interactions and follow up		
	eveningEliquis 2 tabs PO QDGabapentin 1 PO				orders to be received from MD	).	
		O QDLevothyroxine 1 PO			RN to implement requested		
		O QDMetformin 1 PO			changes, update medication		
		[sic]1 PO TID X 3 DaysNorco			profile and educate patient on		
		radjenta 1 PO QDTramadol 1			changes. ACM to review all		
		gTylenol 1 PO Q8H			documentation and run drug		
		2 on SUN and WEDVitamin			interactions on patient medica		
	D3 1 PO QD."				profile to ensure compliance a		
	The record failed to	avidance a madication review			review documentation for char	nges,	
		evidence a medication review medications put into layman's			applicable MD orders, and	mod	
		y for the patient to understand,			documented education perform	neu	
		hat an accurate medication			with patient. ACM will utilize		
		as completed and was sent to			comprehensive assessment	ator	
	the physician as evi	-			checklist created by Administr		
	the physician as evi	denoca by.			to ensure consistency of audit  Administrator to audit 10% of		
	On 02/19/19 an age	ncy Drug to Drug interaction			documentation per month to	VISIL	
		gency's software program. The			ensure requirements are		
	_	ogram failed to identify a drug			completed.		
		. The record failed to evidence			Completed.		
		teractions were run as there					
		ion or tracking within the					
	system to show that	<u>-</u>					
	by stern to show that	. it was completed.					
	On 02/20/19 the fol	lowing medications were					
		com for interactions: Major					
		yclobenzaprine and Tramadol;					
		, e.c. enzaprine and riumaut,	1		I		l

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15K094		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION  00	COM	E SURVEY PLETED 26/2019	
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP C OGWOOD CT MO, IN 46902	OD	
(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 COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
TAG	Major interactions with Cy Major interactions with Cy Major interactions of D3 and Major interaction stated "H Avoid combination outweighs the bene D3. The clinical record on 2/20/19 and indition 10/2/18. The record the certification per The record contains effective 10/2/18 w "Allopurinol 1 PO BIDDicyclomine QDLexapro 1 PO Mirapex 1 PO BID. PRNTopiramate DQHSVitamin B 12 QD"  The record failed to that identified medication and was sent to the On 02/20/19, an ago was run from the agagency software proto drug interactions that drug to drug intera	with Aspirin and Eliquis; Major velobenzaprine and Norco; with Vitamin D 2 and Vitamin actions with Norco and ags.com Major interaction ighly clinically significant. So, the risk of the interaction fit."  ord of patient #4 was reviewed cated a start of care date of a contained a plan of care for iod of 10/2/18-11/30/18.  ord a current Medication profile in the following medications; QDBuspirone 1 PO 1 PO QIDLevothyroxine 1 PO QDMiltivitanin [sic] 1 PO QD,Norco 1 PO Q6H PO BIDTrazodone 1 PO 2 1 PO QDVitamin D3 1 PO evidence a medication review cations in layman's terms, that the interaction check completed, physician as evidenced by:  ency Drug to Drug interaction gency's software program. The orgam failed to identify a drug at the record failed to evidence teractions was ran as there ion or tracking within the	TAG	DEFICIENCY		DATE
	On 02/20/19 the fol	lowing medications were om for interactions: Major				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15K094		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	re survey ipleted 26/2019	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP ( OGWOOD CT	COD	_
SCOTT'S	S HOME HEALTHC	ARE LLC		MO, IN 46902		
(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 CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	interactions with Di Major interactions of Major interactions, the routweighs the beneficial of Major interactions of Major interact	cord of patient #9 was reviewed cated a start of care date of a contained a plan of care for iod of 01/10/19-03/10/19.  Ed a current Medication profile with the following medications: puff QDAspirin 1 PO QD  Benadryl PO PRNBelsomra e)Benadryl 1-2 tabs PO PO QDClopidogrel 1 PO BIDCombivent Respimat 1 Puff ly) PRNCOQ 10 1 PO Q QHS berry 1 PO QD PRND3 2 Caps e 1 PO QDFenofibrate 1 PO ay each Nostril BIDGlucose 1				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K094	B. W	ING		02/26/	/2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			OGWOOD CT		
SCOTT'S	S HOME HEALTHC	ARFIIC		1	10, IN 46902		
	·	AIRE LEO		RORON	10, 114 40002		
(X4) ID		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 APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		tient to understand, had an					
		n interaction check completed,					
	and was sent to the	physician as evidenced by:					
	0.00/00/10	<b>.</b>					
	On 02/20/19, an agency Drug to Drug interaction						
	was run from the agency's software program.						
	The agency software program identified the						
	following interactions: Major interactions with						
	Atorvastatin and Fenofibrate; Major interactions with Venlafaxine and Maxalt; Major interactions						
		-					
	with Ibuprofen and Aspirin and major interactions with Baclofen and Norco.						
	with Bucioten and	ttoreo.					
	On 02/20/19, the following medications were checked on Drugs.com for interactions: Tramadol,						
	_	kine, Maxalt, Norco, Baclofen,					
		ibrate, Ibuprofen, and Aspirin.					
		with Venlafaxine and Maxalt;					
	-	with Venlafaxine and Tramadol;					
	-	with Tramadol and Maxalt;					
	-	with Norco and Belsomra;					
	Major interactions	with Baclofen and Norco;					
	Major interactions	with Hydrocodone and					
	Tramadol; Major in	teractions with Atorvastatin					
	and Fenofibrate; Ma	ajor interactions with					
		rin; Major interactions with					
		adol. The Drugs. com Major					
		on stated "Highly clinically					
		combinations; the risk of the					
	interaction outweig	hs the benefit."					
	6 m 1: 1	1.6					
		ord of patient #15 was reviewed					
		cated a start of care date of					
	5/24/13.						
	The record contains	ed a plan of care for the					
		ed a plan of care for the of 01/23/19-03/23/19. The					
	_	current Medication profile					
		with the following medications:					
	" Aspirin 1 PO Q	_					
	Азриш 1 1 0 Q	DDillilla 110					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE S COMPL: 02/26/	ETED
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	(milligrams) PO dai 100 mg PO dailyI 500 mg PO BID wi 1 PO QDNexium	e 1 PO QDFurosemide 40 mg llyGlipizide 1 PO QDJanuvia Lipitor 1 PO Q IHSMetformin th mealsMetoprolol 25 mg ER 40 mg QD before breakfast"				
	that identified medi was easy for the pat accurate medication	cations in layman's terms, that ient to understand, had an interaction check completed, physician as evidenced by:				
	was run from the ag The agency softwar following interactio between Furosemid	ency Drug to Drug interaction gency's software program. e program identified the ns: Moderate interactions e and Metformin; Moderate in Furosemide and Januvia.				
	On 02/20/19, the fo	llowing medications were om for interactions: Major tassium Chloride and Ramipril.				
	duplicative medicat (milligrams) 1 PO ( date of 08/16/17 and before breakfast stat Medication profile of were entered on PO The clinical record	tion profile evidenced ions of Esomeprazole 40 mg by mouth) QD (every day) start d Nexium 40 mg 1 PO QD rt date 02/08/17. The evidenced both medications C (plan of care) on 1/23/19. failed to evidence if the notified of duplicative Nexium.				
	Administrator stated review the nurse review the nurse reviewth. If discrepantional should be sent to the	iew on 2/15/19, at 9:28 AM, the d, during a drug regimen viewed all medications with the noies were found, an order e physician and the agency's yould do an interaction check.7.				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULT A. BUILE B. WING		NSTRUCTION  00	(X3) DATE ( COMPL <b>02/26</b> /	ETED
	ROVIDER OR SUPPLIER		1	817 DC	DDRESS, CITY, STATE, ZIP COD DGWOOD CT O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	2/18/19 and indicate 3/21/18. The record the certification per	of patient #1 was reviewed ed a start of care date of d contained a plan of care for iod of 1/15/19-3/15/19.					
	" amlodipine 1 PO atorvastatin 1 PO Q 1 PO QD Buspar clopidogrel 1 PO Q	with the following medications:  O (by mouth) QD (daily)  PM [every evening] benicar  1 PO TID [3 times per day]  D colace 1 PO QD PRN [as					
	1 PO QD flonase gabapentin 1 PO TI [intramuscular] PRI units subQ [subcuta levothyroxine 1 F Maalox PO Q 8 hr [	ex 2 PO QPM ferrous sulfate 2 sprays each nostril QD D glucagon IM N hypoglycemia Levemir 24 neous] BID [2 times per day] PO QAM [every morning] hour] metoprolol tartrate 1 magnesia PO QD PRN					
	montelukast 1 PO Q Novolog 14 units su nuedexta 1 PO QD probiotic 1 PO QD quetiapine 1 PO QP [right lower extrem	PPM myrbetriq 1 PO QD  ibQ QID [4 times per day]  pepcid 1 PO QPM  protonix 1 PO QD  PM triamcinolone to RLE  ity] BID tylenol 2 tabs PO Q  N voltaren gel zofran 1 PO					
	that identified medi was easy for the pat accurate medication	evidence a medication review cations in layman's terms, that cient to understand, had an interaction check completed, physician as evidenced by:					
	was run from the ag indicated 3 moderat and 2 minor drug to failed to evidence the	cy drug to drug interaction gency's software system and the drug to drug interactions. The record that drug to drug interactions as no documentation or					

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STATEMEN	NT 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
		15K094	B. W	ING		02/26/	/2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			OGWOOD CT		
SCOTTIS	S HOME HEALTHC	ARELIC			10, IN 46902		
300110	TIONE HEALTHO	AND LEG		KOKON			
(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 COMI CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	system to show that it was					
	completed.						
	On 2/21/19, the following medications were						
	checked on Drugs.com for interactions:						
	amlodipine, atorvas						
	_	opidogrel, colace, divalproex					
		fate, Flonase, gabapentin,					
		levothyroxine, Maalox,					
	_	e, montelukast, Myrbetriq,					
	Novolog, Nuedexta, Pepcid, Acidophilus Probiotic						
	Blend, Protonix, quetiapine, triamcinolone,						
	Tylenol, Voltaren, and Zofran. The Drugs.com list						
		wing reactions: Major					
		uspar and Zofran; Major					
		uedexta and Zofran; and Major					
		uedexta and quetiapine. The					
		nteraction definition stated					
	"Highly clinically s	_					
	outweighs the bene	isk of the interaction					
	outweighs the bene	III.					
	The clinical reco	ord of patient #2 was reviewed					
		ed a start of care date of					
		d contained a plan of care for					
		riod of 1/22/19-3/22/19.					
	the certification per	Tod 01 1/22/19-5/22/19.					
	The record contains	ed a current Medication Profile					
		with the following medications:					
		puff inhale BID albuterol 1					
		clofen 1 PO BID PRN					
		adryl) 1-2 tabs PO Q 4-6 hr PRN					
		PO QD calcium 1 tab PO TID					
	_	s PO TID doxycycline 1 PO					
	_	PO BID ibuprofen 3 PO QD					
	_	2 sprays to nares Q 4 hr PRN					
		D levaquin 1 PO QD					
		ch to back for 8 hrs QD PRN					
	* * * *	O meloxicam 1 tab PO QD					
	-	O BID montelukast 1 tab PO					
	1						l

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Event ID:

SEGS11 Facility ID: 012928

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2019		
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	REGULATORY OR QD myrbetriq 1 t nitrofurantoin 1 PO omeprazole 1 tab 1 tab PO QD prarprednisone 3 PO QI tessalon perle [sic] inhale 1 puff QD ur QD"  The record failed to that identified medi was easy for the pat accurate medication and was sent to the On 2/19/19 an agen was run from the agindicated no drug to record failed to evic interactions were rundocumentation or trishow that it was complysician.  On 2/19/19, the foll checked on Drugs.c cephalexin, lidocair myrbetriq, paroxetin pyridium, tessalon, albuterol, baclofen,	ab PO Q HS [bedtime] BID Norco 1-2 tabs QD PRN PO QD oxygen paroxetine vastatin 1 tab PO QD D pyridium 1 PO BID PRN 1 PO BID PRN tudorza titil gone vitamin D3 1 tab PO  evidence a medication review cations in layman's terms, that ient to understand, had an interaction check completed, physician as evidenced by:  cy drug to drug interaction tency's software system that o drug interactions. The dence that drug to drug n as there was no acking within the system to mpleted and sent to the  owing medications were om for interactions: Benadryl, the, lyrica, montelukast, the, pravastatin, prednisone, tudorza, vitamin D3, Advair,			AIE
	Januvia, meloxicam Norco, and omeprazidentified the follow interactions with me interactions with No interactions with bu Major interactions w	n, metoprolol, nitrofurantoin, zole. The Drugs.com list ving reactions: Major eloxicam and eliquis; Major nedexta and Zofran; and Major spirone and hydrocodone; with calcium and vitamin D3; with buspirone and paroxetine;			
	1710JOI IIICIACIONS	vitti odolololi dild			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15K094		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	ie survey ipleted 26/2019	
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP OGWOOD CT MO, IN 46902	COD	
(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 CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	and eliquis. The Didefinition stated "H	or interactions with ibuprofen rugs.com Major interaction ighly clinically significant. s; the risk of the interaction fit."				
	2/21/19 and indicate	ard of patient #5 was reviewed ed a start of care date of 3/2/18. Ed a plan of care for the of 6/30/18-8/28/18.				
	effective 2/18/2019 " amitriptyline 1 I PRN buproprion PO Q AM at [and] a divalproex 3 tabs Po gabapentin 1 PO Ql Miralax QD PRN	ed a current Medication Profile with the following medications: PO QD baclofen 1 PO TID 1 PO QD clonazepam 1/2 tab moon, 1 tab PO QHS D QPM flomax 1 PO QD HS lisinopril 1 PO QD percocett 2 tabs po q 4 hrs PO QID tramadol 1 PO Q 6 hr PO QD"				
	that identified medi was easy for the par accurate medication	evidence a medication review cations in layman's terms, that ient to understand, had an interaction check completed, physician as evidenced by:				
	was run from the ag indicated no drug to record failed to evid interactions were ru documentation or tr	cy drug to drug interaction gency's software system that drug interactions. The dence that drug to drug n as there was no acking within the system to impleted and sent to the				
	checked on Drugs.c	owing medications were om for interactions: fen, bupropion, clonazepam,				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIER		1817 🗅	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(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	
	divalproex, flomax, percocet, protonix, Drugs.com list iden Major interactions of Major interaction definitions interaction definitions interaction outweight of Major interaction outweight of Major interaction outweight of Major interaction definitions interaction outweight of Major interaction definition of Major interaction outweight of Major interaction definition of Major interaction definitio	gabapentin, lisinopril, miralax, tramadol, and trintellix. The tified the following reactions: with bupropion and tramadol; with bupropion and trintellix; ons with clonazepam and teractions with tramadol and teractions with baclofen and teractions with bupropion and teractions with bupropion and teractions with amitriptyline in the rinteractions with intellix. The Drugs.com Major on stated "Highly clinically combinations; the risk of the				
G 0548						
Bldg. 00	Registered Nurse (F Resumption of Care performed after hos who required a ROO Findings include:	view and interview, the RN) failed to ensure a e assessment (ROC) was pitalization for 1 of 1 patient C in a sample of 17 (#2).	G 0548	All patients that are admitted to the hospital for 24 hours or more will receive a resumption of casessment by the RN. This was be evidenced by a resumption care assessment document in patient clinical chart. The ACN will ensure all documentation is reviewed and that the RN receives a resumption order prior to	ore re will of the  M s	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MUI A. BUI B. WIN	LDING	NSTRUCTION 00	(X3) DATE ( COMPL <b>02/26</b> /	ETED
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
SCOTT'S	HOME HEALTHCA	ARE LLC		KOKOM	IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	Р	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	5/26/17. The record the certification period the certification period and a gency care cood the registered nurse stated the patient was room. Hospital doc patient had a hospital 1/14/19-1/18/19.  The agency RN con 1/21/19. The RN fa of care after the patient hospital within 48 h	ed a start of care date of decontained a plan of care for field of 1/22/19-3/22/19.  rdination note completed by (RN) on 1/14/19 at 1:13 PM as going to the emergency umentation indicated that the all inpatient stay from  npleted recertification on ided to complete a resumption item was released from the ours.  To on 2/25/19 at 1:46 PM, the that a resumption of care di within 48 hours of discharge			resuming services. The nurse be notified by the patient/caregof the hospital DC. The nurse inform scheduling and the ACM the impending resumption. The nurse will get a resumption or from the MD prior to the resumption of care visit. Once ACM is notified of the impending resumption, they will track the status of the patient to ensure order was received from the M and that the resumption of care assessment was completed. The ACM will meet daily at the stare each work day with clinical stareview current status of each patient and to ensure resumption of care is performed on all pating DC from hospital. The Administrator will ensure all prodocumentation is completed or patients resumed by meeting where ACM daily to review status of patients and documentation required for each patient. The Administrator will review 10% of visit documentation monthly to ensure this process is upheld.	giver will A of e ler the ng the b he t of ff to on ents oper n vith	
G 0570							'
Bldg. 00	interview the Regist ensure a complete a was developed (see written visit schedul	on, record review and stered Nurse (RN) failed to and individualized plan of care tag G574); failed to ensure a le was provided to the 14) and failed to ensure that a	G 05	70	The RN will compose a complet and individualized care plan for patient upon admission and wireview the patient care plan with the patient at each nurse visit. The RN will do so by utilizing the electronic patient system and	r the II th	03/28/2019

