STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIER	L R HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
(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
G 0153 Bldg. 00	484.16 GROUP OF PRODE The group of profeestablishes and a agency's policies offered, admission medical supervision emergency care, of qualifications, and least one member	FESSIONAL PERSONNEL ressional personnel ressional personnel responsible to the governing scope of services responsible to and discharge policies, responsible to an and plans of care, relinical records, personnel responsible to the group is neither an oloyee of the agency.	G 0		N/A		01/02/2018
G 0154 Bldg. 00	The group of profe frequently to advis professional issue evaluation of the a assist the agency other health care	EVALUATION FUNCTION essional personnel meets se the agency on es, to participate in the agency's program, and to in maintaining liaison with providers in the community 's community information	G 0	154	N/A		01/02/2018
G 0156 Bldg. 00	484.18 ACCEPTANCE O SUPER	F PATIENTS, POC, MED	G 0		N/A		01/02/2018
G 0157 Bldg. 00	SUPER Patients are acceptasis of a reasonapatient's medical,	F PATIENTS, POC, MED pted for treatment on the lable expectation that the label nursing, and social needs lately by the agency in the					

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: 11IK12 Facility ID: 014118 If continuation sheet Page 1 of 77

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017		
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC	• :	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 40 NAPOLIS, IN 46256	00		
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE	
	patient's place of residence.		G 0	157	N/A		01/02/2018	
G 0158 Bldg. 00	SUPER Care follows a wri established and p	EF PATIENTS, POC, MED etten plan of care eriodically reviewed by a e, osteopathy, or podiatric	G 0	158	N/A		01/02/2018	
G 0159	484.18(a)							
Bldg. 00	with the agency sidiagnoses, including services and equition of visits, prognosist functional limitation nutritional required treatments, any safety.	•	G 0	159	N/A		01/02/2018	
G 0166	484.18(c)							
Bldg. 00	ORDERS Verbal orders are and dated with the registered nurse of defined in section	put in writing and signed e date of receipt by the or qualified therapist (as 484.4 of this chapter) rnishing or supervising the	G 0	166	N/A		01/02/2018	
G 0168	484.30 SKILLED NURSIN	NG SERVICES						J

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

Event ID:

11IK12

Facility ID: 014118

If continuation sheet Page 2 of 77

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2017
	PROVIDER OR SUPPLIER /E NURSING AND HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400 /APOLIS, IN 46256	
(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
Bldg. 00		G 0168	N/A	01/02/2018
G 0172 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates			
	the patients nursing needs.	G 0172	N/A	01/02/2018
G 0173 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care			
Diag. 00	and necessary revisions.	G 0173	N/A	01/02/2018
G 0175 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates appropriate preventative and rehabilitative nursing			
	procedures.	G 0175	N/A	01/02/2018
G 0176 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs.			
	in the patient's condition and needs.	G 0176	N/A	01/02/2018
G 0178 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel.	0.0172	N/A	01/02/2015
G 0224	484.36(c)(1)	G 0178	N/A	01/02/2018
Bldg. 00	ASSIGNMENT & DUTIES OF HOME HEALTH AIDE			

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

Event ID:

11IK12

Facility ID: 014118

If continuation sheet

Page 3 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING B. WING	e construction 6 <u>00</u>	(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC	9840	ET ADDRESS, CITY, STATE, ZIP COD D WESTPOINT DRIVE, SUITE 4 ANAPOLIS, IN 46256	400
(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 CROSS-REFERENCED TO THE APPROLIDERICIENCY)	BE COMPLETION
	Written patient can health aide must be registered nurse of professional who	re instructions for the home be prepared by the or other appropriate is responsible for the home health aide under	G 0224	N/A	01/02/2018
G 0235	484.48 CLINICAL RECOR	RDS			
Bldg. 00			G 0235	N/A	01/02/2018
G 0236 Bldg. 00	and current finding accepted profession maintained for even health services. It care, the record or identifying informating, dietary, treating signed and dated copies of summar	ontaining pertinent past gs in accordance with	G 0236	N/A	01/02/2018
G 0330 Bldg. 00	PATIENTS Each patient must provide, a patient-assessment that a patient's current h information that m the patient's progr desired outcomes	receive, and an HHA must specific, comprehensive accurately reflects the ealth status and includes ay be used to demonstrate ess toward achievement of . The comprehensive identify the patient's			

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

Event ID:

11IK12

Facility ID: 014118

If continuation sheet

Page 4 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>				COMPLETED	
			B. WING 12/04/2017			/2017		
	PROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC	<u> </u>	9840 W	ADDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROWING BLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	patient's medical, social, and discha Medicare beneficiathe patient's eligibhealth benefit incluboth at the time of and at the time of assessment. The assessment must the current versior Assessment Inforrusing the language	or home care and meet the nursing, rehabilitative, rge planning needs. For aries, the HHA must verify ility for the Medicare home uding homebound status, the initial assessment visit the comprehensive comprehensive also incorporate the use of a of the Outcome and mation Set (OASIS) items, e and groupings of the specified by the Secretary	G 0.	330	N/A		01/02/2018	
							01,02,2010	
G 0332 Bldg. 00	either within 48 ho hours of the patier	MENT VISIT ment visit must be held burs of referral, or within 48 nt's return home, or on the start of care date.	G 0	222	N/A		01/02/2018	
			0.0	332	IN/A		01/02/2018	
G 0334 Bldg. 00	ASSESSMENT The comprehensive completed in a time with the patient's in	re assessment must be nely manner, consistent mmediate needs, but no dar days after the start of	G 0.	334	N/A		01/02/2018	
G 0337	484.55(c)							
Bldg. 00	DRUG REGIMEN The comprehensivinclude a review o is currently using i	REVIEW ve assessment must f all medications the patient in order to identify any effects and drug reactions,						

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

Event ID:

11IK12

Facility ID: 014118

If continuation sheet Page 5 of 77

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE COMPL 12/04 /	ETED	
	PROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC		9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256		
(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
	side effects, signifi	re drug therapy, significant icant drug interactions, rapy, and noncompliance	G 03	337	N/A		01/02/2018
G 0339 Bldg. 00	ASSESSMENT The comprehensive updated and revise administration of the of every 60 days becare date, unless the elected transfer; of condition resulting assessment; or discontinuous condition assessment; or discontinuous condition assessment.	re assessment must be ed (including the ne OASIS) the last 5 days reginning with the start of there is a beneficiary r significant change in in a new case mix scharge and return to the the 60 day episode.	G 00	339	N/A		01/02/2018
N 0000							
Bldg. 00	Survey dates: No. 1, 2017 Facility Number:	w up initial state licensure ovember 30 and December 1 014118 Reviewed: 3 (2 active and	N 00	000			

