CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-	-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED 06/25/2019	
		15K094	B. WING			
		101(004	B. WING		00/20/2013	
NAME OF E	ROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD		
	NO VIDEN ON SOLVEIE			OGWOOD CT		
SCOTT'S	S HOME HEALTHC	ARE LLC	KOKOI	MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	T	(X5)	<u>)</u>
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE	
G 0000						
Bldg. 00						
Diag. 00			G 0000			
	This was a revisit for the Federal home health		0 0000			
		ey completed on February 26,				
	2019.	ey completed on 1 cordary 20,				
	2017.					
	Facility #: 012928					
	1 defility #1. 012920					
	Provider #: 15K09	4				
	11011001 11. 13110)	•				
	Medicaid #: 20109	01400				
	m. 2010)	1100				
	Survey dates: June	24 25: 2019				
	burvey dates. suite	1, 23, 2017				
	Skilled Services: 1					
	Home Health Aide	only: 81				
	Personal Service or					
	Total Current Cens	2				
	Total Callent Cons	u 5. 01				
	Record reviews wit	h home visit: 2				
	Record review with					
	Discharged record					
	Total clinical record					
	Total chimeal record	as forfered. S				
	During this survey	three (3) Condition level				
		enty-one 21 Standard level				
		orrected. Two (2)standard-				
		er re-cited and two (2) new				
	standard-level defic					
	standard-level delic	chemey were ched.				
	Quality Review Co	mpleted 7/1/10				
	Quality Review Co.	inpieted //1/19				
G 0550						
2 0000						
Bldg. 00						
zg. 00			G 0550	The Administrator to educated	I all 07/11/2	2019
	Based on record rev	view and interview, the RN	0.000	clinical staff and review the	0//11/2	2017

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

TITLE

(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SEGS12 Facility ID: 012928 If continuation sheet Page 1 of 12

07/17/2019 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 06/25/2019 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 [registered nurse] failed to perform a Discharge, Transfer, and Planning comprehensive assessment at discharge for 1 of 1 policy during the weekly nurse records reviewed (#3). staff meeting on 7/11/19. The Administrator to review the Findings include: timeline for each patient from admission through discharge to An agency policy titled, "Discharge, Transfer, and ensure all clinical staff is clear on Planning" dated as revised on 3/28/2019 stated, " the policy specifications. The ... 8. ... C. A Discharge Summary form is ACM to audit all clinical completed within 48 hours of the date of documentation to ensure the discharge and completed at the time of the discharge comprehensive patient's complete discharge from home health assessment is not completed prior services" to the last home health aide visit. Furthermore, the ACM will review The clinical record of patient #3 was reviewed on the RN schedule daily and meet 06/25/19 and indicated a start of care date of with each case manager daily to 09/12/18. The record contained a plan of care ensure the comprehensive (POC) for the certification period of 03/11/19 assessment is not completed 05/09/19. The record contained an "OASIS before the last HHA visit for a [outcome and information assessment set] discharging patient and to clarify Discharge from agency" performed by Employee any issues regarding patient C. dated 04/04/19. issues, orders or paperwork. The ACM will utilize the discharge Additionally, the record contained a "Discharge audit form to ensure the timeline is From Agency (OASIS) clinical note" performed by met regarding the last home Employee C, dated 04/04/19 that stated, " ... no health aide visit and visit-MD [medical doctor] notified et [and] comprehensive assessment discharged on 4/4/19" following. All documentation to be kept in the discharge audit binder An agency document titled "[agency in the medical chart room for proof documentation system], provided by the of compliance. The Administrator Administrator included multiple visits for patient to ensure this policy is followed by #3 and included HHA [home health aide] reviewing the discharge audit documentation for patient care provided on binder at the last nurse staff 04/06/19 and 04/07/19. meeting of the month. During an interview on 06/25/19 at 12:30 PM with the Administrator, she indicated the patient had a discharge OASIS on 4/4/19, but the patient had called asking to extend services until 4/8/19.