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

PRINTED: 04/03/2019 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15K094	A. BUILDING B. WING	00 00	COMPLETED 02/26/2019
	PROVIDER OR SUPPLIER S HOME HEALTHCA		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902	
(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
	medication list was tag G616).  The cumulative efferesulted in the agency with the Condition of	provided to the patient (see  act of this systemic problem by being out of compliance of Participation 42 CFR 484.60 dination, quality of care.		creating individual tasks for eapatient. Each task will be speas to when (day and/or time of day) the task should be computing the visit and the degree involvement the aide will have helping the patient complete to task. The Administrator will inservice all nursing staff on the plan requirements by 3/28/19. ACM will review all visit documentation for thoroughnes and to ensure care plan is speat to patient needs. Administrate ensure procedure is followed auditing 10% of all charts more for accuracy. Scheduling to notify administrator the last week of each month to report schedule were mailed. Schedule to be in patient folder. Schedule to show date, time and schedule aide. The RN to put copy of completed patient medication in patient folder in patient hom RN to update as applicable. Recheck patient folder at each not visit to ensure patient schedul and medication profile is pressin patient folder and replace if missing. ACM to perform nurs supervisory visits monthly and inspect patient folder for all mandatory items including patischedule and medication profile and	ach ciffic of leted de of sin he le care The letes decific or to by anthly hail he letes decept dece

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<u> </u>		X2) MULTIPLE CONSTRUCTION X3) DATE SU					
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 02/26/2019				
		15K094	B. W			02/26/	∠019 
	ROVIDER OR SUPPLIER			1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWNERS BY 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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	1.5	DATE
					during daily meetings with AC	M.	
G 0574							
Blda. 00							
Bldg. 00	interview, the Regis accurately complete pertinent diagnoses (#2, 3, 4, 5, 9, 15), of for all identified nee (#1, 2, 3, 4, 5, 9, 15) frequency and durat reviewed (#2) and cequipment (DME) is records reviewed (# Findings include:  1. An agency policy Plan of care," Policy nursing care-plan w Services to be providuration of visits 6. administration and relinical notes from a services11. Patier preferences, including used to demonstrate achievement of the patient"  2. The clinical record on 02/18/19 and ind 8/23/17. The record (POC) for the certificity 2/14/19-4/14/19 who was a service on 12/14/19-4/14/19 who was accurately complete the certification of the certificati	ich indicated diagnoses of "	G 0	574	The RN will utilize the comprehensive assessment checklist at each nursing visit ensure all required tasks are completed. All diagnosis to be listed in plan of care. All medications listed to have an appropriate diagnoses to support the patient medication prescrible. ACM to audit all documentate for accuracy after each nurse and to ensure all assessment findings have a listed diagnosis support findings. Patient specific frequency and duration to be reviewed and verified with the order. RN to ask patient at each nurse visit to state all DME in home and list on the plan of cain DME specific section. ACM ensure all DME reported in assessment is listed in DME section of plan of care. ACM ensure process is followed by performing nursing supervisor visit and reviewing DME observant reported in the patient howard reviewing each medical diagnoses with patient to ensurall diagnoses are listed on placare. ACM to educate nurse of any deficiencies found. Nurse correct deficiencies within 48	port ped. pon visit sto cific MD ch the are to y ved me ure n of pn e to	03/28/2019
		llitus without complications sion" The plan of care			hours and deliver updated pat information to patient folder in		

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i i		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED  B. WING 02/26/2019				
		15K094	B. W	ING		02/26/	2019
	PROVIDER OR SUPPLIER			1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT 10, IN 46902		
(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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		goals related to the type 2			home if applicable and patient		
		idism, and failed to evidence			medical chart. Administrator to		
		es (if any) or NKA (no known			meet with ACM daily and revie	ew	
	allergies).				all nursing supervisory visits.		
	The agency comme	hongiva receptification			Administrator to review superv	risory	
		hensive recertification 12/19, indicated the patient			visit forms to ensure ACM completed form and addresse	lle h	
		ne (antihistamine), Eliquis			deficiencies with nurse.	u ali	
	(blood thinner) and	· · · · · · · · · · · · · · · · · · ·			Administrator to ensure nurse	has	
		The plan of care failed to			corrected any deficiencies and		
		diagnoses and goals related to			documented updated informat		
	use ceterizine, eliqu	is, and levothyroxine.			was delivered to patient within		
					given time frame.		
		ord of patient #4 was reviewed					
		cated a start of care date					
		d contained a POC for the					
	_	of 10/2/18 -11/30/18 that of: chronic obstructive					
	-	(COPD)Chronic congestive					
		The plan of care failed to					
		ecific goals related to COPD					
	and CHF.						
	The agency compre	hensive recertification					
		0/2/18 indicated the patient					
		yspnea and edema and a					
		ension. The POC failed to					
		t diagnosis of hypertension					
		dyspnea and edema.					
	4. The clinical reco	ord of patient #9 was reviewed					
		cated a start of care date					
		d contained a POC for the					
	certification period	of 1/10/19-3/10/19 which					
	indicated, but not lin	mited to diagnoses of Type 2					
		ithout complication. The plan					
		dence goals related to Type 2					
	diabetes.						
	The agency compre	hensive recertification					

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	OF CORRECTION  OF CORRECTION  15K094	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SU COMPLET 02/26/20	ED
	PROVIDER OR SUPPLIER S HOME HEALTHCARE LLC	1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
	assessment dated 1/17/19 indicated the patient was taking Atorvastatin (hypercholestrol), Belsomra (insomnia), Colace (constipation), Miralax (constipation), Pepcid (gastroesophageal reflux), Maxalt (migraines), Venlafaxine (antidepressant), and Clopidogrel (blood thinner). The plan of care failed to evidence pertinent diagnoses and goals related to use of the medications identified in the comprehensive assessment.  5. The clinical record of patient #15 was reviewed on 02/21/19 and indicated a start of care date of 05/24/13. The record contained a plan of care for				
	the certification period of 01/23/19 - 03/23/19 that indicated diagnoses but not limited to"Type 2 diabetes mellitus without complications and unspecified osteoarthritis DME [durable medical equipment] glucometer, test strips, lancets, alcohol pads, urinary drainage bag, urinary leg bagSN (skilled nurse) to RN will educate patient on measure to decrease edema" The plan of care failed to evidence patient specific goals related to diabetes and osteoarthritis and failed to evidence a diagnosis related to edema.				
	The agency comprehensive recertification assessment dated 01/21/19 identified the patient had an indwelling foley catheter and hypertention and edema. The plan of care failed to evidence pertainent diagnosis and goals related to the patients indwelling foley catheter, and hypertension (due to the use of metoprolol), failed to evidence foley catheter size, infection control measures and emergency plans related to the catheter based on needs of the patient.6. The clinical record of patient #1 was reviewed 2/18/19 and indicated a start of care date of 3/21/18. The record contained a plan of care for the certification period of 1/15/19-3/15/19. The plan of care failed				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/26/2019
	PROVIDER OR SUPPLIER S HOME HEALTHC		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	pain, and diabetes b	elated to edema, constipation, pased on the identified needs e comprehensive assessment			
		rehensive recertification dated the patient had edema, and was a diabetic.			
	2/19/19 and indicate 5/26/17. The record the certification per indicated a frequency attendant hours. The evidence patient-spincontinence, type I obstructive pulmon evidence a diagnosi antihypertensive me specific frequency a attendant care needs	ord of patient #2 was reviewed ed a start of care date of d contained a plan of care for iod of 1/22/19-3/22/19 that ey of 70 hours a month waiver he plan of care failed to ecific goals related to urinary I diabetes, asthma and chronic ary disease (COPD), failed to as related to the use of edication and failed to have and duration for the patient's st.			
	10:00 AM, with pat practical nurse (LPI skilled care. DME grabber, nebulizer, emergency alert bra	cient #2, employee C, licensed N), was observed providing in the home observed was a hospital bed, and an acclet. The plan of care failed ipment identified in the home.			
	6/1/17 identified the incontinence, and sloxygen use. The pl goals related to ede shortness of breath the needs of the pat				
ı	8. The clinical reco	ord of patient #5 was reviewed			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/26/2019	
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902	
(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
	2/21/19 and indicated. The record contained certification period indicated "Incision with no s / sx infect period" The plan patient-specific goal incontinence, intern hypertension failed to the incision goal use.  The agency's compre 6/27/18 identified the constipation, and ur of care failed to evic constipation, and ur needs.	ed a start of care date of 3/2/18. Ed a plan of care for the of 6/30/18-8/28/18 that will cont [continue] to heal ion throughout certification in of care failed to evidence ls related to urinary			
	administrator stated contain all DME in	that the plan of care should the home, all pertinent the patient's medications,	nould		
G 0614					
Bldg. 00	interview, the agency visit schedule was phome visits observe agency scheduling party.  Findings include:  1. A policy dated 1	on, record review and by failed to ensure a written provided for review for 3 of 3 d and failed to follow the policy (#1, 2, 3) in a sample of 14/19 titled "Patient Care" stated, "9. Patient's	G 0614	The agency will provide pape schedules to the patient mont The agency policy will reflect change and states the patient schedules are to be mailed by scheduling department the last week of the month. Nursing to verify at the monthly supervisit to see if patient received schedule. Nurse to encourage patient to keep schedule in patient to keep schedule in patient and refer to as needed.	hly. this t this t the this t the this t the this the this the this the this the this the this this the this this this this this this this this

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLI A. BUILDINC B. WING	E CONSTRUCTION  G 00	(X3) DATE COMPL 02/26/	ETED
	ROVIDER OR SUPPLIER		1817	EET ADDRESS, CITY, STATE, ZIP COD 7 DOGWOOD CT KOMO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA	ATE	(X5) COMPLETION DATE
	individual two-weel entirety every other patient home by Throther arrangements  2. During a home v D, home health aide AM, at patient #1's the patient's home hit failed to evidence the agency.  3. During a home v C, licensed practica 10:00 AM, at patient 5/26/17), the patient observed and it faile provided by the age  4. During a home v E, HHA, on 2/18/19 home (start of care a health folder was observed and it failed provided by the agency. 5. During a PM, the administration used to be mailed to it was confusing the stated about a month implemented a new pull up the schedule Wednesday and rev following week. The	c schedule to be completed in Tuesday and mailed to arsday of that week unless have been made"  isit observation with employee (HHA), on 2/18/19 at 8:00 home (start of care 3/21/18), ealth folder was observed and a visit schedule provided by  isit observation with employee I nurse (LPN), on 2/18/19 at tt #2's home (start of care s's home health folder was ed to evidence a visit schedule nicy.  isit observation with employee of at 12:00 PM, at patient #3's 8/23/17), the patient's home observed and it failed to edule provided by the in interview on 2/18/19 at 1:55 or stated written schedules of the patient's every week but a patients. The administrator		Scheduling department to repart Administrator on the last wee the month once schedules had been mailed to ensure this process is upheld. Nursing to verify patient received paper a schedule each month at the supervisory visit. Nurse to document patient received schedule and schedule is pre in patient folder unless otherword (Ex: patient prefers to k visit schedule on refrigerator.) ACM to ensure patient received paper copy of patient schedule when nurse supervisory visit performed. If paper schedule not mailed the last week of the month, scheduling will be disciplined per agency discipl process. Scheduling to notify Administrator prior to required mailing date if there is an issuit that will prohibit scheduler from mailing patient schedules at appropriate time. Administrator ensure paper schedules are mailed the last week of the month by scheduling report given. Administrator or her delegate mail paper patient schedules scheduling department states are unable to do so by required date.	k of ve visit  sent vise keep ed le is sare e ine d ue m or will onth will if t they	
G 0616						
Bldg. 00			G 0616	The nurse will review all patie	ent	03/28/2019

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

PRINTED: 04/03/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       02/26/2019			ETED		
	PROVIDER OR SUPPLIER			1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Based on observation failed to ensure that provided to the pation observed (#3).  Findings include:  During a home visit home health aide (F at patient #3's home patient's home healt	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION on and interview, the agency a medication list was ent for 1 of 3 home visits  tobservation with employee E, IHA), on 2/18/19 at 12:00 PM, e (start of care 8/23/17), the ch folder was observed and it medication list provided by		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  medications at each nurse visi update medications if appropri request order from MD to ensumedication changes are accur and verify medication schedule present in patient home folder RN to replace medication schedule at nurse visit if missi or inaccurate. The ACM will ensure nursing completes this task by utilizing the updated supervisory visit form which prompts the nurse to check the medication profile in the patier	t, ate, ure ate e is	(X5) COMPLETION DATE
		y on 2/19/19 at 3:30 PM, the stated a current medication list ient's home folder.			folder. The ACM will also utilize the visit check list which also requires the nurse check the patient folder to ensure the current medication list is present the ACM will also check the patient folder for the medication profile list at the nursing supervisory visit performed. Utilizing these three processes will ensure the medication list present in the patient folder. Administrator will ensure this process is followed by reviewing the nursing supervisory visit documentation performed by the ACM or her delegate. The Administrator will meet with the ACM daily to review current patient status and review all nursupervisory visit forms complet The nurse supervisory visits to filed in nurse employee file for verification of completion.	ze ent. on sis The ng he e urse ted. o be	