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 6 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017		
	ROVIDER OR SUPPLIER E NURSING AND I	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
(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 0449 Bldg. 00	410 IAC 17-12-1(d) Home health ager administration/mar Rule 12 Sec. 1(c)(may also be the stregistered nurse reshall do the follow (6) Ensure that the meets all rules and Based on record failed to ensure that the rules and of 1 agency. Findings included 1. The Administrate Quality Assess Improvement Prospecific data in recoordination, and 456 and N472) 2. The Administrate and N472) 2. The Administrate and N472 and N472 and N472 and N472 are recoordinated to expecially physician listed of specialty physician reviewed. (See National Rule)	c)(6) ncy nagement (6) The administrator, who upervising physician or equired by subsection (d), ing: e home health agency d regulations for licensure. review, the Administrator the home health agency met regulations for licensure in 1 c: trator failed to ensure that ssment and Performance ogram (QAPI) identified tegards to patient care, d documentation. (See N rator failed to ensure the forts were coordinated with the care agency, primary care on the plan of care, and ans in 1 out of 3 records (VAR)	N 0		N449 UPDATE: In conjunction with the Director of Nursing and Compliance/designee, the Administrator is going to ensurthat the agency meets all state laws and regulations for licensure by implementing and following this plan of correction. This will be don by reviewing chart documentation, audit results, and monitoring staff education for areas of concern. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	e	02/16/2018
	and services was	trator failed to ensure care provided to a patient e on the basis that his / her					

State Form Event ID: 11 K12 Facility ID: 014118 If continuation sheet Page 7 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
			B. WING		12/04/2017	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC		/ESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	health needs could adequately be met. (See		TAG	DEFICIENCE!	DATE	
	N 520)					
	N 320)					
	4. The Admini	strator failed to ensure the				
	Registered Nurs	se followed the plan of care				
	1	pervisory visits and the home				
	1 -	ed to follow the plan of care.				
	(See N 522)	_				
	5. The Administrator failed to ensure that					
	the development of the plans of care were					
	_	e comprehensive assessment				
	1	clude a duration of services to				
		lee N 524 and N 542)				
	(2					
	6. The Adminis	strator failed to accurately				
		nt's dialysis access and failed				
		ossible dialysis access sites.				
	(See N 541)	societe diary sis decess sites.				
	(3001, 341)					
	7. The Adminis	strator failed to ensure that				
		ventative nursing measures				
		ace with patient identified as				
		ional risk. (See N 543)				
	a ran and numin	ionarrisk. (BCC IV 575)				
	8 The Adminis	strator failed to ensure that a				
	8. The Administrator failed to ensure that a					
	patient was educated on a new medication order upon a return home from the hospital.					
	(See N 546)	am nome nom me nospitai.				
	(366 11 340)					
	9 The Adminis	strator failed to ensure verbal				
	orders in writing	g after an admission				

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 8 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPL A. BUILDING	e construction g <u>00</u>	(X3) DATE SURVEY COMPLETED		
			B. WING 12/04/2017			
	PROVIDER OR SUPPLIER /E NURSING AND I	HEALTHCARE SERVICES, INC	984	EET ADDRESS, CITY, STATE, ZIP COD O WESTPOINT DRIVE, SUITE 40 IANAPOLIS, IN 46256	0	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	CROSS-REFERENCED TO THE APPROPR		
TAG	assessment. (See	,	TAG	DEFICIENCE	DATE	
	10. The Administrator failed to ensure that the comprehensive 60 day reassessments were accurate, consistent and contained adequate amount of information to support the plan of care. (See N 563) 11. The Administrator failed to ensure supervisory visits included observance of care, assessment of the relationship between the patient and the home health aide and supervisory visits were conducted every 30 days. (See N 606)					
N 0456 Bldg. 00	responsible for an program designed (1) Objectively an	nagement The administrator shall be ongoing quality assurance to do the following: d systematically monitor quality and appropriateness				
	administrator fai agency's Quality Performance Imp identified specifi	review and interview, the led to ensure that the Assessment and provement Program (QAPI) to data in regards to patient on, and documentation.	N 0456	N456 The Administrator will update the agency's Quality Assessment and Performance Improvement Progra (QAPI) by 1/2/18. The updated Chart Audit Form will include the following questions: a. Has appropriate care been provided? b. Is the Comprehensive Assessment complete and accurat		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 9 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/04/2017			
	PROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
(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
IAU	Findings included 1. Review of the 11/30/17, the bir form titled "Mec October, 2017. agency exceeded Administration, 485, Medication 485. 2. Review of the patient #9 and # failed to include appropriate care to ensure the conwere complete, a plans of care, far care included in falls and weight coordination of physicians after ensure case man conducting hom visits and observe between the patient aide, and failed twere being follows.	e agency's QAPI binder on ading included an agency dical Record Review) in The former indicated the dexpected thresholds in Assessment / Plan of Care / Review, and Plan of Care / Review, and Plan of Care information to determine if had been provided, failed apprehensive assessment accurate, and supported the filed to ensure the plans of the terventions for prevention of loss, failed to ensure eare with the patients appointments, failed to agers were appropriately the health aide supervisory fring care and interaction ent and the home health to ensure the plans of care		IAU	c. Does the Comprehensive Assessment support the Plan of Care? d. Does the Comprehensive Assessment include interventions for fall prevention? e. Does the Comprehensive Assessment include interventions for weight loss? f. Has care coordination with MDs been documented? g. Were aide supervisory visits done timely? h. During aide supervisory visits was care observed? i. During aide supervisory visits was the interaction between patient and aide documented? j. Was the aide plan of care followed? k. Was the nursing plan of care followed? On 12/26/17, this agency contracted with a Homecare Consultant. 100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Then quarterly, will be audited by Administrator or designee. Administrator/designee will in-service current nurses on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination doing aide supervisory visits timely		DATE
	Administrator were interviewed on 12/1/17				and documenting care observed		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 10 of 77

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2017			
	PROVIDER OR SUPPLIED	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	Compliance / A had been their cutime, working w	indicated the Director of Iternate Director of Nursing compliance officer for a long with the Jeffersonville agency ilable for the exit		being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To be done be 1/20/18. Administrator/designee will ensur orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aide and documenti interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. Administrator/designee will in-service current aides on following aide plan of care as written. To be done by 1/20/18. Administrator/designee will ensur orientation of newly hired aides winclude training on following the aide plan of care as written. To begin immediately and be on-goin Consultant will train Administrator/designee on how to accurately do chart reviews by 1/20/18. The Administrator or designee will be responsible for monitoring thes corrective actions to ensure that this deficiency is corrected and will not recur. UPDATE: The Administrator coupled with to Director of Nursing and Compliance/designee will monitored and evaluate the guality and and compliance/designee will monitored and evaluate the guality and and compliance/designee will monitored and evaluate the guality and and compliance/designee will monitored and evaluate the guality and and compliance/designee will monitored and evaluate the guality and and compliance/designee will monitored and evaluate the guality and and compliance/designee will monitored and evaluate the guality and and compliance/designee will monitored and evaluate the guality and and compliance/designee will monitored and evaluate the guality and and compliance/designee will monitored and evaluate the guality and and compliance/designee will monitored and evaluate the guality and and compliance.	e e e e e e e e e e e e e e e e e e e			