07/17/2019 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 06/25/2019 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 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Further, the Administrator stated there was no additional discharge comprehensive after 04/04/19. G 0574 Bldg. 00 G 0574 The agency contacted Riversoft 06/27/2019 Based on record review and interview, the agency Office software company on failed to provide orders for home health aide 6/27/19 which is the company that services on the plan of care for 1 of 3 records supplies the medical charting for reviewed (#2). the agency. The agency investigated why the HHA orders Findings include: were not carried over on the plan of care for patient #2. The The clinical record of patient #2 was reviewed on company stated they were unsure 06/25/19 and indicated a start of care date of why following a system analysis of 06/12/18. the agency's software by the IT department. The administrator The record contained a plan of care (POC) for the reviewed the process with certification period of 06/07/19 - 08/05/19. Further, Riversoft Office to ensure the the plan of care contained a 60 day summary that agency fully comprehended the stated, "... Pt [patient] continues to have a need proper way to carry the orders over for a HHA for assistance with bathing, foot care, to each plan of care. No changes transfers, and light housekeeping" were found. The Administrator will ensure each plan of care has the The home health aide services were provided in correct and current orders for HHA the last cert period as well. The dates the HHA through the provided care without an order were as follows: admission/recertification auditing process. Each plan of care will be The home health aide provided services on June audited before printing and 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24 and sending to MD for signature. The 25 of 2019. The plan of care failed to evidence ACM or her delegate will audit physician orders for continuing home health aide each plan of care using the services (HHA). Admission/Recertification audit form. Once the plan of care has During an interview on 6/25/19 at 9:30 AM, when been audited and no errors found,

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asked about the plan of care lacking home HHA

[documentation system] generated automatically

orders, the Administrator stated, "It's

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the plan of care will be printed by

the ACM or her delegate and

faxed to the MD for signature.

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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	A. BUILDING <u>00</u>		COMPLETED	
		15K094	B. W	NG		06/25/	/2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			OGWOOD CT		
SCOTT'S	HOME HEALTHC	ARE LLC			1O, IN 46902		
(X4) ID	SHIMMADV	STATEMENT OF DEFICIENCIE	Ι	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		ere." The administrator then		1110	Any corrections needed will be		Ditte
		of care and then stated, "It			returned to the CM for correcti		
	-	ugh and automatically puts			The Administrator will ensure		
		nething changes. It asks you if			policy is being followed by		
		last POC orders, then we			reviewing the completed audit		
	•	M, the Administrator stated, "I			forms at the weekly nurse		
		em error; I don't have an			meeting. A record of all		
	answer on why it's i				completed audit forms are to b	e	
	_				kept in a binder in the medical		
					chart room at all times titled		
					Admission/Recertification Aud	its	
G 0682							
Bldg. 00							
			G 0	682	The agency will complete the		08/02/2019
		on, record review and			annual mandatory Home Heal		
		cy failed to ensure all staff			Aide Blitz and include a persor	nal	
		control policies and standard			care station to review proper		
	precautions for 1 of	2 home visits observed (#2).			handwashing and glove		
	Fig. 41				procedures to ensure gloves a		
	Findings include:				changed between patient cont		
	An aganay naliay ti	tled, "Infection Control" dated			and all procedures during visit		
		19 stated, " 7. Gloves should			This station will be overseen be the RN Case Managers and he	-	
		n patient contact and			health aides will demonstrate	ome	
	procedures"	n patient contact and			proper handwashing and glove	_	
	procedures				procedures for RN to show		
	During a home visit	t observation on 6/25/19 at 8:00			compliance. The Administrator	r will	
	-	2, Employee E home health aide			oversee the HHA Blitz to ensu		
		ed providing personal care.			this process is completed. The	_	
		ed supplies for the patient			date of the HHA Blitz is 8/2/19		
		nand hygiene and donned			which will take the place of the		
	_	mployee assisted the patient			required monthly continuing		
	-	intervals as requested by the			education for all home health		
		E washed back, legs, feet and			aides to keep their license		
		ded wash cloth. After shower			current. The agency policy sta	ates	
	was completed, and	l without changing gloves,			the monthly in service date is		
		d lotion to the patient's back,			mandatory for the first Friday of	of	
		s and followed by patting the			the month and will stay consis		