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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. BU	A. BUILDING <u>00</u> COMPLET			LETED
		15K094	B. W	ING		02/26	/2019
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			OGWOOD CT		
SCOTTIS	HOME HEALTHC	ADELLO			MO, IN 46902		
300113	TIOWIL HEALTHU	TILL LLO	_	NONON	, IIV <del>1</del> 0302		
(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 OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
G 0682							
Bldg. 00							
			G 0	682	The agency handwashing poli	cy to	03/28/2019
		on and interview, the agency			state employee must scrub all		
		staff followed infection control			surfaces of hands for 20 secon	nds.	
		rd precautions for 3 of 3 home			All clinical staff to be reeducat	ed	
	visits observed (#1,	2, 3).			and checked off on handwash	ing	
					by nursing staff before 3/28/19		
	Findings include:				Nursing staff to be checked of	f by	
					Administrator before 3/28/19.		
		disease control (CDC) website			Copy of check off to be filed in	1	
		washing procedure was the			employee file as proof of		
		ur hands with clean, running			compliance. Administrator to		
		d), turn off the tap, and apply			ensure all field staff was comp	liant	
		ands by rubbing them			before 3/28/19 by reviewing		
	-	ap. Be sure to lather the backs			employee handwashing check	off	
	-	een your fingers, and under			report showing completion of		
		our hands for at least 20			employee check off. Case		
	seconds."				manager nurse to supervise p	roper	
					handwashing technique at each	ch	
		y dated 1/10/18 titled			supervisory visit. This will be a		
		' Policy # 259.00 stated " If			item on the supervisory visit for	orm.	
		acterial soap, they will wash			CM will educate aide as need	ed	
		ap and warm water, scrubbing			and document on Supervisory	'	
		ands, for at least 10 seconds			visit. Supervisory visit will be		
		icy failed to follow the CDC			audited by ACM or delegated	RN	
	guidelines for profe	ssional standards.			for compliance. All new		
					employees to receive employe		
	_	visit observation on 2/18/19 at			handbook including handwash	ning	
		ent #1, employee D, home			policy.		
		was observed providing					
		loyee D started the visit with a					
		sh and applied gloves. After					
		with shower employee D					
	* *	e patient back and bilateral feet					
	-	d completed a 12-second hand					
	-	etion of the visit, employee D					
		ond hand wash. Employee D					
	failed to perform ha	and hygiene per CDC [centers					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  02/26/2019	
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		recommendation of at least 20	TAG		DATE
	10:00 AM, with pat practical nurse (LP) skilled care. Emplo 13-second hand was	risit observation on 2/18/19 at tient #2, employee C, licensed N), was observed providing yee C started the visit with a sh. Employee C failed to one per CDC recommendation ds.			
	12:00 PM, with pat observed providing started the visit with During the course of completed a 5 second hand wash. Employ	risit observation on 2/18/19 at ient #3, employee E, HHA, was personal care. Employee E in an 11-second hand wash. If the visit employee E ind and an additional 11-second ree E failed to perform hand ecommendation of at least 20			
	_	iew on 2/18/19 at 1:43 PM, the that staff should be washing econds.			
G 0710					
Bldg. 00	nurse (SN) failed to with the plan of car with skilled nurse s Findings include: The clinical record 2/19/19 and indicate 5/26/17. The record	view and interview, the skilled o conduct visits in accordance e for 1 of 2 records reviewed ervices (#2) in a sample of 17.  of patient #2 was reviewed ed a start of care date of d contained a plan of care for iod of 1/22/19-3/22/19 that	G 0710	The agency will indicate a frequency for the skilled nurse by documenting the visit per w and not hours per week the pais seen for an MD ordered skill. The frequency and order for skill the frequency and order for skill be on the patie plan of care. The ACM will educate the nursing staff, at the daily nurse meeting, on this process and implement the change by 3/28/19. The ACM will start the change by 3/28/19. The ACM will start the change by 3/28/19. The ACM will start the skill th	eek Itient I. Killed ent

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019		
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902			
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	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	
1	1 hour per week to f follow the plan of ca frequency as eviden. On week 1 the SN v for 30 minutes.	by for the skilled nurse (SN) of fill the pillbox. The SN failed to have by not meeting the ced by:  isit was completed on 1/22/19  isit was completed on 1/28/19		ensure this process is upheld if reviewing all clinical documentation completed by the nurse and utilizing the comprehensive assessment checklist when auditing all clinical documentation, specifically the patient plan of care. The Administrator will ensure this	he	
i •	for 45 minutes.	isit was completed on 2/4/19		process is upheld by reviewing 10% of all nursing visits month		
	On week 2 the SN v for 45 minutes.	isit was completed on 2/12/19				
	On week 2 the SN v for 45 minutes.	isit was completed on 2/18/19				
1	-	on 2/25/19 at 1:47 PM, the that staff should be following				
G 0716						
	nurse (SN) failed to completely and accuraceiving skilled nur (#4). Findings include: The clinical record of 2/20/19 and indicate The record containe	iew and interview, the skilled prepare clinical notes trately for 1 of 2 patients rsing services in a sample of 17 of patient #4 was reviewed on ed a start of care date 10/2/18. d a POC for the certification 1/30/18 that indicated	G 0716	The ACM will review all clinical documentation after the nurse completes the applicable visit the electronic medical chart. T ACM will utilize the comprehensive assessment vicheck list to verify accuracy of documentation. ACM to check patient pain level that was documented by nurse and if all baseline was reported to MD v follow up instructions received patient education performed as	in he sit	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15K094		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  02/26/2019	
	PROVIDER OR SUPPLIER		1817 🛭	ADDRESS, CITY, STATE, ZIP COD DOGWOOD CT MO, IN 46902	
(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
	Disease, Unspecified chronic pain, Period pain level assessment: 0 Per relief measures: 7 Physician notified of COPD: No Chronic disease YES dyspevidenced conflicting pain, respiratory stainterview on 2/25/1	de Obstructive Pulmonary d abnormalities of gait, other ic congestive heart failure"  hensive recertification 0/2/18 indicated the patient Hypertension and was ea and edema. The document 10 pain scale and indicated, el during the day of received pain level AFTER pain . CaseManager and/or of the elevated pain level: No nic obstructive pulmonary onea NO" The document ag documentation in relation to tus, and diagnoses.During an 9 at 1:48 PM, the administrator locumentation should not be		resolution documented. ACM check diagnosis documentation ensure consistency between profession of care and assessment in clir software. The visit check list was prompt the ACM to review each diagnosis listed in the plan of and assessment against the reducumentation in the clinical coassessment visit. The ACM was instruct the nurse to correct an inconsistencies and review the corrected documentation before locking in the clinical chart. The Administrator to ensure the process is upheld and will auch 10% of monthly visit documentation.	on to colan chical vill ch care curse chart ill ch e
G 0750 Bldg. 00	Rosed on record ray	iew and interview, the agency	G 0750	The agency will obtain a contr	
	administrator, failed home health aide en required in their ent on the home health failed to ensure that completed for each the aide care plan w tasks timeframe's to and the home health the plan of care (see The cumulative efferesulted in the agency of the complete of the complete of the cumulative efferesulted in the agency of the cumulative efferesulted in the cumulative efferesulted in the agency of the cumulative efferesulted in the cumulativ	It to ensure that all perspective inployees performed all tasks irety as required for placement aide registry (see tag G768; an aide careplan was shift and failed to ensure that as individualized with specific be completed (see tag G798); a aide (HHA) failed to follow		health aide employees perform tasks in their entirety required placement on the registry. The RN will meet the required state standards and qualifications be the state. The RN will have a contract on file with the agence The RN will observe perspect HHAs performing tasks required on a live patient, in the patient home, in it's entirety. The RN observe the aide performing at task that can be demonstrated a laboratory setting in its entire	m all for is e y  y y ive ed t's will any d in

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	PROVIDER OR SUPPLIE		1817 🗅	ADDRESS, CITY, STATE, ZIP C DOGWOOD CT MO, IN 46902	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
	Home Health Aide			The completed check signed by the perspect employee and contract filed in the employee ficontract RN will registed employee with the state department of health if contract RN document completion of all requires the employee. Any employee and successfully the check off will not be with the state and the will repeat the check of orientation before being appropriate for licensing manager will customize patient care plan for eavisit. The RN will spectask which visit the tast completed if multiple wordered. The CM will care plan is followed dobserving the aide propatiting specialist will home health aide note completion and accurate note auditing specialist will home health aide note completed and the aide note on the report. Every aident care plan will be by HR per the agency policy. The deficiency reviewed and the aide educated on how to cate action to ensure the in action is not repeated.	tive  It RN and be ide. The er the er the er the er the er the er the ered tasks by aployee that complete eregistered employee eregistered employee eregistered employee ere the each patient cify on each sk is to be eresure the eally by eviding care ereview every erfor every e	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019	
NAME OF F	PROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP COD	•	
SCOTT'S	S HOME HEALTHC	ARE LLC			OGWOOD CT IO, IN 46902		
(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 APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG		h a	DATE
					counseling documentation will in the electronic employee file. The Administrator will ensure compliance with this process be reviewing the counseling repoweekly prepared by the note auditing specialist and verifyin the counseling was performed documented in the employee file.	oy rt g and	
G 0768							
Bldg. 00							
	administrator, failed home health aide (F tasks required, in the not simulated, as replacement on the hoof 1 agency.  Findings include:  1. A policy dated 1 Aide Supervision, T stated, " Training: competency and cere health aides. The prequired guidelines.  2. During an interv Nurse Practioner (N the HHA (home hear going through the Incompetency. The N hours on Fridays witraining with the Acevery aide performed.	riew and interview, the agency I to ensure that all prospective IHA) employees performed all eir entirety with a patient and quired to show competence for ome health aide registry for 1  [7] 14/19, titled "Home Health Training and Education" [agency] provides a tification program for home rogram utilizes the Medicaid"  [aiew on 2/19/19 at 9:00 AM the IP) indicated she developed alth aide) training program after indiana State test for HHA IP indicated the training is 8 th her after the orientation diministrator. The NP reported and all tasks required to be registry independently. She	G 0	768	The agency will obtain a contribution of the alth aide employees perform tasks in their entirety required placement on the registry. The RN will meet the required state standards and qualifications by the state. The RN will have a contract on file with the agency of the RN will observe perspectiful HAs performing tasks required on a live patient, in the patient home, in it's entirety, specifica (b)(3)(1), (iii), (ix), (x), and (xi). These areas will be observed being performed on a live patient. The RN will observe the aide performing any task that the demonstrated in a laborato setting in its entirety. The completed check off will be signly the perspective employee a contract RN and be filed in the employee file. The contract R will register the employee with state department of health if the contract RN documents the	me n all for is e y ve ed 's lly ne can ry gned and y the	03/28/2019

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	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD DOGWOOD CT MO, IN 46902	
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
IAU	indicated patient #9 HHA's to perform a shampoo during one the HHA's in the pr Administrator and h they did a good job registry." When asl in which the prospe placed on the State felt they didn't do ca properly or foot car  3. During an interv employee I (date of received 2 days of t the State registry. If the training, she did and while performin HHA rotated tasks. finish."  4. During an interv employee H (date o did 2 partial days of assigned a schedule  5. During an interv employee G (date o had "4 hours trainin G indicated she "alr limb with an ace wr training."  6. During an interv Alternate Administr competency check of the 75 hours the sta money to do the 2 v	had allowed 9 prospective complete tub bath and e visit. The NP indicated all ogram were trained by the terself and stated, "If I feel in the field, I sign the ked if there was any instance ctive HHA would not be registry, the NP stated, "If I ath care properly or Hoyer	IAG	successful completion of all required tasks by the employ Any employee that does not successfully complete the choff will not be registered with state and the employee will be required to repeat the check portion of orientation success before being appropriate for licensing. The Administrator review all completed paperwith the contract RN to ensure the employee has successfully completed the competency off. The Administrator will contract the patient (s) utilized for the check off to verify each perspective employee complete the required tasks in their endon the patient. Once verificate obtained from the patient, the Administrator will initial the competency check off as documentation of completion this time the contract RN will notified and approved to registed incoming employee.	eek the pe off sfully will ork by e check phack phact live eted tirety tion is e

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION  G  00	СОМ	e survey pleted 26/2019
	PROVIDER OR SUPPLIER		181	EET ADDRESS, CITY, STATE, ZIP ( 7 DOGWOOD CT KOMO, IN 46902	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETION DATE
TAG	7. During an intervent Administrator indiction on the State registry if more than one perfor competency trainee to perform put trained to make a subject of the patients in their care.  8. During an intervent Administrator indiction health aide training "out in the field of here to train them." assessment form titted to train them." assessment form titted demonstrated on a sponge bath, tub bas shampoo, bed sham urinal, bathroom and care, perineal care, hygiene and gum care, perineal care, hygiene and gum care, of fering of gait belt, transfer from chair to toilet, wheelchair, assisting ambulating with care walker, assist with demonstrates passive upper and lower boupper interpresentatives, care demonstrates ability sheet, temperature,	riew on 2/25/19 at 2:00 PM the cated each HHA should ed tasks prior to being placed y. The Administrator indicated ospective HHA was in the field ining it was acceptable for each parts of the bath or task, taking to verify competency and ining the HHA to assess the	TAG	DEFICIENCY)		DATE
	Pressure (optional)	casta on agency poncy,	1			İ

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	PLAN OF CORRECTION IDENTIFICATION NUMBER  15K094  A. BUILDING  00  B. WING		COMPLETED 02/26/2019		
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT	
SCOTT'S	S HOME HEALTHC	ARE LLC	KOKON	MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
	titled "Skills evalua demonstration, writ training," indicated demonstrated but di on a live patient wa knowledge of signs dehydration, edema knowledge of norm knowledge of speciskin, risk factors for and symptoms] of simportance of changhelping a patient drusing a safety razor elastic/compression hoyer lift, back rub, has an infusion line in place, reminds the normal body function that must be reported safety hazards/issumethods, making of unoccupied bed, knocleaning equipment situations, knowled emergency, inciden reporting of suspect with individual patiplan, demonstrates respect privacy, knocleaning equipment in demonstrates know information covered insurance portability knowledge of profect understanding of the knowledge of work	apetency assessment form ted through simulation by ten /case scenarios, or oral the skills that needed d not have to be completed s "assist with a medical lift, and symptoms of , and importance of hydration, al dietary requirements, al diets, knowledge of normal r skin problems, s / s [signs kin breakdown, knowledge of ging positions frequently, ess, proper body mechanics, , using an electronic razor, n stocking application, use of working with a patient who , if patient had telehealth unit em to do checks, knowledge of ons, knowledge of information red to supervisor, identifies es in the home, basic cleaning recupied bed, making owledge of food safety, , recognizes emergency ge of what to do in an t report, recognizes and a abuse/ neglect, is familiar ent emergency preparedness understanding of the need to owledge of patient rights, ledge of confidentiality and d under HIPAA [health y and accountability act],			