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 11 of 77

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2017
	ROVIDER OR SUPPLIE E NURSING AND	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 40 NAPOLIS, IN 46256	0
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
				appropriateness of patient care, a resolved problems to ensure qual of care by utilizing the updated Qu tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are dontimely and staff is educated clinical matters. The Administrator or design will monitor corrective action by reviewing every chart audit on a weekly basis for 2 morand then quarterly thereafted ensure there is follow up to correct noted issues and the issues don't reoccur. After 2 months, all charts the meet 100% of compliance with the designee. All charts the designee. All charts the designee. All charts the designee. All charts the designee or designee or designee. We have updated our QAPI tool that we will continue to use ongoing to ensure these standards are met. We will continue to use these week for the next 2 months and the quarterly. This tool includes issues cited from previous survey as well as other area. The agency will ensure the	de d

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 12 of 77

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2017
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256	
(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)	(X5) COMPLETION DATE
				Director of Nursing and Compliance/designee are educated on chart audits and completing chart audits appropriately by meeting with the Consultant to be educated. The Administrator will ensure that compliance is met by teaming with the Director of Nursing and Compliance/designee to ensure chart audits are ongoing.	h ed. e
N 0472 Bldg. 00	Rule 12 Sec. 2(a) must develop, im evaluate a quality performance improgram must ref home health orga (including those sunder arrangeme agency must take improvements in performance acro The home health assessment and	ance improvement The home health agency plement, maintain, and assessment and rovement program. The elect the complexity of the anization and services services provided directly or ent). The home health e actions that result in the home health agency's loss the spectrum of care.	N 0472	N472	02/16/2018
	agency failed to Assessment and	I review and interview, the ensure that their Quality Performance Improvement identified specific data in		The Administrator will update the agency's Quality Assessment and Performance Improvement Prograr (QAPI) by 1/2/18. The updated Chart Audit Form will include the following questions: a. Has appropriate care been provided?	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 13 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
			B. WIN	IG		12/04/	2017
		<u>.</u>	'	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R		9840 W	ESTPOINT DRIVE, SUITE 400		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC			APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		nt care, coordination, and			b. Is the Comprehensive Assessment complete and accurate?	>	
	documentation.				c. Does the Comprehensive	•	
					Assessment support the Plan of		
	Findings include	2 :			Care?		
					d. Does the Comprehensive		
	1. Review of th	e agency's QAPI binder on			Assessment include interventions		
		nding included an agency			for fall prevention? e. Does the Comprehensive		
	·	dical Record Review) in			Assessment include interventions		
		The former indicated the			for weight loss?		
	· ·				f. Has care coordination with		
		d expected thresholds in			MDs been documented?		
	·	Assessment / Plan of Care /			g. Were aide supervisory visits done timely?		
	· ·	Review, and Plan of Care /			h. During aide supervisory		
	485.				visits was care observed?		
					i. During aide supervisory		
	2. Review of th	e chart audits performed on			visits was the interaction between		
	patient #9 and #	11, the chart audit forms			patient and aide documented? j. Was the aide plan of care		
	failed to include	information to determine if			j. Was the aide plan of care followed?		
	appropriate care	had been provided, failed			k. Was the nursing plan of care		
		mprehensive assessment			followed?		
		accurate, and supported the			0.40/06/47 11:		
	1 * 1	, 11			On 12/26/17, this agency contracted with a Homecare		
	*	iled to ensure the plans of			Consultant.		
		terventions for prevention of			100% of all clinical records will be		
	1	loss, failed to ensure			audited weekly for the next 2		
	coordination of	care with the patients			months by the Homecare Consultan	t	
	physicians after	appointments, failed to			to ensure compliance with plan of		
	ensure case man	agers were appropriately			correction. Then quarterly, will be audited by Administrator or		
		e health aide supervisory			designee.		
		ving care and interaction			Administrator/designee will		
		ient and the home health			in-service current nurses on:		
	_				completing the Comprehensive		
		to ensure the plans of care			Assessment accurately, coordinating care with other		
	were being follo	owed.			physicians involved in patient's		
					care and documenting coordination	,	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 14 of 77