l í		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLET B. WING 06/25/20			
		15K094	B. WI	NG		06/25/	2019
	PROVIDER OR SUPPLIER		-	1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, 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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	and buttocks. Furth Employee E assisted followed by brushin changing gloves, Er clean wash cloth fro sprayed cleanser to toilet. Without char then wiped down th toilet area and scrub employee continued sprayed the bathroo towel. Finally, the of the floor in front of and discarded the to linen basket and ren	rso, arms, legs, personal area are, without changing gloves, d the patient to to dress and ag patient's hair. Without imployee E then removed a som the stored linen area and shower area, sink and on the inging gloves, the employee e shower area and the sink, abed the toilet bowl. The d with the same gloves, im mirror and wiped with paper employee wiped the fluids from the toilet with a clean towel owel and wash cloth in the inoved her gloves. Employee E ves between patient contact			with this policy. Proof of completion by the HHA will be the employee file for each age aide. All agency home health aides will be scheduled to complete the HHA Blitz on the scheduled date and any aide unable to attend will have 7 dato make up the required educa or be removed from the patien schedules until compliance is met. HR will give the Administrator a report of all aid and compliance with the HHA Blitz by 8/9/19 to ensure agen employees have met educatio requirements.	ays ation t des	
	Administrator and A	on 6/25/19 at 9:30 AM, the Alternate Administrator buld be changed between					
G 0804							
Bldg. 00	interview, the home changes in a patient nurse for 1 of 2 pati home health aide se Findings include: An agency policy ti Supervision, Training reviewed 1/14/19, s	on, record review, and health aide failed to report 's condition to the registered ents observed who received rvices (#2). tled, "Home Health Aide and Education" dated tated, " The home health aide to nursing supervisor any	G 08	804	The agency will complete the annual mandatory Home Heal Aide Blitz and include a station review reporting patient changer. This station will be overse by the RN Case Managers and each home health aides will demonstrate how to report changes based on scenarios of by the RN. The Administrator oversee the HHA Blitz to ensure this process is completed. The date of the HHA Blitz is 8/2/19	n to les to een d given will re	08/02/2019

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Event ID:

SEGS12 Facility ID: 012928

If continuation sheet Page 5 of 12

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> COMPLE		LETED	
		15K094	B. W	ING	06/25/2019		/2019
	OD OLUBER OR STORE	`		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	<			OGWOOD CT		
SCOTT'S	S HOME HEALTHC	ARE LLC	_		MO, IN 46902		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	changes observed in the patient's conditions and				which will take the place of the	е	
	needs as they arise	····			required monthly continuing		
	During a homo vigi	t observation on 6/25/10 at 9:00			education for all home health		
	_	t observation on 6/25/19 at 8:00 2, Employee E, home health			aides to keep their license	ataa	
	_	nployee C, RN (Registered			current. The agency policy st	ates	
	1 1	e, Employee E was observed			the monthly in service date is mandatory for the first Friday	of	
		care. After patient #2 had			the month and will stay consist		
		ands to the right leg and foot			with this policy. Proof of	ole III	
					completion by the HHA will be	in ·	
	and one area to right great toe were observed. At 8:35 AM during the observation, Employee C				the employee file for each age		
	asked Employee E if the areas to the right leg were				aide. All agency home health	Siloy	
	new. Employee E indicated they were not new.				aides will be scheduled to		
	new. Employee E maleated they were not new.				complete the HHA Blitz on the	9	
	The clinical record	of patient #2 was reviewed on			scheduled date and any aide		
		ated a start of care date of			unable to attend will have 7 d	avs	
	06/12/18. The reco	ord contained a plan of care			to make up the required educ	-	
	(POC) for the certif	fication period of 06/07/19 -			or be removed from the patier		
	08/05/19.				schedules until compliance is		
					met. HR will give the		
	The comprehensive	e assessment recertification			Administrator a report of all ai	des	
	dated 06/04/19 indi	cated, " Skin is pink, warm,			and compliance with the HHA		
	_	no open areas noted or			Blitz by 8/9/19 to ensure ager	су	
	reported"				employees have met education	on	
					requirements.		
		nt titled, " Request for					
	1 -	Up Orders" dated 6/6/19,					
		orted patient has fluid filled					
	blister on lower rig	ht shin "					
	A Physician office	note dated 6/17/19 stated, "					
		presents with a new 2 x 2 cm					
		tibial ulceration that does					
	appear venous in na						
		titled, "Visit Note [agency					
	I	em] Clinical Note" dated, 6/4,					
		4, 6/17, 6/18, 6/20, and 6/24, by					
		mentation failed to indicate the					
	RN was notified re	garding patient leg wounds.					