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	PROVIDER OR SUPPLIER S HOME HEALTHC		1	817 DC	DDRESS, CITY, STATE, ZIP COD DGWOOD CT O, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	observations, identicondition or appear demonstrates ability appropriate person accurately documer document in the clineffective, handwash handwashing, dispoprecautions, recogninfections, understated for infection"  11. During an interemployee D (date of agency put her on the stated she only did to be checked off.  12. During an interformer employee J stated she had gone for check offs, wash other people being schedule the next did schedule the next did agency do tub bath patient #9 stated the agency do tub bath patient stated every would come to his fadministrator or the patient reported on time, sometimes maked while the aidwould multiple tub in which the patient stated, "If I skin would be so ra	k knowledge of general patient fies changes in a patient's ance that should be reported, to report patient changes to (s), demonstrates ability to at tasks, care or observations, nical record id accurate and hing, use of sanitizer versus is sal of waste, standard ized signs of potential ands methods to decrease risk view on 2/18/19 at 8:00 AM, if hire 11/5/15), HHA stated the he aide registry. Employee D as shower in someone's home view on 2/19/19 at 12:01 PM, (date of hire 9/27/18), HHA, to a patient's home one day hing someone's hair while with checked off and was on the ay.  View on 2/20/19 at 11:39 AM, at he/ she would let the check offs in their home. The Friday, a group of new aides ther home accompanied by the enurse practitioner (NP). The average 3-4 aides trained at a pre or less. The patient was es were in the home if he/ she baths from each aide present, a stated: "no, never." The got multiple baths per day my w." The patient explained the ound robin," approach where					

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	ROVIDER OR SUPPLIER			1817 DO	NDDRESS, CITY, STATE, ZIP COD OGWOOD CT NO, IN 46902		
(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)	ΓE	(X5) COMPLETION DATE
	one rinsed the area, areas. The patient s would do pericare." would not be okay woul	they would all do different stated the "odd man out The patient stated they with a full bath being aide.  view on 2/20/19 at 11:57 AM, e/ she would allow agency as on Fridays. The patient of 2-3 people would come rms washing different areas of					
G 0798							
Bldg. 00	registered nurse (R) care plans were con to ensure that the ai individualized with completed for 7 of 7 (home health aide) s.  Findings include:  1. The clinical reco on 02/18/19 and ind 8/23/17. The record (POC) for the certif 2/14/19-4/14/19 wh of 1-3 hours per day with diabetic foot ca (activities of daily I (instrumental activity HHA care plan.	specific tasks timeframe's to be 7 patients receiving HHA services (#1, 2, 3, 4, 5, 9, 15).  ord of patient #3 was reviewed dicated a start of care date of d contained a plan of care fication period of ich indicated a HHA frequency 7 1-3 days per week to assist are and with all ADL's	G 0'	798	The RN will compose a complete and individualized care plan for patient per the agency policy. RN will do so by utilizing the electronic patient system and creating individual tasks for ear patient. Each task will be species to when the task should be completed during the visit and degree of involvement the aided have in helping the patient complete the task. The ACM or review all visit documentation thoroughness and to ensure caplan is specifics to patient need The ACM will utilize the comprehensive assessment checklist to specifically prompt the ACM to check the care plat for specific tasks, specific time/days tasks are to be performed and ensure the care plan is current for the patient	r the The ch cific the e will for are ds.	03/28/2019

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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. B	A. BUILDING <u>00</u>		COMPLETED		
		15K094	B. W	B. WING			02/26/2019	
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD			
COOTTIC	NUOME LIEM TUO	ADELLO			OGWOOD CT			
SCOTTS	S HOME HEALTHC	ARE LLC		KUKUN	MO, IN 46902			
(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 DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	dated 2/12/19 indicated	ated, "Aide Care Plan -			needs based on the visit			
	Effective on 11/29/	17: The agency aide/			assessment performed by the			
	homemaker care pla	an had the tasks to be			nurse. Administrator to meet v			
	completed as follow	vs: Assist with shower, assist			ACM daily to review patient st	atus		
	with sponge bath, c	lean bathroom, dustingfoot			on all agency's patients. ACM			
	care, spray with alc	ohol before and after visit,			also review care plan at nursir			
		s, up as tolerated, up with			supervisory visits.Administrato	-		
	_	clean kitchen, dishes, laundry,			ensure procedure is followed I			
		e HHA care plan failed to be			meeting with ACM daily to rev			
	updated and identify	y the timeframe (every visit or			all nursing supervisory			
	once a week for exa	ample) the tasks that were to be			documentation. Administrator	to		
	completed.				ensure compliance with proce	SS		
					by auditing 10% of all charts			
	2. The clinical reco	ord of patient #4 was reviewed			monthly for accuracy.			
	on 2/20/19 and indi	cated a start of care date						
	10/2/18. The record	d contained a POC for the						
	certification period	of 10/2/18 -11/30/18 indicated a						
	HHA frequency of	2-4 hours a day, 5-7 days a						
	week to assist with	ADL's and IADL's per the						
	HHA care plan.							
	The agency docume	ent titled "Aide/ Homemaker						
	Care Plan" indicate	d, "Patient goal:						
	[blank]Current Ai	ide Plan (Effective Date						
	10/4/2018) Assist	with Shower Utilizing Shower						
	Chair - AM Clear	Bathroom, Comb Hair,						
	Complete Bed Bath	- AM visit, Encourage [sic]						
	patient to do as muc	ch as possibleHave patient						
	stand up to change	pull-upHoyer lift - May use						
	after pt has attempte	ed to transfer, Incontinent						
	carePeri Care, Pu	t 2 pull-ups at each visitUp						
	with Assistance - W	heelchair" The HHA care						
	plan failed to identi	fy the timeframe (every visit or						
		ample) the tasks that were to be						
	completed.							
	3. The clinical reco	ord of patient #9 was reviewed						
		cated a start of care date						
	9/12/18. The record	d contained a POC for the						
	certification period	of 1/10/19-3/10/19 indicated a						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	e survey pleted 6/2019
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP C OGWOOD CT	COD	
SCOTT'S	S HOME HEALTHC	ARE LLC		/IO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	HHA frequency of week to assist with	2-3 hours a day 5-7 days per ADL's and IADL's.				
	Care Plan" indicate [blank]Current A 9/12/2018)Assist Dressing, Assist with Stransfer, Assist with Clean Dentures, Care Malker" The HH what timeframe (evexample) the tasks  4. The clinical recoverage date of 05/24/101/23/19 - 03/23/19 indicated a HHA fr days a week to assist The agency docume Care Plan" indicate [blank]Current A 11/30/2017)Assign included:Assist with stransferCatheter of FootcarePeri care sugarShampoo ha and after visit" To identify patient-specomplete during eafailed to identify with once a week for examples.	ide Plan (Effective Date: with Ambulation, Assist with th Shower Utilizing Shower Sponge bath, Assist with th Tub BathClean Bathroom, ean Kitchen, Clean up after Hair, Dishes, Foot Care, Make bed, Peri Care, mpoo Hair, Sweeping, Take out sted, Up with Assistance - A care plan failed to identify ery visit or once a week for were to be completed.  ord of Patient # 15 with a start of 3 and certification periods of 0 was reviewed on 02/21/19 equency of 4 hours a day 7 st with ADL's and IADL's.  ent titled, "Aide/Homemaker d " Patient goal: ide Plan (Effective Date:				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE COMPL 02/26	LETED
	PROVIDER OR SUPPLIER		1817 [	ADDRESS, CITY, STATE, ZIP COD DOGWOOD CT DMO, IN 46902		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE
	date of 3/21/18. The care for the certificath that indicated a hor frequency of 1 hour.  The agency aide/ hour.	19 and indicated a start of care e record contained a plan of ation period of 1/15/19-3/15/19 me health aide (HHA) a, 3-5 days per week.				
	non-medicated lotic ambulation, assist w chair, assist with tra dentures, comb hair Make Bed, Oral car put in / assist with h put on glasses. The	on to the skin, assist with with showering utilizing shower ansfer, clean bathroom, clean foot care Incontinent Care, e, Peri Care, remind patient to aide care plan failed to tame (every visit or once a				
	During a home visit AM, with patient #1 aide (HHA), was ob- care. Employee D s the patient showere- employee D wash tl lotion to the back po- care the patient pro- failed to clean dente- care or remind the p	the tasks were to be completed.  To observation on 2/18/19 at 8:00 I, employee D, home health observed providing personal tood outside the shower while d self. The patient requested he back. The aide applied er patient request. All other wided to self. Employee D ares, complete oral care, perioatient to put in hearing aide. to follow the aide care plan.				
	2/19/19 and indicate 5/26/17. The record the certification per indicated a HHA from 4-6 days per week.  The agency aide/hot tasks to be complete.	ard of patient #2 was reviewed ed a start of care date of d contained a plan of care for iod of 1/22/19-3/22/19 that equency of 3-5 hours per day, omemaker care plan had the ed as follows: assist with with dressing, assist with				

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K094		, ,	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 02/26/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902					
(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)	ATE	(X5) COMPLETION DATE	
IAG	showering utilizing sponge bath, blood bathroom, clean kit Incontinent- bladde care prepare mea trash, Make Bed, O care plan failed to it visit or once a week be completed.  7. The clinical record the certification per aide careplan indicat assist with shower, bathroom, dusting (with assistance (war During a home visit 12:00 PM, with pat observed providing stood outside of the showered self. Empthe patient's legs and out of the shower, elegs and feet. The patient's legs and to follow the aide completed.  8. The clinical record 2/21/19 and indicat The record contained.	shower chair, assist with a sugar reminder, clean chen, comb hair, dishes r, Incontinent laundry peri l shampoo hair take out ral care, Peri Care. The aide dentify what timeframe (every a for example) the tasks were to ord of patient #3 was reviewed ed a start of care date of d contained a plan of care for iod of 12/16/18-2/13/19. The ated the aide was to complete: assist with sponge bath, clean Wednesday), foot care, up lker).  It observation on 2/18/19 at ient #3, employee E, HHA, was personal care. Employee E e shower while the patient ployee E washed the back of d back. After the patient got employee E dried the patient got employee E dried the patient's patient dressed self, brushed d to the chair. Employee E e patient's feet, and the patient shoes on. Employee E failed are plan.  Ord of patient #5 was reviewed ed a start of care date of 3/2/18. ed a plan of care for the of 6/30/18-8/28/18 4-6 hours		IAG			DATE	
		omemaker care plan had the ed as follows: Apply						

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15K094	B. WI	B. WING			2019
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID		DO CARDENA DE LA CORDECACIONA		(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 APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
	ambulation, assist w feeding patient, assist w feeding patient, assist transfer, clean linen kitchen, comb hair, reminders, Oral care failed to identify whonce a week for exa completed.  9. During an intervadministrator stated specific to the patien (aide documenting states)	on to skin, assist with with dressing, assist with st with shower utilizing with sponge bath, assist with so, clean bathroom, clean Make Bed, medication e, Peri Care. The aide care plan that timeframe (every visit or mple) the tasks were to be siew on 2/25/19 at 1:33 PM, the that the aide care plan is not and that the Elvis system system) only allows the aide care plan for all shifts					
G 0800							1
Bldg. 00	health aide (HHA) if for 3 of 7 full record sample of 17.  Findings include:  1. An agency job de "Home health aide," Performance Responsian of care"  2. The clinical recond 2/20/19 and indicated to 10/2/18. The record care) for the certifice-11/30/18, which includes the sample of 17.	riew and interview, the home failed to follow the plan of care dis reviewed (#4, 5, 9) in a total rescription dated 1/10/18, titled Policy # 606.00 stated " nsibilities Follows a written ord of patient #4 was reviewed cated a start of care date discontained a POC (plan of ation period of 10/2/18 dicated a frequency of 2-4 days per week. The agency	G 0	800	The agency will provide home health services based on the Mapproved order. Any time the agency falls below the hours of days of the approved order the will be notified. The process where will be notified. The process where as follows: The note auditing specialist will review all complex visits utilizing the note verifier in the medical software system. Completed visit falls below the ordered hours or the patient when the note auditing special will write a communication to the case manager. The case manager will notify the MD that the patient was not seen for the minimum hours or days per the	er e MD vill ng eted in If a as num ist he	03/28/2019