AND PLAN OF CORRECTION DENTIFICATION NUMBER A. BRILLIPING B. WINO STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46255 SUMMARY STATEMENT OF DEPICIENCE B. D. PROPERTY AND CORRECTIVE CASE DEPARTMENT OF TROMBATION 3. The Administrator ware interviewed on 12/1/7 at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator description of the exit conference of the compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. The compliance of the exit conference of the compliance of the exit conference of the compliance o	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE :	SURVEY
NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC AND SUMMARY STATEMENT OF DEFICIENCE (IACCI DEPICIENCY MUST IN PRICTIDED IN 1911.) TAG REQUILATORY OR SCIENTIFIES OF DIVIDING AND TAG. 3. The Administrator and Alternate Administrator and Alternate Administrator were interviewed on 12/1/17 at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator were interviewed on 12/1/17 at 4:30 PM, and indicated the Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating, care with other physicians involved in putents's care and documenting interaction between patient and aide and following nursing plan of care. To be again immediately and be on-aging. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and appropriateness of patient	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	00	COMPL	ETED
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC INDIANAPOLIS, IN 46256 SUMMARY STATEMENT OF DEFICIENCY. PREFEX TAG 3. The Administrator and Alternate Administrator were interviewed on 12/1/17 at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator designed with the Jeffersonville agency and was not available for the exit conference. The state of the st				B. WIN	NG		12/04/	2017
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC INDIANAPOLIS, IN 46256 SUMMARY STATEMENT OF DEFICIENCY. PREFEX TAG 3. The Administrator and Alternate Administrator were interviewed on 12/1/17 at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator designed with the Jeffersonville agency and was not available for the exit conference. The state of the st					CTDEET A	DDRESS CITY STATE ZIR COD		
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC INDIANAPOLIS, IN 46256 SUMMARY STATEMENT OF DEFICIENCE TAG REGULATORY OR LSC IDENTIFYING INFORMATION 3. The Administrator and Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Solutions of the exit conference of the exit conf	NAME OF P	PROVIDER OR SUPPLIER						
SUMMARY STATIMENT OF DIFFICIENCES TREETY GRACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG COMPLETION TAG COMPLE	A D A D T IV	/E NILIDOINIO AND I	HEALTHCARE SERVICES INC					
REFIX TAG REGULATORY OR LOCALITY TO BY FULL TAG REGULATORY OR LOCALITY OR LOCA	ADAPTIV	E NURSING AND I	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 46256		
3. The Administrator and Alternate Administrator were interviewed on 12/1/17 at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing alde suspervisory visits timely and documenting interaction between patient and aid eand following nursing plan of care. To be do not by 1/20/18. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing alde suspervisory visits timely and documenting care observed being performed by aide and documenting cursing plan of care. To be done by 1/20/18. Administrator documenting coordination, doing alde suspervisory visits timely and documenting care observed of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing alde suspervisory visits timely and documenting care be done by 1/20/18. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing alde suspervisory visits timely and documenting care observed being performed by aide and documenting cordination of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordination, doing alde suspervisory visits timely and documenting care with other physicians involved to comprehensive A	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
3. The Administrator and Alternate Administrator were interviewed on 12/1/17 at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing alde suspervisory visits timely and documenting interaction between patient and aid eand following nursing plan of care. To be do not by 1/20/18. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing alde suspervisory visits timely and documenting care observed being performed by aide and documenting cursing plan of care. To be done by 1/20/18. Administrator documenting coordination, doing alde suspervisory visits timely and documenting care observed of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing alde suspervisory visits timely and documenting care be done by 1/20/18. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing alde suspervisory visits timely and documenting care observed being performed by aide and documenting cordination of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordination, doing alde suspervisory visits timely and documenting care with other physicians involved to comprehensive A	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	re	COMPLETION
Administrator were interviewed on 12/1/17 at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aide and documenting coordination, doing aide supervisory visits timely and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Mursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAP tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure that audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor or or linear these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
Administrator were interviewed on 12/1/17 at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aid and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aid and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aid and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aid and documenting care observed being performed by aid and documenting care with other physicians involved in patient's care and documenting care with other physicians involved in patient's care and documenting care with other physicians involved in patient's care and documenting care with other physicians involved in patient's care and documenting care with other physicians involved in patient's care and documenting care with other physicians involved in patient's care and documenting care observed being performed by aid and documenting care observed being performed by aid and documenting care observed being patients' accurately, coordinating care with other patients' accurately, coordinating care observed being patients' accurately, coordinating care observed bei		3 The Administ	trator and Alternate			doing aide supervisory visits timely		
at 4:30 PM, and indicated the Director of Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The chartist will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The chartistrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure quality and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						and documenting care observed		
Compliance / Alternate Director of Nursing had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator/designee will ensure orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting care documenting coordination, doing aide supervisory visits timely and documenting recoberved being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above terms. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor ordesignee will monitor will monitor ordesignee.						being performed by aide and		
had been their compliance officer for a long time, working with the Jeffersonville agency and was not available for the exit conference. Administrator/designee will ensure orientation of newly hired nurses includes training completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting reprinted by aid early deal and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor ordesignee will monitor or designee will monitor ordesignee will monitor ordesigneed with the consultant ordesigneed with the patients and the patients of		at 4:30 PM, and	indicated the Director of			documenting interaction between		
time, working with the Jeffersonville agency and was not available for the exit conference. ### Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting race observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care, To begin immediately and be on-going. ###################################		Compliance / Al	ternate Director of Nursing			•		
time, working with the Jeffersonville agency and was not available for the exit conference. Administrator/designee will ensure orientation of newly hired urses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant and Director of Nursing and Compliance/designee to ensure these above items. The Administrator or designee will monitor corrective actions by		had been their co	ompliance officer for a long			= '		
and was not available for the exit conference. orientation of newly hired nurses includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
includes training on: completing the Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordinating, doing aide supervisory visits timely and documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by		'	6 ,					
Comprehensive Assessment accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory wisits timely and documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by			lable for the exit			-		
accurately, coordinating care with other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The Administrator will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by		conference.						
other physicians involved in patient's care and documenting coordination, doing aide supervisory visits timely and documenting are observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						•		
patient's care and documenting coordination, doing aide supervisory visits timely and documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
supervisory visits timely and documenting performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
documenting care observed being performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						coordination, doing aide		
performed by aide and documenting interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						supervisory visits timely and		
interaction between patient and aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						documenting care observed being		
aide and following nursing plan of care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						performed by aide and documenting	3	
care. To begin immediately and be on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						•		
on-going. UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						= = :		
UPDATE: The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						= '		
The Administrator coupled with the Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
Director of Nursing and Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
Compliance/designee will monitor and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						<u> </u>	•	
and evaluate the quality and appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						_		
appropriateness of patient care, and resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
resolved problems to ensure quality of care by utilizing the updated QAPI tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by							d	
tool on a weekly basis for all patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
patients. The charts will be reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						of care by utilizing the updated QAI	PI	
reviewed by the consultant to ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
ensure these above items. The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						•		
The Administrator will work with the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						•		
the Consultant, and Director of Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
Nursing and Compliance/designee to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
to ensure chart audits are done timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by						•		
timely and staff is educated on clinical matters. The Administrator or designee will monitor corrective actions by								
clinical matters. The Administrator or designee will monitor corrective actions by								
The Administrator or designee will monitor corrective actions by						•		
monitor corrective actions by								
						•		
						reviewing every chart audit on a		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 15 of 77

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00 00	COMPLETED 12/04/2017
	ROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256	
(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)	DATE
				weekly basis for 2 months and ther quarterly thereafter to ensure there is follow up to correct noted issues and that issues don't reoccul. After 2 months, all charts that mee 100% of compliance will be audited on a quarterly basis by Director of Nursing and Compliance or designee. Any chart that does mee 100% on the QAPI tool will continuate to be audited weekly until 100% compliance. We have updated our QAPI tool this we will continue to use ongoing to ensure these standards are met. We will continue to use these weekly for the next 2 months and then quarterly. This tool includes issues cited from previous survey as well other areas. The agency will ensure the Director of Nursing and Compliance/designer are educated on chart audits and completing chart audits appropriately by meeting with the Consultant to be educated. The Administrator will ensure that compliance is met by teaming with the Director of Nursing and Compliance/designee to ensure chart audits are ongoing.	r. t t t e at
N 0486 Bldg. 00	shall coordinate its	,	N 0486	<u>N486</u>	02/16/2018
				The Administrator will provide	an

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 16 of 77

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		12/04/	2017
	PROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC	•	9840 W	ADDRESS, CITY, STATE, ZIP COD 'ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256	•	
(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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on record	review and interview, the			in-service to all internal emplo	-	
	agency failed to	ensure their efforts were			including Clinical Managers by		
	coordinated with an outlying home care				1/16/18. The in-service will re coordination of care with other		
	agency, primary care physician listed on the				healthcare providers. Clinical		
		specialty physicians in 1			Managers should conduct		
	out of 3 records				coordination of care at a minir	num	
	out of 3 records	ieviewed. (#9)			of once per month to ensure n	10	
					duplication of services.		
	Findings include:				Supervisory note updated to		
					include other services provide	d,	
	1. The clinical record of patient #9, was				dates, and times. Clinical	o t	
	reviewed on 12/1/17. The clinical record				Managers in-serviced to conta other providers providing care		
	contained the fo	llowing documents:			client and document services,		
					dates, and times they are in th		
	Λ Λη ασοη	cy document titled "Nursing			home. The in-service will also		
	_	· ·			review with Clinical Managers	to	
	1 .	e" dated 9/1/17, indicated			follow up and document physi		
	•	n appointment with a			appointments to ensure possil		
		7. The clinical record			changes in orders or condition		
	failed to evidence	eed documentation of			patient are documented and s in the home is educated.	ιаπ	
	coordination wit	h the surgeon's office in			in the nome is educated.		
	regards to follow	v up / possible change in			Administrator/designee will en	sure	
	orders or patient	condition and failed to			orientation of newly hired Clin		
		ces being provided by the			Managers includes: coordinati	on	
		long with dates and times.			of care with other healthcare		
	Shared agency an	iong with dates and times.			providers. Clinical Managers	_	
	.	1			should conduct coordination o		
		cy document titled "Nursing			care at a minimum of once pe month to ensure no duplication		
	1 1	e" dated 9/25/17, indicated			services. Supervisory note	11 01	
	the patient had an appointment with a Nurse Practitioner for "[name of physician]" and the patient was receiving services from another home health agency. The clinical				updated to include other servi	ces	
					provided, dates, and times.		
					Clinical Managers to contact of	other	
					providers providing care to clie		
		evidenced documentation of			and document services, dates		
		h the Nurse Practitioner /			and times they are in the hom		
	coordination Wit	ii the Nuise Plactitioner/			Clinical Managers to follow up	and	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 17 of 77