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

PRINTED: 07/17/2019 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	COM	TE SURVEY MPLETED 25/2019
	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
	Employee B, alterna	on 6/25/19 at 10:23 AM, ate administrator stated, " My eve the newer wounds were				
N 0000						
Bldg. 00		or a Home Health Care State ompleted on February 19, 2019.	N 0000			
	Facility #: 012928					
	Provider #: 15K094	4				
	Medicaid #: 20109	1400				
	Survey Dates: June	24, 25; 2019				
	Skilled Services: 1 Home Health Aide Personal Service on Total Current Censu	ly patients: 2				
	Record reviews with Record review with Discharged record r Total clinical record	out home visits: 1 eviews: 1				
		urvey, 9 deficiecies has been cited, and 1 new deficiecy was				
	Quality Review Cor	mpleted 7/1/19				
N 0470	410 IAC 17-12-1(r Home health ager	The state of the s				

State Form Event ID: SEGS12 Facility ID: 012928 If continuation sheet Page 7 of 12

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. W	ING		06/25/20	019
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
	HOME HEALTHCA	ARE LLC			MO, IN 46902		
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORREC			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DETERNOT!		DATE
Bldg. 00	administration/mai	nagement Policies and procedures					
	` '	d implemented for the					
	control of commun	-					
		pplicable federal and state					
	laws.	ppa.s.a.a.a.a.a.a					
		ng 0682, Regulation D101	N 0	470	The agency will complete the annual mandatory Home Heal		08/02/2019
		ig 0002, Regulation D101			Aide Blitz and include a perso		
	Hughes, Sonya				care station to review proper handwashing and glove		
	Based on observation	on, record review and			procedures to ensure gloves a	are	
		cy failed to ensure all staff			changed between patient conf	tact	
		control policies and standard			and all procedures during visit	is.	
	precautions for 1 of	2 home visits observed (#2).			This station will be overseen b	-	
					the RN Case Managers and h	ome	
	Findings include:				health aides will demonstrate		
	A	thad "Infration Control" dated			proper handwashing and glove	e	
		tled, "Infection Control" dated 9 stated, " 7. Gloves should			procedures for RN to show	النبدء	
	be changed between				compliance. The Administrato oversee the HHA Blitz to ensu		
	procedures"	patient contact and			this process is completed. The		
	procedures				date of the HHA Blitz is 8/2/19		
	During a home visit	observation on 6/25/19 at 8:00			which will take the place of the		
	_	2, Employee E home health aide			required monthly continuing		
	(HHA), was observe	ed providing personal care.			education for all home health		
	Employee E gathere	ed supplies for the patient			aides to keep their license		
	shower performed h	and hygiene and donned			current. The agency policy sta	ates	
	•	mployee assisted the patient			the monthly in service date is		
		ntervals as requested by the			mandatory for the first Friday	of	
		E washed back, legs, feet and			the month and will stay consis	tent	
		ded wash cloth. After shower			with this policy. Proof of		
	_	without changing gloves,			completion by the HHA will be		
		l lotion to the patient's back,			the employee file for each age	ency	
		and followed by patting the			aide. All agency home health		
		rso, arms, legs, personal area			aides will be scheduled to		
		er, without changing gloves,			complete the HHA Blitz on the	•	
		d the patient to to dress and			scheduled date and any aide		
		ng patient's hair. Without			unable to attend will have 7 da	-	
	cnanging gloves, Er	nployee E then removed a			to make up the required education	ation	

State Form Event ID: SEGS12 Facility ID: 012928 If continuation sheet Page 8 of 12