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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	COMPLETED	
		15K094	B. WI	NG		02/26/	2019
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
CCOTTIC	NUOME LIENTTUO	ADELLO			OGWOOD CT		
SCOTTS	HOME HEALTHC	ARE LLC		KOKON	/IO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DEAN 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' DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	visit schedule indica	ated a HHA visit was			MD order. The case manager	will	
	completed on 10/25	/18 and was 1 hour 30 minutes			inform the MD who provided ca		
	^	HA failed to follow the			for the patient and the status of		
		rs on the plan of care (2-4			the patient during the time not		
	hours).	p (			seen by the agency. The ACM		
	110 415).				will be copied on the notification		
	3 The clinical reco	ord of patient #9 was reviewed			by the note auditing specialist		
		cated a start of care date			order to track and ensure that		
		d contained a POC for the			case manager notified the MD		
		of 1/10/19-3/10/19, which			documented appropriately. Th		
		ey of 2-3 hours per day, 5-7			ACM will review all documenta		
		e agency visit schedule					
		visits on 1/17/19 and 2/16/19			by the case manager in order	.0	
					verify notification to the MD is		
	<del>-</del>	length.4. The clinical record			completed in a timely manner.	41- : -	
	-	viewed 2/21/19 and indicated a			The Administrator will ensure		
		3/2/18. The record contained			policy is upheld by meeting with		
	-	e certification period of			the ACM daily to review the sta		
		t indicated a frequency of 4-6			of each patient and any and al		
		lays per week. The agency			follow up needed and complete		
		ated HHA visits completed on:			The Administrator will audit 10		
		ours in duration, 7/4/18 was 3.5			all clinical documentation mon	-	
		nd 7/17/18 was 3 hours in			to ensure nursing is following t	he	
		failed to follow the frequency			process appropriately. Home		
	parameters on the p	lan of care (4-6 hours).			health aides to be educated or		
					3/26/19 by letter with paychecl		
	-	iew on 2/25/19 at 1:47 PM, the			explaining order frequency and		
		that staff should be following			duration and discussing this w		
	ordered frequencies				clinical Manager or delegate w	ho	
					will ensure understanding thro	ugh	
					question and answer with each	า	
					aide by phone or face to face.	All	
					new employees will be trained		
					about frequency and duration	n	
					same manner upon hire.		
G 0984							
Bldg. 00							
			G 0	984	The agency will utilize the		03/28/2019
	Based on observation	on, record review, and			comprehensive assessment		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		15K094	B. WI	ING		02/26/	2019
			<u> </u>	CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				OGWOOD CT		
SCOTT'S	HOME HEALTHCA	ADELLO			MO, IN 46902		
300113	HOWE HEALTHO	ARE LLC		KOKOK	/iO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN 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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	interview, the Clinic	cal Manager failed to ensure			checklist for every skilled nurs	е	
	· ·	N) performed a complete			visit. The nurse will complete t	he	
		t per professional standards			checklist in its entirety. The		
	for 1 of 1 skilled nu	rse home visits observed (#2).			checklist will review each system	em	
					for a complete head to toe		
	Findings include:				assessment. The assessment		
					include vital signs, cardiovaso	cular	
		tled, "Nurse Care Visit Note"			assessment including		
	-	d: "Policy: Nurse Care Visit			auscultation, listen and note a	ny	
		CM (case manager) Nurse to			abnormal sounds, palpate		
		sment and documentation of			peripheral pulses, inspecting		
	_	dure: 1. CM Nurse to address			extremities for color, capillary		
		e Care Visit Note while			refill, edema, ulcerations,		
	completing the phys	sical assessment"			pulmonary assessment, include	ling	
					inspecting the thoracic cage,		
		SN, RN, C-FNP. (2004, June 15).			palpate the thoracic cage,		
		g Health Assessment.			auscultate the anterior and		
	_	26, 2019, from rn.com,			posterior chest, counting		
		essment can be performed			respirations for one minute,		
		examination When			auscultate between each rib,		
	_	EXAMINE the following:			assessing the		
		on and texture, Edema,			abdomen/gastrointestinal syst		
	_	Hair, Nails. Remember that skin			investigate any abdominal pai	n,	
		mon problem with the ill and			any change in bowel habits,		
		s. Skin assessment is vital to			auscultate for bowel sounds a		
	-	Inerability in the prevention of			bruits, dividing the abdomen ir		
	-	Cardiovascular Assessment:			quadrants and auscultating ea		
	_	cardiovascular system,			quadrant. Heart rate x 1 min,		
		ng Auscultate hear sounds			assessment including general		
	-	tra heart soundsPalate			pigmentation and texture, ede		
		nspect extremities (color,			bruising, lesions, hair, and nai	lS,	
	capillary refill, eder				genitourinary assessment		
		SESSMENT: When examining			including any pain or discomfo	DIT	
		em Inspect the thoracic			and incontinent status if		
		oracic cage, Auscultate the			applicable. The ACM will revie	w all	
	anterior and posterior chest: Have patient breath				nursing documentation for	_	
slightly deeper than normal through their mouth, Auscultate from C-7 to approximately T-8, in a left				thoroughness after each skille	a		
					nurse visit utilizing the		
		e sequence. You should			comprehensive assessment		
	auscultate between	every rib Identify any			checklist to ensure all sections	}	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K094	B. W	ING		02/26	/2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			OGWOOD CT		
SCOTT'S	HOME HEALTHC	ARE LLC			лО, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		sounds Assessing the			are completed. Each SN will	ре	
		testinal System: When			checked off by the Clinical		
	_	omen/gastrointestinal system,			Manager for completing a		
		owing Any abdominal pain,			comprehensive assessment,		
		vel habits Auscultate for			will be supervised at a patien		
		bruits. Begin by dividing the			home 1 time monthly by Clini		
		adrants, by drawing an			Manager or Assistant Clinical		
		ically and horizontally across			Manager or delegate RN. The	9	
		ersect the umbilicus. Right,			Administrator will ensure the	400/	
	* * .	eft Upper Quadrant, Right eft Lower Quadrant.			process is upheld by auditing	10%	
		d begin in the right lower			of all clinical documentation monthly and meeting with the		
		sounds are not heard, in order			ACM daily to review current		
		vel sounds are truly absent,			patient status and all follow u	n and	
	listen for a total of	•			outstanding documentation	p and	
	instell for a total of	iive minutes.			needed by clinical staff.		
	During a home visi	it observation on 2/18/19 at			Ticcuca by chillical stall.		
	_	tient #2, employee C, licensed					
	_	N), was observed providing					
		byee C took patient vital signs of					
		and pulse via pulse oximeter					
		via wrist cuff. Employee C					
		or lungs in 4 areas and the					
		Employee C failed to					
	_	sessment, full lung assessment,					
	_	cardiac assessment, or					
	endocrine assessme	ent.					
		0/10/10 11 50 72 5 1					
	_	w on 2/18/19 at 1:50 PM, the					
		d that during a skilled nurse					
		uld complete a head to toe					
		nt, perform any skill the patient					
		vital signs, and review all					
	medications.						
G 1022							
Bldg. 00							
			G 1	022	The agency case manager w	ill	03/28/2019
	Based on record re	view and interview, the agency			send a completed discharge		

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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 15K094 B. WING 02/26/2019 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1817 DOGWOOD CT SCOTT'S HOME HEALTHCARE LLC **KOKOMO. IN 46902** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE failed to ensure that a transfer summary was summary per the admission, completed and sent to the admitting inpatient discharge, and transfer policy, to facility for 2 of 2 patients hospitalized (#2, 8) in a the primary care practitioner or sample of 17. other health care professional who will be responsible for providing Findings include: care and services to the patient after discharge from the HHA 1. The clinical record of patient #2 was reviewed within 5 business days of the 2/19/19 and indicated a start of care date of patient discharge. If the patient 5/26/17. The record contained a plan of care for will be transferred to a health care the certification period of 1/22/19-3/22/19. facility a transfer summary will be sent to the facility within 2 An agency care coordination note completed by business days of the planned the registered nurse (RN) on 1/14/19 at 1:13 PM transfer. A completed transfer stated the patient was going to the emergency summary will be sent within 2 business days of becoming aware of an unplanned transfer, if the Hospital documentation indicated the patient had patient is still receiving care in a a hospital inpatient stay from 1/14/19-1/18/19. The health care facility at the time agency failed to complete and send a transfer when the HHA becomes aware of summary to the hospital when the patient was the transfer. The case manager admitted. will inquire what facility the patient will be transferred to and the 2. The clinical record of patient #8 was reviewed contact information of the facility. 2/25/19 and indicated a start of care date of 3/9/18. The case manager will contact the The record contained a plan of care for the facility to give report on patient certification period of 1/3/19-3/3/19. status. The case manager will also fax the current plan of care, An agency skilled nurse visit was completed by including medication profile, to the employee T, a registered nurse on 2/220/19. The facility for coordination of care. note indicated the patient was transported to the The case manager will document local hospital's emergency department per all communication and ambulance at 11:35 AM. The agency failed to coordination of care with the complete a transfer summary to send to the facility in the patient medical hospital when the patient was admitted. chart. If the patient is discharged from the agency, the case 3. During an interview on 2/25/19 at 2:52 PM, that manager will complete the administrator stated a transfer should be discharge summary in the clinical completed when a patient goes into the hospital chart and send to the health care for skilled patients. professional within 5 days. The

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CENTERS FOR	R MEDICARE & MEDIC		OM	B NO. 0938-039			
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15K094	B. Wl	NG		02/26/	2019
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					OGWOOD CT		
SCOTT'S	S HOME HEALTHC	ARE LLC		KOKON	MO, IN 46902		
(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 OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					ACM will track the status of all		
					patients in the agency and me	et	
					daily with the clinical staff to review the status of each patie	ant	
					and any outstanding	71 IL	
					documentation needed. The A	ACM	
					will ensure all transfer		
					documentation and discharge		
					summaries are sent to the		
					appropriate provider within the		
					regulated time frame. The ACI	M	
					will review all documentation		
					provided by the case manager		
					prior to sending to the medical		
					provider. The Administrator wi meet daily with the ACM to rev		
					patient status and ensure all	/IEW	
					documentation has been sent	to	
					the appropriate provider in the		
					regulated time frame required.		
					Administrator will also review		
					of all documentation monthly t	0	
					ensure the documentation was		
					sent in the regulated time fram	ıe	
					for all patients transferred or		
					discharged from the agency.		
G 1024							
Bldg. 00							
ыиу. 00			G 1	024	The ACM will review all clinica	ıl	03/28/2019
	Based on record rev	view and interview, the agency	0 1	UZ <del>4</del>	documentation composed by t		03/20/2019
		te visit documentation for 3 of			nursing staff for accuracy. The		
	7 full records review	wed. (#2, 4, 5)			nursing staff will complete visit		
					documentation in the electroni		
	Findings include:				medical chart and select		
					"complete" at the conclusion o	f	

FORM CMS-2567(02-99) Previous Versions Obsolete

1. A policy dated 1/14/19, titled "Clinical Records-

Purpose and Content #252.00" stated, "...7.

Signed and dated clinical notes for each contact

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complete, the ACM will receive the

their documentation. Once

electronic documentation and

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15K094	B. W	ING		02/26/	2019
				GTDEET	ADDRESS SITY STATE TIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
0007710	NI OME LIENT THO	ADELLO			OGWOOD CT		
SCOTTS	S HOME HEALTHCA	ARE LLC		KOKON	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	which are written th	ne day of service and			review each document for		
	incorporated into th	e patient's clinical record at			completion. The ACM will rev	iew	
	least weekly"				for content, date and signature		
					the nurse. The ACM will utilize	-	
	2. The clinical reco	ord of patient #4 was reviewed			comprehensive assessment		
	on 2/20/19. An age	ency discharge comprehensive			checklist to audit all visit		
	assessment was con	npleted on 11/2/18. The			documentation. The ACM will	lock	
		dence a date, time, or a			the document once the visit		
		illed Nurse (Employee T) who			documentation is complete. A	II	
	_	ment. 3. The clinical record of			nursing staff will be in serviced		
	patient #2 was revie	ewed 2/19/19 and indicated a			re educated on the documenta		
	start of care date of	5/26/17. The record contained			process by 3/28/19. Field staff	fwill	
	a plan of care for th	e certification period of			notify the agency at any time t	:he	
	1/22/19-3/22/19.				visit can not be completed in t		
					patient home due to a change	d	
	An agency care coo	ordination note completed by			condition in the patient medica	al	
	the registered nurse	(RN) on 1/14/19 at 1:13 PM			status. The field staff will conf	tact	
	stated that the patie	nt was going to the			the agency and request to spe	eak	
	emergency room.				with the case manager. If the	case	
					manager is not present the fie	ld	
	Hospital documenta	ntion indicated that the patient			staff will request to speak to a		
	had a chest X-ray co	ompleted at the hospital on			member of the nursing staff		
	1/14/19 at 3:23 PM	and had a hospital inpatient			present at the agency at the ti	me	
	stay from 1/14/19-1	/18/19.			of the call. Nursing staff will		
					instruct the field staff on how t	0	
	_	ted by employee S, home			proceed with the patient visit a	and	
		was documented on 1/14/19			instruct the field staff to end th		
	from 3:40 PM-5:02	PM. The agency failed to			patient visit if the patient is tak	en	
	authenticate the visi	it for employee S, home health			to the hospital and the aide ca	ın	
		as the patient was in the			not complete the visit as		
	1	the time the visit was			scheduled. Nursing will docur		
	completed.				in the phone log of the patient	the	
					instructions given and verbal		
	_ ~	2/25/19 at 3:49 PM, the			understanding of the instruction		
		the scheduler should have			Nursing will inform scheduling		
	notified the aide to leave after taking the patient to		department and note auditing				
the hospital, they are not sure what happened but		specialist of visit status. All field					
		yed at the hospital with the	staff will be in serviced by 3/28/19				
	patient until the shift	ft ended.			on reporting patient status		
					instructions to agency when vi	isit	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED	
		15K094	B. W	ING		02/26/	/2019	
					Property and the state of the s			
NAME OF P	ROVIDER OR SUPPLIER	_			ADDRESS, CITY, STATE, ZIP COD			
				1817 DOGWOOD CT				
SCOTTS	HOME HEALTHCA	ARE LLC		KOKON	1O, IN 46902			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	N		(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'		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
		rd of patient #4 was reviewed			can not be completed in patier	nt		
		cated a start of care date			home in its entirety. All office s			
		DC comprehensive			will be in serviced	otan		
		ipleted on 11/2/18. The						
		lence a date, time, or a			on authenticating visit	•		
					documentation by 3/28/19. The	9		
		lled nurse who completed the			Administrator will ensure this			
	document.				procedure is upheld by review	•		
	F The alteriors	nd of notion t #5			all phone log reports daily by	eria		
		rd of patient #5 was reviewed			of each business day.			
		ed a start of care date of 3/2/18.			Administrator to meet with AC			
		e (DC) comprehensive			daily to review patient status a			
		ipleted on 8/2/18. The record			utilize this information to ensur			
		date, time, or a signature for			all documentation is completed			
	the skilled nurse wh	o completed the document.			the patient phone log of patien	t		
					chart.			
	-	iew on 2/26/19 at 10:40 AM,						
		nd alternate administrator was						
		ngs and had nothing further to						
	submit for review.							
N 0000								
Bldg. 00								
			N 0	000				
	This was a state re-l	icensure home health survey						
	with three (3) comp	laints.						
	Complaints:							
	IN00175656; substa	intiated with findings						
	IN00212618; substa	intiated with findings						
	IN00277902; substa	intiated with findings						
	Facility #: 012928							
	Provider #: 15K094	1						
	Medicaid #: 20109	1400						
	Survey dates: Febru	uary 15, 18, 19, 20, 21, 22, 25,						
	26; 2019							

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	î í	ILDING	INSTRUCTION  00	(X3) DATE ( COMPL <b>02/26</b> /	ETED
		Tortoo	D. 111		ADDRESS, CITY, STATE, ZIP COD	02/20/	2010
	PROVIDER OR SUPPLIER  HOME HEALTHCA		1817 DOGWOOD CT KOKOMO, IN 46902				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
N 0470 Bldg. 00	Skilled Services: 2 Home Health Aide of Unduplicated Census Record reviews with Record review with Discharged record review Total clinical record administration/main Rule 12 Sec. 1(m) shall be written an control of communicompliance with a laws.  Based on observation failed to ensure all spolicies and standar visits observed (#1, Findings include:  1. The centers for distated that the hands following: "Wet you water (warm or cold soap. Lather your hat together with the so of your hands, between your nails. Scrub your seconds."  2. An agency policies "Infection Control,"	only: 78 as: 128 a home visit: 3 out home visits: 14 eviews: 6 ews: 10 als reviewed: 17 an) acy nagement Policies and procedures d implemented for the nicable disease in pplicable federal and state on and interview, the agency staff followed infection control d precautions for 3 of 3 home	N 0-	470	The agency handwashing policitate employee must scrub all surfaces of hands for a minimus of 20 seconds. All clinical staff be reeducated and checked of handwashing by nursing staff before 3/28/19. Nursing staff to checked off by Administrator before 3/28/19. Copy of check to be filed in employee file as pof compliance. Administrator tensure all field staff was comp before 3/28/19 by reviewing employee handwashing check report showing completion of employee check off. Case manager nurse to supervise put handwashing technique at each supervisory visit. This will be a sitem on the supervisory visit for CM will educate aide as needed.	um  f to  ff on  be  off  oroof  do  liant  off  roper  ch  l line  orm.	03/28/2019