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
			B. WIN	NG		12/04/	2017
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
		HEALTHCARE SERVICES, INC			'ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE	 	ID ID	,		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	I	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA	VIE.	DATE
	physician office	in regards to follow up /			document physician appointm		
	possible change in orders or patient				to ensure possible changes in orders or condition of patient		
	condition and failed to include the services				documented and staff in the h		
	being provided by the shared agency along				is educated.		
	with dates and t	imes.			4000/ of all alicitations and it		
					100% of all clinical records wi audited weekly for the next 2	и ре	
	_	cy document titled "Nursing			months by the Homecare		
		te" dated 10/5/17, indicated			Consultant to ensure complian		
	_	a vascular lab appointment			with plan of correction. Clinica records that meet 100%	ıl	
		ysis on Tuesday, Thursday,			compliance after the 2 month		
	_	nd was receiving services			period will be audited quarterly	y by	
		me health agency. The			Administrator or designee. An	-	
		ailed to evidenced			clinical record that does not m		
		th the physician or dialysis			100% compliance will be audited weekly until that threshold is met.		
	-	s to follow up / possible					
	_	s or patient condition after			The Administrator or designed	e will	
		and failed to include the			be responsible for monitoring these corrective actions to en	2115	
		rovided by the shared			that this deficiency is correcte		
	agency along w	ith dates and times.			and will not recur.		
	D 4	and do num out titled "Deticat					
	_	ncy document titled "Patient					
		on" dated 10/5/17 and					
		ed the patient continued to					
	_	ency come into the home to					
	*	e patient's instrumental					
		y living and that the agency					
		e services being provided by					
	Adaptive. The coordination document failed						
		ervices being provided by the					
	snared agency a	long with dates and times.					
	2. The findings	was reviewed with the					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 18 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
			B. WI	NG		12/04/	2017
	ROVIDER OR SUPPLIER E NURSING AND I	HEALTHCARE SERVICES, INC		9840 W	ADDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(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	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		cal Services, Administrator,					
	and Alternate Ac	dministrator on 12/1/17 at					
	4:30 PM and all management personnel						
	acknowledged an	nd agreed that follow up					
	was needed by th	ne case manager after the					
	patient's physicia	an appointments.					
N 0520 Bldg. 00	for care on the base expectation that the can be adequately agency in the patients. Based on record agency failed to was provided to on the basis that adequately be more reviewed of a part 8/3/17. Findings include 1. The clinical response of care 9/28/17, the certification of 11/26/17, with one of the care of the c	Patients shall be accepted sis of a reasonable ne patient's health needs whether the patient's place of residence. review and interview, the ensure care and services a patient accepted for care his / her health needs could et in 1 out of 1 records tient newly admitted since d: ecord for patient #12, start included a plan of care for period of 9/28/17 to reders for Home Health aide	N 03	520	N520 The Administrator will provide an in-service to all internal employees by 1/16/18. The in-service will review the agency bed bug policy. On 12/26/17, the Agency's bed bug policy was updated. The policy was updated to reflect that the agency has ensured care and services are provided adequately even in the event of bed bug infestation. The policy is uploaded as a supporting document. 100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited.	t	02/16/2018
	the certification 11/26/17, with or services 2 hours	period of 9/28/17 to			to ensure compliance with plan of correction. Clinical records that	-	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 19 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
			B. WIN	IG		12/04/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ESTPOINT DRIVE, SUITE 400		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC			APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	P	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	daily living) such as banking, you're care,				does not meet 100% compliance wil	I	
	dressing, nail car	re, incontinence care, meal			be audited weekly until that threshold is met.		
	prep, light house	ekeeping, transfers and			Administrator/designee will ensure		
	medication remi				orientation of newly hired clinical		
					staff will include review of agency		
	2 Danian afala	1:-:14			bed bug policy. To begin		
		e clinical record on			immediately and be on-going.		
	1	sician's order dated			The Administrator or designee will be responsible for monitoring these		
	11/6/17, indicate	ed that Home Health aide			corrective actions to ensure that		
	services to be pla	aced on hold as of 11/6/17,			this deficiency is corrected and will		
	due to the patien	t having bed bugs. The			not recur.		
	clinical record failed to evidence any				On 11/13/17, the agency followed		
		of the agency following up			up with the patient's primary		
		or caregivers in regards to			caregiver in regards to the extermination of infestation. The		
	_				primary caregiver understood that		
	extermination of	the infestation.			they would need to get the bed bug	s	
					taken care of before services would		
	3. The director of	of clinical services and the			resume. On 11/21/17 the agency		
	administrator we	ere queried on their			followed up with the patient's		
	expectations of s	services to be provided with			primary caregiver in regards to the extermination of infestation. On		
	a patient with kn	nown bed bugs on 11/30/17			12/1/17, the agency followed up		
	-	e director of clinical services			with the patient's primary caregiver		
					in regards to the extermination of		
		their policy to place services			infestation and confirmed a first		
		ministrator queried about			treatment was being completed nex week. On 12/8/17, the agency	τ	
		des refusing to provide			followed up with the patient's		
	services due to a	fear of transporting the bed			primary caregiver in regards to the		
	bugs to other pat	tients' homes or into their			extermination of infestation. On		
	_	e administrator then			12/15/17, the agency followed up		
		rvices should continue			with the patient's primary caregiver		
					in regards to the extermination of infestation. On 12/21/17, the		
	"	bed begs because the			agency followed up with the		
	_	eed of services and if they			patient's primary caregiver in		
	_	de services during this time,			regards to the extermination of		
	then the patient s	should be discharged and			infestation. On 12/26/17, when the		
	referred to anoth	er agency who could meet			bed bug policy was updated, the		
					agency followed up with the		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 20 of 77