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

PRINTED: 07/17/2019 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K094	 ILDING	INSTRUCTION 00	COM	E SURVEY PLETED 5/2019
	PROVIDER OR SUPPLIER		1817 D	ADDRESS, CITY, STATE, ZIP COE OGWOOD CT 10, 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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
IAU	clean wash cloth from sprayed cleanser to toilet. Without charthen wiped down the toilet area and scrube employee continued sprayed the bathroot towel. Finally, the the floor in front of and discarded the tollinen basket and refailed to change gloth and procedures. During an interview Administrator and Administrator	om the stored linen area and shower area, sink and on the nging gloves, the employee e shower area and the sink, obed the toilet bowl. The d with the same gloves, m mirror and wiped with paper employee wiped the fluids from the toilet with a clean towel owel and wash cloth in the moved her gloves. Employee E wes between patient contact	IAU	or be removed from the pschedules until complianmet. HR will give the Administrator a report of and compliance with the Blitz by 8/9/19 to ensure employees have met edurequirements.	ce is all aides HHA agency	DATE
N 0524 Bldg. 00	plan of care shall: (A) Be developed home health agen (B) Include all set skilled service is builded (B) Cover all pert (C) Include the four (i) Mental statu (ii) Types of set required. (iii) Frequency at (iv) Prognosis. (v) Rehabilitation (vi) Functional liut (vii) Activities per (viii) Nutritional reconstruction (ix) Medications	in consultation with the cy staff. vices to be provided if a being provided. inent diagnoses. llowing: s. vices and equipment and duration of visits. on potential. mitations. rmitted.				

State Form Event ID: SEGS12 Facility ID: 012928 If continuation sheet Page 9 of 12

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>			COMPLETED	
		15K094	B. Wl	ING		06/25/2019		
NAME OF I			•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	C		1817 D	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	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
	against injury.	fanting by dia de ann an						
	(xi) Instructions for timely discharge or referral.							
		dalities specifying length of						
	treatment.	danties specifying length of						
	(xiii) Any other ap	ppropriate items.						
			N 0	524	The agency contacted Riverso	oft	06/27/2019	
		view and interview, the agency			Office software company on			
	•	ders for home health aide			6/27/19 which is the company	that		
		of care for 1 of 3 records			supplies the medical charting	for		
	reviewed (#2).				the agency. The agency			
					investigated why the HHA ord			
	Findings include:				were not carried over on the p	ian		
	The clinical record of patient #2 was reviewed on				of care for patient #2. The company stated they were uns	cure		
		ated a start of care date of			why following a system analys			
	06/12/18.				the agency's software by the I			
					department. The administrato			
	The record contained	ed a plan of care (POC) for the			reviewed the process with			
	_	of 06/07/19 - 08/05/19. Further,			Riversoft Office to ensure the			
	_	tained a 60 day summary that			agency fully comprehended th			
		nt] continues to have a need			proper way to carry the orders			
		tance with bathing, foot care,			to each plan of care. No chan	_		
	transfers, and light	nousekeeping"			were found. The Administrato			
	The home health air	de services were provided in			ensure each plan of care has correct and current orders for			
		as well. The dates the HHA			through the	11117		
	_	out an order were as follows:			admission/recertification audit	ina		
					process. Each plan of care wil	-		
	The home health ai	de provided services on June			audited before printing and			
	4, 5, 6, 7, 10, 11, 12	2, 13, 14, 17, 18, 19, 20, 21, 24 and			sending to MD for signature.	The		
		an of care failed to evidence			ACM or her delegate will audit	:		
		r continuing home health aide			each plan of care using the			
	services (HHA).				Admission/Recertification aud			
	Duning and interest				form. Once the plan of care h			
	_	on 6/25/19 at 9:30 AM, when			been audited and no errors for	•		
	orders, the Adminis	n of care lacking home HHA			the plan of care will be printed the ACM or her delegate and	υy		
		tem] generated automatically			faxed to the MD for signature.			
		ere." The administrator then			Any corrections needed will be	<u>د</u>		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED			ETED
		15K094	B. Wl	NG	06/25/	06/25/2019	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			1	OGWOOD CT		
SCOTT'S	HOME HEALTHCA	ARE LLC		KOKON	ЛО, IN 46902		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT OF CORRECT PLAN		(X5)	
PREFIX	`	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		LSC IDENTIFYING INFORMATION	_	TAG			DATE
	•	f care and then stated, "It			returned to the CM for correcti	-	
		ugh and automatically puts			The Administrator will ensure t	inis	
		nething changes. It asks you if last POC orders, then we			policy is being followed by		
	-	A, the Administrator stated, "I			reviewing the completed audit forms at the weekly nurse		
		em error; I don't have an			meeting. A record of all		
	answer on why it's r				completed audit forms are to b	ι Δ	
	answer on why it's i	iot there.			kept in a binder in the medical		
					chart room at all times titled		
					Admission/Recertification Audi	its	
			İ				
N 0604	410 IAC 17-14-1(n	n)					
	Scope of Services						
Bldg. 00	Rule 14 Sec. 1(m) The home health aide must report any changes observed in the						
	•	s and needs to the					
	supervisory nurse	or therapist.					
			N 0	604	The agency will complete the		08/02/2019
		on, record review, and			annual mandatory Home Heal		
		health aide failed to report			Aide Blitz and include a station		
		's condition to the registered			review reporting patient chang		
	home health aide se	ents observed who received			RN. This station will be overse		
	nome nearm aide se	Tvices (#2).			by the RN Case Managers and each home health aides will	J	
	Findings include:				demonstrate how to report		
	i manigs merade.				changes based on scenarios g	niven	
	An agency policy ti	tled, "Home Health Aide			by the RN. The Administrator		
		ng and Education" dated			oversee the HHA Blitz to ensu		
		tated, " The home health aide			this process is completed. The		
		to nursing supervisor any			date of the HHA Blitz is 8/2/19		
		the patient's conditions and			which will take the place of the		
	needs as they arise.	"			required monthly continuing		
					education for all home health		
	During a home visit	observation on 6/25/19 at 8:00			aides to keep their license		
	AM, with patient #2	2, Employee E, home health			current. The agency policy sta	ates	
		ployee C, RN (Registered			the monthly in service date is		
	· · · · · · · · · · · · · · · · · · ·	e, Employee E was observed			mandatory for the first Friday o		
		care. After patient #2 had			the month and will stay consist	tent	
		nds to the right leg and foot			with this policy. Proof of		
	and one area to righ	t great toe were observed. At			completion by the HHA will be	in	