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	r í	JILDING	onstruction 00	(X3) DATE COMPL <b>02/26</b> /	ETED
	PROVIDER OR SUPPLIER S HOME HEALTHC		•	1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(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)	TE	(X5) COMPLETION DATE
	their hands with soa all surfaces of the h" The agency pol guidelines for profe  3. During a home of the second seco	ap and warm water, scrubbing ands, for at least 10 seconds licy failed to follow the CDC essional standards.  Visit observation on 2/18/19 at ent #1, employee D, home was observed providing loyee D started the visit with a sh and applied gloves. After with shower employee D e patient back and bilateral feet d completed a 12-second hand etion of the visit, employee D and hygiene per CDC [centers recommendation of at least 20 visit observation on 2/18/19 at tient #2, employee C, licensed N), was observed providing yee C started the visit with a sh. Employee C failed to one per CDC recommendation			and document on Supervisory visit. Supervisory visit will be audited by ACM or delegated for compliance All new employ to receive employee handbook including handwashing policy, agency field staff to have annulated infection control review at the Blitz that is conducted at the agency by the nursing staff and reviews all requirements of the field staff while performing path visits. The Administrator to oversee the annual skill review ensure every employee has infection control education annually.	RN vees < The ual HHA d eient	
	-	riew on 2/18/19 at 1:43 PM, the I that staff should be washing econds.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  02/26/2019		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  1817 DOGWOOD CT  KOKOMO, IN 46902			
(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	
N 0508 Bldg. 00	or her rights as a pagency as follows (2) The patient hollowing: (E) Confidentiali maintained by the home health agen of the agency's poregarding disclosured based on observation interview, the agence ensure a confidential maintained for 1 of utilizing electronic of the interview, the agence ensure a confidential maintained for 1 of utilizing electronic of the interview of the	as the right to exercise his patient of the home health as the right to the ty of the clinical records home health agency. The cy shall advise the patient dicies and procedures are of clinical records.  In record review and ey administrator failed to all clinical record was 1 home visits observed documentation (#1).  The ty of the clinical records and procedures are of clinical records.  In record review and ey administrator failed to all clinical record was 1 home visits observed documentation (#1).	N 0508	The agency will ensure all pat clinical records are kept confidential. For field employ specifically, the agency will enforce the policy titled "Com Terminals/Workstations/Hand Held Devices," specifically #3 said policy stating "A user ma not leave his/her workstation, terminal or hand held device unattended for periods of time breaks, lunch, meetings, etc) unless the terminal or device screen is cleared and the use logged off." #4 A user must of the terminal and device scree the workstation or terminal is unattended. All field staff will serviced by 3/28/19 on confid clinical records. The agency's field staff will be required to lot their hand held device per the above mentioned policy and specifically #8 Hand held devimust have a security pass code/word, screen lock or fing print lock enabled on the lock	ees  puter  of y  e (e.g  r is lear n if left be in ential s ock e dices	

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  02/26/2019	
	PROVIDER OR SUPPLIE		1817 [	ADDRESS, CITY, STATE, ZIP COD DOGWOOD CT MO, IN 46902	1	
(X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
TAG	agency's software employee D would did not have her repassword, but raths screen that it had be to ensure staff proferecord against unation unlocked persondid not require use re-entered when leprogram.  During an intervie employee D was accould pick her phoclinical record and didn't know it did to buring an intervie administrator state main agency software.	w on 2/18/19 at 1:59 PM, the d that she would have to call are program company about s supposed to have staff	TAG	screen. The field staff is to lot their screen any time their de is not actively in use by the firstaff. The field staff will compute home health aide note by marking the completed tasks, receive the patients signature verification of tasks and department from the electronic home heal aide note. The field staff will be on their hand held device this time and will lock their dewhen they are not actively completing their home health note. The in service record with kept in the employees file to ensure completion. The Administrator will ensure all fistaff were in serviced by nurse staff by reviewing the compleservice log. All new field employees will be trained on proper HIPAA procedures and the above mentioned policy proper to FPC. The agency will not on the clinical software system ensure employee electronic of its secured and will utilize this process to guarantee patient medical information is kept confidential. The case manage will monitor compliance by checking aide phone and if it locked when not in use at supervisory visit. CM will also educate about hand held devias needed and at supervisory concerning locking screen and HIPAA. This will be added as of the supervisory visit form.	vice eld elete efor rt lth only during vice aide vill be eld ing ted in d sign rior rely m to elevice  levice  levice  ices v visit d	

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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. WING 02/26/2019				
		15K094	B. WI	_		02/26/	2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD  1817 DOGWOOD CT  KOKOMO, IN 46902			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
N 0514	410 IAC 17-12-3(c	:)			Supervisory visits will be audit by ACM or other RN delegate compliance.		
Plda 00	Patient Rights						
Bldg. 00	following: (1) Investigate copatient or the patier representative reg following: (A) Treatment or furnished. (B) The lack of reproperty by anyon behalf of the home (2) Document be complaint and the Based on record revadministrator failed complete complaint complaint investigate.  1. An agency policy Grievance / Inciden Family Grievance / reviewing and resol concerns is based on content of the patients of the pa	oth the existence of the resolution of the complaint.  Friew and interview, the agency to investigate and document investigations for 2 of 2 tions reviewed (#9, 12).  Frocess," stated " Client / Incident Policy for receiving, ving complaints and / or in the premises of the patient's politics" The policy failed to	N 05	514	The Client/Grievance Incident recreated to show the details of the grievance process from initiation to resolution. The for will be as follows: Date Grievance/Incident received, Grievance Filed by, Individual complaint pertains to, Details of grievance, Employee(s) investigating complaint, Detail investigation, Time frame of investigation, patient notification resolution and follow up to ensure solution was completed. The Administrator to review all complaints and delegate resolution. The Administrator	of rmat of s of on of sure e	03/28/2019
	on 02/20/19 and ind	ord of patient #9 was reviewed licated a start of care date of or document titled, "Grievance /			review completed complaint for in its entirety to ensure resolut is acceptable and all sections	orm	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       02/26/2019			ETED			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902					
(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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
	employee report of The "Resolution / C 10/20/16 indicated of from the employee possible bed bugs in up with patient" Th	bed 10/19/16 indicated an bed bugs in the patient home. Counseling" for the incident on the patient was to be removed schedule and "RN notified of a patient home. RN to follow the grievance failed to evidence ation as no patient follow up			correctly completed and resolve. The Administrative Billing Specialist to keep all complete Grievance/Incident forms in a lin the Administrative Billing off All agency staff will be in servicible by 3/28/19 to educate on the updated Client/Grievance Incident form process.	d log ice. ced		
	2/25/19 and indicate agency document ti Form" dated 6/18/1 phoned in a concerr another HHA signed a visit. The "Resolute incident dated 6/19/1 resources employee sign for a client. If Immediately! Aide / incident failed to expense of the sign of	ard of patient #12 was reviewed ed a start date of 10/4/16. An tled "Grievance / Incident 8 indicated an employee in for patient #12 that regarded dipatient #12's signature after attoin / Counseling" of the '18 indicated "HR [human W] counseled aide to never can't sign to call the office. understood" The grievance evidence a through patient follow up in regards to						
	administrator stated /counseling" area of	f the complaint was the ated it "could be more						
N 0522 Bldg. 00	written medical pla	Medical care shall follow a an of care established and yed by the physician, or, optometrist or						
		riew and interview, the home	N 0:	522	The agency will provide home health services based on the N	ИD	03/28/2019	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       02/26/2019			ETED		
	ROVIDER OR SUPPLIER			1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	health aide (HHA): for 3 of 7 full records sample of 17.  Findings include:  1. An agency job de "Home health aide," Performance Responsion of care"  2. The clinical records are con 2/20/19 and indition 10/2/18. The record care) for the certifice-11/30/18, which in hours per day, 5-7 of visit schedule indicated on 10/25 in duration. The HI frequency parameter hours).  3. The clinical record certification period indicated a frequency days per week. The indicated the HHA were only 1 hour in of patient #5 was restart of care date of a plan of care for the 6/30/18-8/28/18 that hours per day, 5-7 of the certification period in the control of the certification of the certification period indicated the HHA were only 1 hour in of patient #5 was restart of care date of a plan of care for the 6/30/18-8/28/18 that hours per day, 5-7 of the certification period in the care of the following per day, 5-7 of the certification period indicated the HHA were only 1 hour in of patient #5 was restart of care date of a plan of care for the following per day, 5-7 of the certification period in the certification period indicated the HHA were only 1 hour in of patient #5 was restart of care date of a plan of care for the following period in the certification period in the certification period indicated the HHA were only 1 hour in of patient #5 was restart of care date of a plan of care for the following period in the certification period in the certific				approved order. Any time the agency falls below the hours of days of the approved order the will be notified. The process where as follows: The note auditing specialist will review all complete visits utilizing the note verifier in the medical software system. completed visit falls below the ordered hours or the patient who not seen for the ordered minimited days, the note auditing special will write a communication to the case manager. The case manager will notify the MD that the patient was not seen for the minimum hours or days per the MD order. The case manager inform the MD who provided cafor the patient during the time not seen by the agency. The ACM will be copied on the notification by the note auditing specialist order to track and ensure that case manager notified the MD documented appropriately. The ACM will review all documentated by the case manager in order to verify notification to the MD is completed in a timely manner. The Administrator will ensure policy is upheld by meeting with the ACM daily to review the state of each patient and any and all follow up needed and complete the Administrator will audit 10 the Admin	r MD  vill ng eted in a sum ist he e will are for in the and he to this he to the eter.	
	2/2/18 that was 2 ho hours in duration, a	ours in duration, 7/4/18 was 3.5 and 7/17/18 was 3 hours in failed to follow the frequency			all clinical documentation mon to ensure nursing is following t process appropriately. Home	thly	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15K094			JILDING	00	(X3) DATE : COMPL 02/26/	ETED	
	PROVIDER OR SUPPLIER			1817 DC	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(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 APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	5. During an interv	olan of care (4-6 hours).  Tiew on 2/25/19 at 1:47 PM, the lathat staff should be following			health aides to be educated or 3/26/19 by letter with paycheck explaining order frequency and duration and discussing this will clinical Manager or delegate will ensure understanding through question and answer with each aide by phone or face to face. new employees will be trained about frequency and duration is same manner upon hire.	k d ith ho ugh n All	
N 0524 Bldg. 00	plan of care shall: (A) Be developed home health agen (B) Include all ser skilled service is b (B) Cover all perti (C) Include the fo (i) Mental statu (ii) Types of ser required. (iii) Frequency a (iv) Prognosis. (v) Rehabilitatio (vi) Functional lii (vii) Activities per (viii) Nutritional re (ix) Medications (x) Any safety ragainst injury. (xi) Instructions referral.	(1) As follows, the medical  I in consultation with the acy staff. rvices to be provided if a being provided. inent diagnoses. allowing: as. rvices and equipment and duration of visits.  on potential. mitations. rmitted. equirements. and treatments. measures to protect  for timely discharge or dalities specifying length of	N O	524	The PN will utilize the		02/28/2010
			N 0:	524	The RN will utilize the		03/28/2019

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  15K094		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019		
	PROVIDER OR SUPPLIER S HOME HEALTHC			1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(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)	TE	(X5) COMPLETION DATE
TAG	Based on observation interview, the Registance accurately completed pertinent diagnoses (#2, 3, 4, 5, 9, 15), of for all identified net (#1, 2, 3, 4, 5, 9, 15) frequency and duration reviewed (#2) and dequipment (DME) is records reviewed (#4). An agency policional plan of care," Policionarising care-plan with Services to be providuration of visits 6 administration and clinical notes from services11. Paties preferences, including used to demonstrate achievement of the patient"  2. The clinical record on 02/18/19 and incomplete the certification of the certificatio	on, record review and stered Nurse (RN) failed to the plan of care to include all for 6 of 7 records reviewed ensure the goals were present eds for 7 of 7 records reviewed), included all patient-specific tion for 1 of 7 records contained all durable medical in the patient's home for 2 of 7 (2, 15) in a sample of 17.  The vill contain the following:4. ided. 5. Frequency and all personnel providing int's strengths, goals, and care fing information that may be the patient's progress toward goals identified by the		TAG	comprehensive assessment checklist at each nursing visit ensure all required tasks are completed. All diagnosis to be listed in plan of care. All medications listed to have an appropriate diagnoses to support the patient medication prescrit ACM to audit all documentation for accuracy after each nurse and to ensure all assessment findings have a listed diagnos support findings. Patient specific frequency and duration to be reviewed and verified with the order. RN to ask patient at each nurse visit to state all DME in home and list on the plan of coin DME specific section. ACM ensure all DME reported in assessment is listed in DME section of plan of care. ACM ensure process is followed by performing nursing supervisor visit and reviewing DME obse and reported in the patient how and reviewing each medical diagnoses with patient to ensuall diagnoses are listed on placare. ACM to educate nurse of any deficiencies found. Nurse correct deficiencies within 48 hours and deliver updated patinformation to patient folder in	to e port bed. on visit is to ciffic MD oth the are to visit is to ito ito ito ito ito ito ito ito ito i	DATE
	failed to evidence diabetes, hypothyro the patient's allergie allergies).	goals related to the type 2 bidism, and failed to evidence es (if any) or NKA (no known			home if applicable and patient medical chart. Administrator to meet with ACM daily and revie all nursing supervisory visits. Administrator to review supervisit forms to ensure ACM	: O <del>E</del> W	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		A. BUILDING <u>00</u> COMPL		(X3) DATE SURVEY COMPLETED 02/26/2019				
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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			
TAG	assessment dated 2/was taking Cetirizin (blood thinner) and (hypothyroidism). evidence pertinent ouse ceterizine, eliquidated 2/20/19 and india 10/2/18. The record certification period indicated diagnoses pulmonary disease theart failure (CHF) evidence patient speam of CHF.  The agency compressessment dated 10 was experiencing didiagnosis of Hypert evidence a pertinent and goals related to 4. The clinical record 2/20/19 and india 9/12/18. The record certification period indicated, but not lidiabetes mellitus with of care failed to evidiabetes.  The agency compressessment dated 1/was taking Atorvasi Belsomra (insomnia disponition).	12/19, indicated the patient are (antihistamine), Eliquis Levothyroxine The plan of care failed to diagnoses and goals related to ais, and levothyroxine.  Ord of patient #4 was reviewed cated a start of care date di contained a POC for the of 10/2/18 -11/30/18 that of: chronic obstructive (COPD)Chronic congestive The plan of care failed to exific goals related to COPD  The plan of care failed to exific goals related to POC failed to diagnosis of hypertension dyspnea and edema and a ension. The POC failed to the diagnosis of hypertension dyspnea and edema.  The poc for the of 1/10/19-3/10/19 which mitted to diagnoses of Type 2 atthout complication. The plan dence goals related to Type 2  The plan of care date di contained a POC for the of 1/10/19-3/10/19 which mitted to diagnoses of Type 2 atthout complication. The plan dence goals related to Type 2  The plan of care date dence goals related to Type 2  The plan of care date dence goals related to Type 2  The plan of care date dence goals related to Type 2	TAG	completed form and addresse deficiencies with nurse. Administrator to ensure nurse corrected any deficiencies and documented updated informat was delivered to patient within given time frame.	d all has dition			
	reflux), Maxalt (mig	on), Pepcid (gastroesophageal graines), Venlafaxine d Clopidogrel (blood thinner).						