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017	
	OF PROVIDER OR SUPPLIED	HEALTHCARE SERVICES, INC		9840 W	ADDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ds. The administrator		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) patient's primary caregiver to give	TE	(X5) COMPLETION DATE
	indicated he need caregivers. 4. An agency perevised 2/15/16, workers that rough a part of their journ bed bugs. Servivisit clients home to follow should contact with a perpolicy ended with working environs provide staff in a patients with a care of the policy ended with the policy en	ds. The administrator ded to follow up with the olicy titled "Bed Bug Policy" indicated " Health care tinely visit clients' homes as be are at risk for contacting ce workers that routinely less as a part of their job " on to include a procedure the worker came into attent with bed bugs. The the "In order to ensure a safe ament, Adaptive does not the homes of clients / urrent bed bug infestation. Of the bed bug infestation that the home is bug free, lient / patient will resume."			her the option of offering other providers who may be able to staff in the event they were not able to finish the treatment of bed bugs within 15 days. On 12/29/17, the agency followed up with the patient's primary caregiver and confirmed that the final treatment was completed on 12/28/17. The extermination company will be coming out in the next week or two to inspect to confirm no prescense of bed bugs. The primary caregiver asked if this agency could follow up next week to obtain an all clear letter at that point and then said she would prefer to resume services at that point rather than switching to another company. On 1/5/18, the agency followed up with the patient's primary caregiver and she said the extermination was scheduled to come out on 1/11/18. She asked for a follow up on 1/12/18.		
	Treatment" revis Patients shall basis of a reason patient's health i	bolicy titled "Plan of sed on 3/21/12, indicated " be accepted for care on the nable expectation that the needs can be adequately met alth agency in the patient's ce "			Update: The Agency will ensure the patient's needs, as addresse by the plan of care, are met be communicating with the client and primary caregiver to ensure that someone is available to assist the client with their personal care need as needed. Agency will also inform the MD and, Case Manager if applicable, in the event they feel the client need to be temporarily transferred.	oy nt Is,	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 21 of 77

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING B. WING	00 00	COMPLETED 12/04/2017
	ROVIDER OR SUPPLIER E NURSING AND F	HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256	
(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
				a facility/another agency. Agency will follow up with client/caregiver at least week to ensure personal care need are being met. Director of Nursing and Compliance/designee will audit 100% of clinical documentation weekly to ensure documentation indicates patient's needs are being met. Once 100% compliance is achieved Director of Nursing and Compliance will audit 25 of documentation quarterly the ensure compliance with patient needs aren't being met. If patient needs aren't being met Director of Nursing and Compliance/designee will monitor for documentation showing attempts by agency staff to assist patient with getting needs met or assisting patient/caregiver with obtaining assistance with getting needs met.	ds % o ent
N 0522 Bldg. 00	written medical pla	Medical care shall follow a an of care established and red by the physician, or, optometrist or			
	ροσιατίιετ, as follov	vo.	N 0522	N522 The agency's supervisory note be updated as of 1/2/18 to inc	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 22 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLI	
			B. WI	NG		12/04/	2017
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
					ESTPOINT DRIVE, SUITE 400		
ADAPTI\	E NURSING AND	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 46256		
(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	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	: -1 -	DATE
Based on record review and interview, the				observation of Home Health A providing direct care to the part			
agency failed to ensure the Registered Nurse				at a minimum of at least every			
	followed the plan	n of care in regards to			days.		
		s in 2 out of 3 records			Administrator/designee will pro	ovide	
	reviewed (#9 and	d 11) and the home health			re-education to both internal s	taff,	
	aide failed to fol	low the plan of care in			which refers to clinical		
	regards to stayin	g in a patient's home for an			managers and external staff, which refers to hourly caregive	are	
	-	rs without an order in 1 out			working in the home, on follow		
	of 3 records revi	ewed (#9).			the plan of care. This will also	9	
					include a review of supplemen	ıtal	
Findings include:				orders and when those are			
	Tillianigs include	·•			necessary. The in-service will		
	1 Don Antiolo 17	7 410 14 C 17 14 1 (p)			provide re-education that when patient or caregiver notifies the		
		7, 410 IAC 17-14-1 (n),			agency that they are working	-	
	_	rse make a supervisory			hours that do not follow the pla	an of	
		ry 30 days, wither when the			care, the registered nurse will		
		e is present or absent, to			obtain a verbal and signed		
	observed the car	e, to assess relationships,			physician order to authorize th		
	and to determine	whether goals are being			change to the plan of care. The order will be maintained in the		
	met." The Regis	stered Nurse failed to follow			clinical record.		
	the plan of care	in regards to performing					
	supervisory visit	s per state regulations.			100% of all clinical records wil	l be	
					audited weekly for the next 2		
	2. The clinical r	ecord for patient #9 was			months by the Homecare		
		1/17. The clinical record			Consultant to ensure compliar with plan of correction. Clinica		
		of care for the certification			records that meet 100%	•	
	_	7 to 12/5/17, with orders			compliance after the 2 month		
	_	d Nurse "to perform			period will be audited quarterly	-	
	_	•			Administrator or designee. Any		
	1 1	s per state regulations RN			clinical record that does not m		
		signs and pulse oximetry at			100% compliance will be audit weekly until that threshold is n		
	· ·	plan of care also included			The Administrator or designee		
	orders for the ho	me health aide to provide			be responsible for monitoring		
	services 2 hours	a day 2 to 3 days a week.			these corrective actions to ens	sure	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 23 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256	
	SUMMARY (EACH DEFICIENT REGULATORY OF A. Review "Nursing Supervincluded care conservices, advance reviewed and aptreatment, other (current plan of reviewed, home plan reviewed, gonumbers availabin chart and updereconciliation conserviewed), Paties satisfaction with agreed with plant patient caregiver educate			•	(X5) COMPLETION DATE d ce all urse isit er rve side f ill red on on ew of n ion en a e an of
	care, oxygen saf stored appropria obtained includi pain assessment: B. Review note dated 11/25 note indicated "I could stay he sta fill good [sic]." AM and the time	and supplies match plan of ety observed, medications tely), assessment (vital signs ng oxygen saturations), and s. of a home health aide visit id 17, the home health aide call they office 2 C if I have home to day he didn't The time in indicated 7:00 e out indicated 11:00 AM.	obtain a verbal and signed physician order to authorize the change to the plan of care. This order will be maintained in the clinical record.		is