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

PRINTED: 07/17/2019 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		JILDING	00	COMPLETED	
		15K094	B. W.	ING		06/25/	/2019
	PROVIDER OR SUPPLIER			1817 D	ADDRESS, CITY, STATE, ZIP COD OGWOOD CT MO, IN 46902		
			T		- ,		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	``	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		e observation, Employee C		IAG	the employee file for each age	ncv	DATE
	_	if the areas to the right leg were			aide. All agency home health	люу	
		ndicated they were not new.			aides will be scheduled to		
					complete the HHA Blitz on the	<u>!</u>	
	The clinical record	of patient #2 was reviewed on			scheduled date and any aide		
		ated a start of care date of			unable to attend will have 7 da	ays	
	06/12/18. The reco	rd contained a plan of care			to make up the required educa	-	
	(POC) for the certif	ication period of 06/07/19 -			or be removed from the patien	ıt	
	08/05/19.				schedules until compliance is		
					met. HR will give the		
	_	assessment recertification			Administrator a report of all aid		
		cated, " Skin is pink, warm,			and compliance with the HHA		
	-	no open areas noted or			Blitz by 8/9/19 to ensure agen	-	
	reported"				employees have met educatio	n	
	Physician's Follow stated "HHA repo blister on lower righ				requirements.		
	-	note dated 6/17/19 stated, "					
		presents with a new 2 x 2 cm					
	appear venous in na	tibial ulceration that does					
	appear vellous in ha	nuie to me					
	documentation syste 6/5, 6/11, 6/13, 6/14 Employee E, docum RN was notified reg During an interview	titled, "Visit Note [agency em] Clinical Note" dated, 6/4, 4, 6/17, 6/18, 6/20, and 6/24, by nentation failed to indicate the garding patient leg wounds.					
		ate administrator stated, " My eve the newer wounds were					

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