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K094		A. BUILDING 00 COMPLETED  B. WING 02/26/201			LETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		ET ADDRESS, CITY, STATE, ZIP COD ' DOGWOOD CT		
SCOTT'S	HOME HEALTHC	ARE LLC		OMO, IN 46902		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION
TAG	The plan of care fair diagnoses and goals medications identifications identifications identificated on 02/21/19 and inco 05/24/13. The recording the certification per indicated diagnoses diabetes mellitus where unspecified osteoar equipment] gluccalcohol pads, urinare bagSN (skilled not on measure to decreate failed to evider related to diabetes a evidence a diagnosis. The agency compresussessment dated 00 had an indwelling frand edema. The pla pertainent diagnosis patients indwelling hypertension (due to evidence foley carmeasures and emergicatheter based on no clinical record of parand indicated a starrecord contained a period of 1/15/19-3 to evidence goals repain, and diabetes be of the patient on the as evidenced by:	hensive recertification 1/21/19 identified the patient oley catheter and hypertention an of care failed to evidence s and goals related to the	TAG	DEFICIENCY		DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15K094		A. BUILDING 00 COMPLETED  B. WING 02/26/2019			PLETED	
	ROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COI OGWOOD CT MO, IN 46902	)	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	1/10/19 identified the constipation, pain and	ne patient had edema, nd was a diabetic.				
	2/19/19 and indicate 5/26/17. The record the certification per indicated a frequency attendant hours. The evidence patient-specincontinence, type I obstructive pulmonal evidence a diagnosi antihypertensive me	rd of patient #2 was reviewed ed a start of care date of d contained a plan of care for iod of 1/22/19-3/22/19 that ey of 70 hours a month waiver e plan of care failed to ecific goals related to urinary I diabetes, asthma and chronic ary disease (COPD), failed to see related to the use of edication and failed to have and duration for the patient's see.				
	10:00 AM, with pat practical nurse (LPN skilled care. DME i grabber, nebulizer, l emergency alert bra	observation on 2/18/19 at ient #2, employee C, licensed N), was observed providing in the home observed was a hospital bed, and an celet. The plan of care failed pment identified in the home.				
	6/1/17 identified the incontinence, and sloxygen use. The plagoals related to eden	nortness of breath with an of care failed to evidence ma, incontinence, and and/ or oxygen use based on				
	2/21/19 and indicate The record containe certification period indicated "Incision" with no s / sx infect	rd of patient #5 was reviewed ed a start of care date of 3/2/18. d a plan of care for the of 6/30/18-8/28/18 that will cont [continue] to heal ion throughout certification in of care failed to evidence				

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K094		ì	JILDING	nstruction <u>00</u>	COMP	E SURVEY PLETED 6/2019	
	PROVIDER OR SUPPLIEI			1817 DO	DDRESS, CITY, STATE, ZIP CO DGWOOD CT IO, IN 46902	OD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE ALL DEFICIENCY)	OULD BE	(X5) COMPLETION
TAG	patient-specific goal incontinence, interr hypertension failed	als related to urinary mittent asthma, and to evidence diagnoses related and anti-anxiety medication		TAG	DEFICIENCY)		DATE
	6/27/18 identified to constipation, and up of care failed to evident	rehensive recertification dated the patient had edema, rinary incontinence. The plan dence goals related to edema, rinary incontinence based on					
	administrator stated contain all DME in	y on 2/25/19 at 1:46 PM, the I that the plan of care should the home, all pertinent the patient's medications, entified needs.					
N 0533	410 IAC 17-13-2 Nursing Plan of C	are					
Bldg. 00	must be develope the purpose of de patient care provi- agency for patien	A nursing plan of care d by a registered nurse for legating nursing directed ded through the home health as receiving only home es in the absence of a					
	following: (1) A plan of care identifying information (2) The name of (3) Services to be	the patient's physician. e provided.					
	(5) Medications,	_					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K094		A. BUILDING <u>00</u> CC			(X3) DATE COMPL 02/26	ETED	
	PROVIDER OR SUPPLIEI S HOME HEALTHC			1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(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)	λΤΕ.	(X5) COMPLETION DATE
		e note. e of the registered nurse					
	registered nurse (R care plans were cor to ensure that the ai individualized with completed for 7 of (home health aide)  Findings include:  1. The clinical record on 02/18/19 and include:  1. The clinical record (POC) for the certification of 1-3 hours per day with diabetic foot of (activities of daily) (instrumental activities o	view and interview, the N) failed to ensure that an aide inpleted for each shift and failed de care plan was specific tasks timeframe's to be repaired plan that services (#1, 2, 3, 4, 5, 9, 15).  ord of patient #3 was reviewed dicated a start of care date of d contained a plan of care fication period of high indicated a HHA frequency y 1-3 days per week to assist are and with all ADL's	NO	533	The RN will compose a compand individualized care plan for patient upon admission and was review the patient care plan with the patient at each nurse visit. The RN will do so by utilizing electronic patient system and creating individual tasks for expatient. Each task will be speas to when (day and/or time or day) the task should be compaturing the visit and the degree involvement the aide will have helping the patient complete task. The Administrator will inservice all nursing staff on the plan requirements by 3/28/19. ACM will review all visit documentation for thoroughneand to ensure care plan is spet to patient needs. Administrate ensure procedure is followed auditing 10% of all charts mor for accuracy. Scheduling to notify Administrator the last week of each month to report schedule were mailed. Schedule to be in patient folder. Schedule to show date, time and schedule aide. The RN to put copy of completed patient medication in patient folder in patient hom RN to update as applicable. For each month to report schedule in patient folder in patient hom RN to update as applicable.	or the rill rith the cific of leted e of e in he e care The ess ecific or to by hall he y ess kept ed list he.	03/28/2019

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CO A. BUILDING B. WING			
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION ord of patient #4 was reviewed	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  Check patient folder at each n	DATE
	on 2/20/19 and indi 10/2/18. The record certification period HHA frequency of 2 week to assist with HHA care plan.  The agency docume Care Plan" indicated [blank]Current Ai 10/4/2018) Assist Chair - AM Clear Complete Bed Bath patient to do as much stand up to change p	cated a start of care date d contained a POC for the of 10/2/18 -11/30/18 indicated a 2-4 hours a day, 5-7 days a ADL's and IADL's per the		visit to ensure patient schedul and medication profile is pres in patient folder and replace if missing. ACM to perform nurs supervisory visits monthly and inspect patient folder for all mandatory items including paschedule and medication prof Administrator to review all completed nurse supervisory during daily meetings with AC	de ent ent ent ent ent ent ent ent ent en
	carePeri Care, Put with Assistance - W plan failed to identi once a week for exa completed.	t 2 pull-ups at each visitUp  Theelchair" The HHA care fy the timeframe (every visit or ample) the tasks that were to be			
	on 2/20/19 and indi 9/12/18. The record certification period	ord of patient #9 was reviewed cated a start of care date d contained a POC for the of 1/10/19-3/10/19 indicated a 2-3 hours a day 5-7 days per ADL's and IADL's.			
	Care Plan" indicated [blank]Current Ai 9/12/2018)Assist Dressing, Assist with Stransfer, Assist with Clean Dentures, Clear Clear Company Combined Transfer, Clear Company Combined Transfer, Clear Dentures, Clear Company Combined Transfer, Combin	de Plan (Effective Date: with Ambulation, Assist with th Shower Utilizing Shower sponge bath, Assist with th Tub BathClean Bathroom, ean Kitchen, Clean up after			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15K094			A. BUILDING B. WING	00	COMPLETED 02/26/2019
	ROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Prepare MealShar Trash, Up as Tolera Walker" The HH what timeframe (ev	npoo Hair, Sweeping, Take out ted, Up with Assistance - A care plan failed to identify ery visit or once a week for were to be completed.			
	care date of 05/24/1 01/23/19 - 03/23/19 indicated a HHA fro	rd of Patient # 15 with a start of 3 and certification periods of was reviewed on 02/21/19 equency of 4 hours a day 7 at with ADL's and IADL's.			
	Care Plan" indicated [blank]Current Ai 11/30/2017)Assig	de Plan (Effective Date:			
	transferCatheter c FootcarePeri care sugarShampoo ha and after visit" T	ponge bathAssist with areChange linensDusting,Remind patient to take blood ir, Spray with Alcohol before the HHA care plan failed to cific tasks for the aide to			
	complete during each failed to identify whonce a week for exacompleted.5. The creviewed 2/18/19 at	ch visit. The HHA care plan nat timeframe (every visit or mple) the tasks were to be linical record of patient #1 was not indicated a start of care date ord contained a plan of care for			
	the certification per indicated a home h 1 hour, 3-5 days per	iod of 1/15/19-3/15/19 that ealth aide (HHA) frequency of			
	tasks to be complete non-medicated lotic ambulation, assist w chair, assist with tra dentures, comb hair	ed as follows: Apply on to the skin, assist with with showering utilizing shower ansfer, clean bathroom, clean , foot care Incontinent Care, e, Peri Care, remind patient to			

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PRINTED: 04/03/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094				JILDING	instruction 00	(X3) DATE ( COMPL <b>02/26</b> /	ETED
	ROVIDER OR SUPPLIER HOME HEALTHC		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902				
(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)	TE	(X5) COMPLETION DATE
1.70	put in / assist with I put on glasses. The identify what timef week for example)  During a home visi AM, with patient # aide (HHA), was of care. Employee D is the patient showere employee D wash to lotion to the back programmer or remind the patient profailed to clean denticare or remind the patient profailed to care indicated a HHA from 4-6 days per week.  The agency aide/ he tasks to be completed ambulation, assist vishowering utilizing sponge bath, blood bathroom, clean kit Incontinent- bladde care prepare mean trash, Make Bed, Ocare plan failed to it visit or once a week be completed.  7. The clinical recognition of the patient profailed to it visit or once a week be completed.	nearing aid, remind patient to a caide care plan failed to rame (every visit or once a the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at the tasks were to be completed.  It observation on 2/18/19 at 8:00 at					
		-					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K094		A. BUILDING 00  B. WING		COMPLETED 02/26/2019	
	ROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902	
(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
	aide careplan indica assist with shower,	iod of 12/16/18-2/13/19. The ted the aide was to complete: assist with sponge bath, clean Wednesday), foot care, up lker).			
	12:00 PM, with patiobserved providing stood outside of the showered self. Empthe patient's legs an out of the shower, elegs and feet. The pteeth and ambulated rubbed lotion on the	t observation on 2/18/19 at ient #3, employee E, HHA, was personal care. Employee E shower while the patient ployee E washed the back of d back. After the patient got employee E dried the patient's patient dressed self, brushed it to the chair. Employee E e patient's feet, and the patient shoes on. Employee E failed are plan.			
	2/21/19 and indicate The record contained	ord of patient #5 was reviewed ed a start of care date of 3/2/18. ed a plan of care for the of 6/30/18-8/28/18 4-6 hours er week.			
	tasks to be complete non-medicated lotic ambulation, assist v feeding patient, assist shower chair, assist transfer, clean linen kitchen, comb hair, reminders, Oral care failed to identify wh	omemaker care plan had the ed as follows: Apply on to skin, assist with with dressing, assist with state with shower utilizing with sponge bath, assist with s, clean bathroom, clean Make Bed, medication e, Peri Care. The aide care plan nat timeframe (every visit or ample) the tasks were to be			
		iew on 2/25/19 at 1:33 PM, the that the aide care plan is			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15K094				JILDING	00	COMPL 02/26/	ETED
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
N 0537 Bldg. 00	specific to the patien (aide documenting sagency to have one and payer types.  410 IAC 17-14-1(a Scope of Services Rule 1 Sec. 1(a) To shall provide nursi nurse or a licensed accordance with the follows:  Based on record revenurse (SN) failed to with the plan of care with skilled nurse secondary in the clinical record of 2/19/19 and indicated 5/26/17. The record the certification periodicated a frequency 1 hour per week to follow the plan of care frequency as eviden.  On week 1 the SN version for 45 minutes.  On week 2 the SN version for 45 minutes.	and that the Elvis system system) only allows the saide care plan for all shifts  The home health agency and services by a registered depractical nurse in the medical plan of care as siew and interview, the skilled conduct visits in accordance are for 1 of 2 records reviewed ervices (#2) in a sample of 17.  The properties of the state of the contained a plan of care for its for the skilled nurse (SN) of the pillbox. The SN failed to the ced by:  The properties of the state of the pillbox of the skilled nurse (SN) of the pillbox. The SN failed to the ced by:  The properties of the state of the pillbox of the pillbox of the skilled nurse (SN) of the pillbox. The SN failed to the pillbox of the state of the pillbox of the pillbox. The SN failed to the pillbox of the pillbox of the pillbox of the pillbox. The SN failed to the pillbox of the pillbox of the pillbox of the pillbox. The SN failed to the pillbox of the pillbox of the pillbox of the pillbox. The SN failed to the pillbox of the pillbox. The SN failed to the pillbox of t	N 0		The agency will indicate a frequency for the skilled nurse by documenting the visit per w and not hours per week the pais seen for an MD ordered skill The frequency and order for sh nurse visits will be on the patie plan of care. The ACM will educate the nursing staff, at the daily nurse meeting, on this process and implement the change by 3/28/19. The ACM ensure this process is upheld be reviewing all clinical documentation completed by the nurse and utilizing the comprehensive assessment checklist when auditing all clinical documentation, specifically the patient plan of care. The Administrator will ensure this process is upheld by reviewing 10% of all nursing visits months.	eek tient . killed ent e will by he	03/28/2019
	for 45 minutes.	risit was completed on 2/12/19					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/26/2019	
	ROVIDER OR SUPPLIER			1817 DO	DDRESS, CITY, STATE, ZIP COD DGWOOD CT 10, IN 46902		
(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)	ΓE	(X5) COMPLETION DATE
N 0541 Bldg. 00	On week 2 the SN v for 45 minutes.  During an interview administrator stated ordered frequencies  410 IAC 17-14-1(a Scope of Services Rule 14 Sec. 1(a) services are limite purposes of practisetting, the register following:  (B) Regularly reeveneeds.  Based on observation interview, the Register ensure contents of the assessment was according reviewed in a sample.  Findings include:  An agency policy decompleting the Constated "Once OASIS accurately and refleed 102/18/19 and indicated 102/18/19/19/19/19/19/19/19/19/19/19/19/19/19/	risit was completed on 2/18/19  If on 2/25/19 at 1:47 PM, the that staff should be following  (a)(1)(B)  (1)(B) Except where do to therapy only, for ce in the home health ered nurse shall do the valuate the patient's nursing  on, record review and stered Nurse (RN) failed to the comprehensive urate for 1 of 7 full records the of 17 (#3).  Attended 1/14/19, titled " imprehensive assessment" is completed but the patient's status "  of patient #3 was reviewed on ted a start of care date of it contained a plan of care	N 05		The CM will provide a comprehensive assessment the accurately reflects the patient status. The agency will ensure consistency of this regulation be requiring all CM to follow and complete an approved checklist form of tasks at each comprehensive assessment vitiled comprehensive assessment vitiled comprehensive assessment checklist. This form includes review of all medications, their and indication, any education regarding initial diagnosis requirescribed medication need are systems review including skin assessment to address all medical diagnosis in plan of calcare plan items will be reviewed with patient at each nurse visit	e by st sit ent use uiring and	03/28/2019
	urinary tract infection mouth three times d	ons) 100 milligrams 1 tablet by aily for 3 days that began osis of Type 2 diabetes. The			ensure no changes in patient hoccurred during current certification period. Care plan	nave	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15K094			A. BUILDING B. WING	00	COMPLETED 02/26/2019
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD	
	HOME HEALTHCA			MO, IN 46902	
(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
N OF 44	infection or the user information about the independently reach shoes as evidenced by the shoes	observation on 2/18/19 at at #3's home, employee E, a and the patient's shower was applied lotion on the patient's patient then lifted the right leggue left knee. The patient beige, callused area below the patient stated the callus had along time" and recently the patient stated the callus had along time" and recently the patient stated the callus of the foot. The led on the sock to the right is process on the left foot. The patient to put both antly.  In the patient stated the callus had along time and recently the patient stated the callus of the foot. The patient is process on the left foot. The patient is process on the left foot. The patient is diabetic and requires abetic foot care at each visit as the her feet The evidence the presence of a to the soles of the feet, failed to the administrator stated that the patient infection infection that the patient infection that the patient infection infection that the patient infection infe		be customized and updated if patient status change occurs reflect patients current needs. ACM to ensure all checklist its for patient visit have been completed by nurse by review all visit documentation for accuracy. The ACM will utiliz the CM checklist in auditing the skilled nurse documentation. Clinica staff will be in serviced and reeducated on comprehensive assessment procedure by 3/28/19. The Administrator or delegate will audit at least 10° all comprehensive assessmen visits to ensure this regulation upheld.	to ems ring e l
N 0544	410 IAC 17-14-1(a Scope of Services				
Bldg. 00		(1)(E) Except where d to therapy only, for			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE ( A. BUILDING B. WING					
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  1817 DOGWOOD CT  KOKOMO, IN 46902				
(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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE		
		ce in the home health ered nurse shall do the					
N of the	Based on record revenurse (SN) failed to completely and accorreceiving skilled nut (#4).  Findings include:  The clinical record 2/20/19 and indicated the record contained period of 10/2/18 -1 diagnoses of Chrone Disease, Unspecified chronic pain, Chrone the agency compresses assessment dated 10 had a diagnosis of the experiencing dyspin evidenced a pain 0-"perceived pain leverassessment: 0 Per relief measures: 7 Physician notified of COPD: No Chrone disease YES dyspevidenced conflicting pain, respiratory stated that nursing of conflicting.	riew and interview, the skilled prepare clinical notes arately for 1 of 2 patients rsing services in a sample of 17  of patient #4 was reviewed on ed a start of care date 10/2/18. Ed a POC for the certification 1/30/18 that indicated it Obstructive Pulmonary d abnormalities of gait, other its congestive heart failure"  hensive recertification 0/2/18 indicated the patient Hypertension and was see and edema. The document 10 pain scale and indicated, el during the day of received pain level AFTER pain and CaseManager and/or of the elevated pain level: No inconstructive pulmonary onea NO" The document and documentation in relation to tus, and diagnoses. During an 9 at 1:48 PM, the administrator documentation should not be	N 0544	The ACM will review all clinic documentation after the nurse completes the applicable vis the electronic medical chart. ACM will utilize the comprehensive assessment check list to verify accuracy documentation. ACM to che patient pain level that was documented by nurse and if baseline was reported to MD follow up instructions receive patient education performed resolution documented. ACM check diagnosis documentate ensure consistency between of care and assessment in consistency between of care and assessment in consistency between the ACM to review endiagnosis listed in the plan of and assessment visit. The ACM instruct the nurse to correct a inconsistencies and review the corrected documentation between the process is upheld and will automore and assessing the process is upheld and will automore and another the process is upheld and will automore and another the process is upheld and will automore and another the process is upheld and will automore and another the process is upheld and will automore and another the process is upheld and will automore and another the process is upheld and will automore and another the process is upheld and will automore and another the process is upheld and will automore and another the process is upheld and will automore and another the process is upheld and will automore and another the process is upheld and will automore another the process is upheld another the process is upheld another the process is upheld	se it in The visit of ck above with ed and and of to cion to plan linical will each f care nurse chart will eany he fore The		
N 0596	410 IAC 17-14-1(I Scope of Services						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		(X2) MULTIPLE CONSTRUCTION (X2)  A. BUILDING 00  B. WING			(X3) DATE COMPL <b>02/26</b> /	ETED	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  1817 DOGWOOD CT  KOKOMO, IN 46902				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
Bldg. 00	shall be responsib patient contact, the home health aide the requirements of (1) The home he (A) have success competency evalue	sfully completed a lation program that f the subjects listed in	N 0	596	The agency will obtain a contra	act	03/28/2019
	administrator, failed home health aide (Hasks required, in the not simulated, as resplacement on the hold of 1 agency.  Findings include:  1. A policy dated 1 Aide Supervision, Tastated, " Training: competency and cerebealth aides. The prequired guidelines.  2. During an interv Nurse Practioner (Nathe HHA (home hear going through the Incompetency. The National Hours on Fridays with training with the Adevery aide performed placed on the State indicated patient #9 HHA's to perform a	riew and interview, the agency of to ensure that all prospective and ensure that all prospective all eir entirety with a patient and equired to show competence for ome health aide registry for 1  [Additional of the competence for ome health aide registry for 1  [Additional of the competence for ome health aide registry for 1  [Additional of the competence for ome health aide and the competence for ome health aide all the competence for the compet		390	RN to observe perspective hor health aide employees perform tasks in their entirety required placement on the registry. Thi RN will meet the required state standards and qualifications by the state. The RN will have a contract on file with the agency The RN will observe perspective HHAs performing tasks required on a live patient, in the patient home, in it's entirety, specifical (b)(3)(1), (iii), (ix), (x), and (xi). These areas will be observed being performed on a live patient. The RN will observe the aide performing any task that the demonstrated in a laborator setting in its entirety. The completed check off will be signly the perspective employee a contract RN and be filed in the employee file. The contract RI will register the employee with state department of health if the contract RN documents the successful completion of all required tasks by the employee Any employee that does not	me n all for s e y ve ed s illy ne can ry ned and N the e	03/28/2019