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 24 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIF	LE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDII	NG	00	COMPL	
			B. WING			12/04/	2017
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
					ESTPOINT DRIVE, SUITE 400		
ADAPIN	E NURSING AND	HEALTHCARE SERVICES, INC	IN	DIANA	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREF TA		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		a verbal order for the home	IA	O I			DATE
		ay an additional 2 hours.					
	The home health						
	plan of care.						
	3. The clinical r						
		1/17. The clinical record of care for the certification					
	period of 11/10/						
	1 *						
		ed Nurse "to perform					
	supervisory visits per state regulations RN						
		signs and pulse oximetry at					
	this time."						
	A D	- C					
		of an agency form titled					
	1 .	visory Note" dated 11/2/17					
	•	luded care coordination					
	`	Services, advance					
	_	of care reviewed and					
	1 1 1	nges to the treatment, other					
	1	nome), chart (current plan of					
		and reviewed, home chart					
	1 -	gency plan reviewed,					
	l =	ranch numbers available,					
		on profile in chart and					
	_	tion reconciliation complete,					
	_	ved), Patient / caregiver					
	I '	sfaction with services,					
	_	reed with plan of care, any					
		nt caregiver involvement,					
	patient / caregive	er education provided if					
	necessary), envir	ronment (patient area / room					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 25 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED	
			B. WI	NG		12/04/	/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					ESTPOINT DRIVE, SUITE 400		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		ized, DME and supplies					
		are, oxygen safety observed,					
		red appropriately),					
	assessment (vita						
	oxygen saturatio						
	4. The findings	were reviewed with the					
	Director of Clini	ical Services, Administrator,					
	and Alternate A	dministrator on 12/1/17 at					
	4:30 PM, and in	dicated the case manager /					
	registered nurse should have been observing						
	"	the home health aide					
		ts and that an order should					
		ned for the additional time.					
	nave been obtain	ica for the additional time.					
	5 An agency no	olicy titled "Plan of					
	" " "	sed on 3/21/12, indicated "					
		shall follow a written					
		care established and					
	_						
	periodically revi	iewed by the physician "					
		11 110 1 110					
	" " "	olicy titled "Supplemental					
	*	s" revised on 3/21/12,					
		ned physician order must be					
		ne an order is taken which					
	modifies the exis	sting orders on the Plan of					
	Care "						
N 0524	410 IAC 17-13-1(a	a)(1)					
	Patient Care						
	1		1				Ī

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 26 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		12/04/2017	
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
AD ADTIV	E NITIDOING AND I	HEALTHCARE SERVICES, INC			ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
ADAPTIV	E NURSING AND I	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 40250		
(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)		DATE
Bldg. 00	Rule 13 Sec. 1(a)((1) As follows, the medical					
	plan of care shall:						
	(A) Be developed in consultation with the						
	home health agen	cy staff.					
	(B) Include all ser	vices to be provided if a					
	skilled service is b	eing provided.					
	(B) Cover all perti	nent diagnoses.					
	(C) Include the fol	_					
	(i) Mental statu						
	(ii) Types of ser	vices and equipment					
	required.						
		nd duration of visits.					
	(iv) Prognosis.						
	(v) Rehabilitatio	-					
	(vi) Functional lin						
	(vii) Activities per						
	(viii) Nutritional re	- T					
	• •	and treatments.					
		measures to protect					
	against injury.						
		for timely discharge or					
	referral.						
		dalities specifying length of					
	treatment.						
	(xiii) Any other ap	propriate items.	NIO	- 2.4	N 504		02/16/2010
	1		N 0:	524	N 524		02/16/2018
	ı				The Administrator will provide		
	Based on record	review and interview, the			in-service to all internal employ	-	
		ensure that the development			including Clinical Managers by 1/16/18. The in-service will	′	
		•			include the following: The		
	_	are were supported by the			clinicians will be educated that	the	
	comprehensive a	ssessment and failed to			duration of services needs to b		
	include a duration of services to be provided				included on the verbal order w		
		ords reviewed. (#9, 11 and			and also on the plan of care.	11011	
	12)	(17, 11 4114			and also on the plan of cale.		
	14)				100% of all clinical records will	l he	
	lane de la company				audited weekly for the next 2		
	Findings include				months by the Homecare		
	1				Consultant to ensure complian	ice	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 27 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
			B. Wl	ING		12/04/	2017
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	3			ESTPOINT DRIVE, SUITE 400		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC			APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		record of #9, SOC (start of			with plan of correction. Clinica records that meet 100%	1	
	1	, was reviewed on 12/1/17.			compliance after the 2 month		
	The clinical reco	ord included a plan of care			period will be audited quarterly	v bv	
	for the certification period of 10/7/17 to				Administrator or designee. An		
	12/5/17, with the following orders /				clinical record that does not m	-	
	information:				100% compliance will be audit		
	mornation.				weekly until that threshold is n		
	A. Home health aide 2 hours a day, 2				The Administrator or designee	will	
	to 3 hours a week, not to exceed 6 hours				be responsible for monitoring these corrective actions to ens		
		·			that this deficiency is corrected		
	per week through the certification period to				and will not recur.	ч	
	assist with all ADLs (activities of daily living)				The Administrator or designee	will	
	such as bathing	(bed / tub / shower), hair			be responsible for monitoring		
	care, dressing, n	ail care (no clipping),			these corrective actions to en	sure	
		re, meal prep, light			that this deficiency is corrected	d	
		ransfers and medication			and will not recur.		
		ansiers and medication			The Administrator/designee w		
	reminders only.				provide an in-service to all inte	ernal	
					employees including Clinical Managers by 1/16/18. The		
	_	ciple diagnoses were			in-service will review coordina	tion	
	sequelae of othe	r cerebrovascular (stroke)			of care with other healthcare		
	with secondary	diagnoses of end stage renal			providers. Clinical Managers v	vill	
	disease, essentia	l hypertension,			conduct coordination of care a		
	•	eart disease, hyperlipidemia			minimum of once per month to		
	and anemia.	, J1 - F			ensure no duplication of		
	and anomia.				services. Clinical Managers w	III be	
	C Th	antla madiantiana izala da			in-serviced to contact other providers providing care to clie	ant	
		ent's medications included			and document services, dates		
	* ` `	gh cholesterol), metoprolol			and times they are in the home		
	(treat high blood pressure), Seroquel				The in-service will also review		
	(treatment of schizophrenia, bipolar and				with Clinical Managers to follo	w up	
	depression), pan	toprazole (treat high levels			and document physician		
	of stomach acid) Isosorbide (treat high			appointments to ensure possil		
	blood pressure a				changes in orders or condition		
		dopa (treat high blood			patient are documented and s	tatt	
	Carbidopa-Levo	aopa (ucai mgn bibba			in the home is educated.		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 28 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
			B. WI	NG		12/04	/2017
NAME OF I	PROVIDER OR SUPPLIE	P.		STREET A	ADDRESS, CITY, STATE, ZIP COD		
					ESTPOINT DRIVE, SUITE 400)	
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG		<i>;</i> ;;;	DATE
		(anemia supplement),			The Administrator/designee w ensure orientation of newly him		
		a treatment during dialysis),			internal staff, including Clinica		
	Hectorol (high p	parathyroid treatment during			Managers, includes: review	•	
	dialysis), and V	enofer (anemia treatment			coordination of care with othe	r	
	during dialysis)				healthcare providers, Clinical		
					Managers should conduct		
	D. Safety measures included but were				coordination of care at a minir		
	not limited to respiratory precautions.				of once per month to ensure r		
	not infinited to respiratory precautions.				duplication of services, Clinica		
					Managers are to contact other providers providing care to cli		
	E. Nutritional requirements indicated				and document services, dates		
	the patient was on a low nutritional status,				and times they are in the hom	•	
	renal diet, low sodium, and fluid restrictions.				and Clinical Managers are to		
					follow up and document physi	cian	
	F. Function	nal limitations included but			appointments to ensure possi		
	were not limited				changes in orders or condition		
	word not minted	i to pararyoro.			patient are documented and s		
	O TTI 1				in the home is educated. To b	•	
	_	n of care indicated the			immediately and be on-going.		
	patient had dialy	ysis 3 times a week.			The Administrator/designee w	vill	
					in-service Clinical Managers of		
	H. The pati	ient goals included no falls			ensuring the plan of care is		
	and no weight le	oss over the next 60 days.			supported by the documentati	on in	
	_	-			the comprehensive		
	I Page 2 of	f the same plan of care			assessment. Clinical Manager	rs to	
	_	ay summary dated 10/5/17,			include, when applicable, the	ia	
					following: if patient has dialysi access site – where is the site		
		atient's dialysis site located			who is responsible to monitor		
		e of the chest was intact,			access site; names of physicia		
		ed "help hands on help",			that may give orders; duration		
	continued to be	unsteady on his feet which			aide services; fluid restriction		
	continued to ma	ike him a high fall risk, had a			amount for a 24 hour period; of	does	
	fistula that was	placed in the right arm and			patient have paralysis or	_	
		appointment in November,			weakness specific to one side		
		ve dialysis three times a			body; fall interventions; descri	ption	
	Commute to Ha	ve dialysis tillee tillles a			of pain; onset of pain; diet		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 29 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		12/04/	2017
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ESTPOINT DRIVE, SUITE 400		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC			APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		y, Thursday, and Saturday,			restrictions; weight loss interventions and name of other	or	
	_	nued to prepare the patient's			agencies providing health care		
	medication, ben	efited from medication			services including when service		
	reminders, conti	nued to live with ex spouse			are being provided. To be don		
	(patient #11) wh	o was also a patient of the			1/16/18.	•	
	agency, had a fa	mily member that checked			<u> </u>		
	on the patient often, no willing caregivers.				The Administrator/designee wi		
					ensure orientation of newly hir Clinical Managers includes:	eu	
	I Review o	of the comprehensive nursing			ensuring the plan of care is		
					supported by the documentation	on in	
	assessment dated 10/5/17, indicated the				the comprehensive assessme		
	patient was on a renal diet with 1000				Clinical Managers are to include		
		restriction under the feeding			when applicable, the following		
		eurological assessment			patient has dialysis access site where is the site, who is	9 –	
	_	tient was alert to person,			responsible to monitor the acc	ess	
	place and time,	unequal hand grasps, left			site; names of physicians that		
	sided weakness,	normal cardiovascular			may give orders; duration of a	ide	
	assessment but h	nad a blood pressure of			services; fluid restriction amou		
	183/54, musculo	oskeletal assessment			for a 24 hour period; does pati	ent	
	indicated the par	tient had limited range of			have paralysis or weakness specific to one side of body; fa	.II	
	1	tion with a cane, had some			interventions; description of pa		
		ss of breath with exertion,			onset of pain; diet restrictions;		
	1	line to the right chest for			weight loss interventions and		
	· ·	•			name of other agencies provid	ling	
	1	nd last changed on 10/3/17			health care services including		
		alysis and location in the			when services are being provi	ded.	
	comments section				To begin immediately and be		
	documentation t	o elaborate the findings.			on-going.		
	K. Review	of the fall risk assessment					
	dated 10/5/17. in	ndicated the patient had					
		nt, pain affecting level of					
	•	ed functional mobility, scored					
		thich a score of 4 or more					
	a 101a1 01 0, 111 W	men a score of 7 of more	1				