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 02/26/2019			
		ROVIDER OR SUPPLIER HOME HEALTHC		STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902				
	(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY 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)	ΓE	(X5) COMPLETION DATE
		the HHA's in the property Administrator and he they did a good job registry." When as in which the prosper placed on the State felt they didn't do comproperly or foot care.  3. During an intervent employee I (date of received 2 days of the State registry. If the training, she did and while performing the training, she did and while performing the training of the State registry. If the training intervent employee H (date of did 2 partial days of assigned a schedule semilar training of indicated she "all limb with an ace with training."  6. During an intervent employee G (date of had "4 hours training indicated she "all limb with an ace with training."  6. During an intervent employee G head "4 hours training."  7. During an intervent employee the competency check of the 75 hours the state money to do the 2 we enough money to partial days of the state of the Top the Top the State of the Top t	ogram were trained by the nerself and stated, "If I feel in the field, I sign the ked if there was any instance ctive HHA would not be registry, the NP stated, "If I ath care properly or Hoyer			successfully complete the checoff will not be registered with the state and the employee will be required to repeat the check of portion of orientation successful before being appropriate for licensing. The Administrator were view all completed paperword the contract RN to ensure the employee has successfully completed the competency choff. The Administrator will conthe patient(s) utilized for the lixtoneck off to verify each perspective employee complete the required tasks in their entire on the patient. Once verification obtained from the patient, the Administrator will initial the competency check off as documentation of completion. This time the contract RN will be notified and approved to regist the incoming employee.	ne  ff ully ill k by eck tact re ed ety on is	

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		IDENTIFICATION NUMBER  15K094	A. BUILDING B. WING	00	COMPLETED 02/26/2019
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP COD	
SCOTT'S	HOME HEALTHC	ARE LLC		MO, IN 46902	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		7. The Administrator indicated	TAG	BEIGERETT	DATE
		ospective HHA was in the field			
	_	ning it was acceptable for each			
		parts of the bath or task, taking			
		t to verify competency and			
	that the NP was trai	ning the HHA to assess the			
	patients in their care	e.			
		riew on 2/25/19 at 2:18 PM, the			
	Administrator indicated the agency had a home				
	health aide training program with a competency				
	"out in the field Other agencies send their staff				
	here to train them."9. An agency competency assessment form titled "Skills evaluated on Live				
	Patient," indicated the skills that needed				
		live patient was: bed bath,			
		th, shower, sink shampoo, tub			
		poo, fracture pan placement,			
	-	d tilting assistance, catheter			
	care, perineal care,	nail care, skin care, oral			
	hygiene and gum ca	are, denture care, bedside			
	commode, offering	bedpan/ placement, proper use			
	_	from bed to chair, transfer			
		bedside commode, transfer to			
	·	g with ambulation, assist			
	_	ne, assist ambulating with a			
	-	wheelchair to/ from,			
		ve ROM [range of motion],			
		dy, demonstrates active ROM, dy, demonstrates proper			
		emonstrates proper chair			
		strates ability to provide			
		Formation to patients,			
		egivers, and agency staff,			
		y to follow patient assignment			
	-	pulses, respirations, blood			
		based on agency policy,			
	reading, writing'	1			
	10. An agency com	npetency assessment form			

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  15K094		(X2) MULTI A. BUILD B. WING		nstruction <u>00</u>	(X3) DATE COMPL 02/26/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD  1817 DOGWOOD CT  KOKOMO, IN 46902					
				OITOIVI				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		II		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE	
		ited through simulation by						
		ten /case scenarios, or oral						
	_ ·	the skills that needed						
		id not have to be completed is "assist with a medical lift,						
	knowledge of signs							
		and importance of hydration,						
		al dietary requirements,						
	_	al diets, knowledge of normal						
		r skin problems, s / s [signs						
		skin breakdown, knowledge of						
	importance of changing positions frequently,							
	helping a patient dress, proper body mechanics,							
	using a safety razor, using an electronic razor,							
	elastic/ compression stocking application, use of							
	_	, working with a patient who						
		e, if patient had telehealth unit						
		nem to do checks, knowledge of						
		ons, knowledge of information						
	that must be reported	ed to supervisor, identifies						
	safety hazards/ issu	es in the home, basic cleaning						
	methods, making o	ccupied bed, making						
	unoccupied bed, kn	owledge of food safety,						
	cleaning equipment	t, recognizes emergency						
		ge of what to do in an						
		t report, recognizes and						
		t abuse/ neglect, is familiar						
	1	ent emergency preparedness						
	_	understanding of the need to						
		owledge of patient rights,						
		ledge of confidentiality and						
		d under HIPAA [health						
	_	y and accountability act],						
		essional boundaries,						
		e patient complaint process,						
	_	ing with patients served by the						
		ing the different types of						
		s knowledge of general patient fies changes in a patient's						
		rance that should be reported,						
	condition of appear	ance mai snound be reported,						

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15K094		A. BUILDING 00  B. WING		COMPLETED 02/26/2019	
	ROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	demonstrates ability appropriate person (accurately document document in the cline effective, handwash handwashing, dispoprecautions, recogninfections, understated for infection"  11. During an interemployee D (date of agency put her on the stated she only did at to be checked off.  12. During an interformer employee J (stated she had gone for check offs, wash other people being of schedule the next date of the stated she had gone for check offs, wash other people being of schedule the next date of the stated every would come to his fadministrator or the patient stated every would come to his fadministrator or the patient reported on a sked while the aide would multiple tube in which the patient patient stated, "If I skin would be so raides would do a "reader would on a "reade	to report patient changes to (s), demonstrates ability to (tasks, care or observations, nical record id accurate and ing, use of sanitizer versus sal of waste, standard ized signs of potential ands methods to decrease risk (view on 2/18/19 at 8:00 AM, and fhire 11/5/15), HHA stated the ne aide registry. Employee D a shower in someone's home (view on 2/19/19 at 12:01 PM, and to a patient's home one day using someone's hair while with checked off and was on the	TAG	DEFICIENCY	DATE
	-	they would all do different tated the "odd man out			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K094		r í	JILDING	onstruction 00	(X3) DATE ( COMPL <b>02/26</b> /	ETED	
	PROVIDER OR SUPPLIER			1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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)	TE	(X5) COMPLETION DATE
N 0610 Bldg. 00	would not be okay completed by every  14. During an interpatient #15 stated haides to do bed bath stated that a group of together and take to the body.  410 IAC 17-15-1(a Clinical Records Rule 15 Sec. 1. (a legible, clear, comauthenticated and must include signal computer entry.  Based on record revisited to authenticate failed to authenticate 7 full records review.  Findings include:  1. A policy dated 1 Purpose and Conter Signed and dated clear which are written the incorporated into the least weekly"  2. The clinical record revision 12/20/19. An age assessment was con record failed to evice signature for the Sk completed the docupatient #2 was revised.	view on 2/20/19 at 11:57 AM, e/ she would allow agency s on Fridays. The patient of 2-3 people would come rns washing different areas of a)(7)  (7) All entries must be plete, and appropriately dated. Authentication atures or a secured  riew and interview, the agency e visit documentation for 3 of	N 0	610	The ACM will review all clinical documentation composed by the nursing staff for accuracy. The nursing staff will complete visit documentation in the electronic medical chart and select "complete" at the conclusion of their documentation. Once complete, the ACM will receive electronic documentation and review each document for completion. The ACM will review for content, date and signature the nurse. The ACM will utilize comprehensive assessment checklist to audit all visit documentation. The ACM will the document once the visit documentation is complete. All nursing staff will be in serviced re educated on the documentation process by 3/28/19. Field staff	the e t ic of e the iew e by e the lock ll d and ation	03/28/2019

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  15K094		(X2) MULTIPLE C A. BUILDING B. WING			(X3) DATE SURVEY  COMPLETED  02/26/2019		
NAME OF PROVIDER OR SUPPLIER  SCOTT'S HOME HEALTHCARE LLC			1817 🗅	STREET ADDRESS, CITY, STATE, ZIP COD  1817 DOGWOOD CT  KOKOMO, IN 46902				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
	An agency care coor the registered nurse stated that the patie emergency room.  Hospital documenta had a chest X-ray condition 1/14/19 at 3:23 PM stay from 1/14/19 at 3:23 PM stay from 1/14/19 at 3:40 PM-5:02 authenticate the visuaide, from 1/14/19 emergency room at completed.  During an interview administrator stated notified the aide to the hospital, they are believe the aide stay patient until the shift.  4. The clinical recondition 2/20/19 and indicated to evide signature for the skift.  5. The clinical recondition 2/21/19 and indicated An agency discharged.	ation indicated that the patient completed at the hospital on and had a hospital inpatient /18/19.  Ited by employee S, home was documented on 1/14/19  PM. The agency failed to it for employee S, home health as the patient was in the the time the visit was  1/ 2/25/19 at 3:49 PM, the Ithe scheduler should have leave after taking the patient to be not sure what happened but yed at the hospital with the		notify the agency at any visit can not be complete patient home due to a condition in the patient in status. The field staff with the agency and request with the case manager. manager is not present staff will request to speamember of the nursing spresent at the agency and of the call. Nursing staff instruct the field staff on proceed with the patient instruct the field staff to patient visit if the patient to the hospital and the anot complete the visit as scheduled. Nursing will in the phone log of the prinstructions given and wunderstanding of the instructions given and wunderstanding of the instructions to agency we can not be completed in home in its entirety. All owill be in serviced on authenticating visit documentation by 3/28/Administrator will ensure procedure is upheld by all phone log reports dared of each business day. Administrator to meet we daily to review patient statutilize this information to determine the completent statutilize  the completent statutilized the comp	ed in the hanged medical ill contact to speak If the case the field ak to a staff t the time if will how to a visit and end the t is taken aide can is document better the erbal structions. Iduling aditing All field by 3/28/19 cus when visit a patient toffice staff.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		X3) DATE SURVEY COMPLETED 02/26/2019		
NAME OF PROVIDER OR SUPPLIER SCOTT'S HOME HEALTHCARE LLC			STREET ADDRESS, CITY, STATE, ZIP COD 1817 DOGWOOD CT KOKOMO, IN 46902				
(X4) ID	SUMMARY S	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 APPROPRIAT	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	failed to evidence a date, time, or a signature for the skilled nurse who completed the document.  6. During an interview on 2/26/19 at 10:40 AM,		all documentation is comple		d in		
				the patient phone log of patien chart.	nt		
	the administrator, ar	nd alternate administrator was					

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