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 30 of 77

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 12/04/2017	
	ROVIDER OR SUPPLIER E NURSING AND I	HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 JAPOLIS, IN 46256	
(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
	was considered a	at risk for falling.			
	L. Review of assessment dated patient scored a factor of the patient had a surgeon on 9/8/1 failed to evidence	of the nutritional risk 1 10/5/17, indicated the 30, in which a score 30 to insidered a medium with recommendations to in, appropriate dietary sult with dieticians as with physician and discuss supplements and to itoring and provided idicated. The comment is the patient was not to have a vegetables, a renal diet iter fluid restriction. The feed the meals were not only spouse and the home health believed prepared and from a community service. Cy document titled "Nursing et" dated 9/1/17, indicated in appointment with a 7. The clinical recorded documentation of the the surgeon's office in			
	regards to follow orders or patient include the servi-	or up / possible change in condition and failed to ces being provided by the ong with dates and times.			

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 31 of 77

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		12/04/2017	
NAME OF D	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
				ESTPOINT DRIVE, SUITE 400		
ADAPTIV	'E NURSING AND	HEALTHCARE SERVICES, INC	INDIAN	IAPOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		cy document titled "Nursing	TAG		DATE	
	_					
	Supervisory Note" dated 9/25/17, indicated the patient had an appointment with a Nurse					
	-	'[physician name" and the				
		iving services from another				
	home health age					
	nome nearm age	ncy.				
	() An agen	cy document titled "Nursing				
	_	e" dated 10/5/17, indicated				
	1 5	vascular lab appointment				
	•	ysis on Tuesday, Thursday,				
		id was receiving services				
	-	me health agency.				
	mon another not	me nearth agency.				
	P. An ageno	cy document titled "Patient				
	Care Coordination	on" dated 10/5/17 and				
	11/2/17, indicate	ed the patient continued to				
		ency come into the home to				
		patient's instrumental				
	-	y living and that the agency				
	·	e services being provided by				
	Adaptive.					
	_					
	The plan of care	failed to be supported by				
	the comprehensi	ve assessment, failed to				
	include the perso	on / facility responsible for				
	the patient's dial	ysis access, failed to				
	correctly identify	y the dialysis accesses to				
		an responsible for the				
		the patient's hypertension /				
	_	o include the names of				
	, ,	orders may be accepted				
		• •	I	l .	1	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 32 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 VAPOLIS, IN 46256	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	from, failed to into be provided by failed to include restricted in a 24 correctly identify or left sided wear interventions for weight loss as weight loss are also of the shared age provided and who provided. 2. The clinical record in certification peri with the following. A. Home he to 3 times a week per week throught to assist with all living) such as behair care, dressing incontinence car housekeeping, treminders only.	relude a duration of services by the home health aide, the amount of fluids hour period, failed to by if the patient had paralysis kness, and failed to include the prevention of falls and ell as diet restrictions. The failed to include the name ency, the services being then those services would be record of patient #11, SOC riewed on 12/1/17. The reluded a plan of care for the rod of 11/10/17 to 1/8/18, and orders / information: The reluded a plan of care for	TAG		
	chronic obstructi	ciple diagnoses were ive pulmonary disease condary diagnoses of type			

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 33 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPLETED 12/04/2017	
			B. WINC	<u> </u>		12/04/	2017
NAME OF P	ROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP COD		
ΔΠΔΡΤΙ\	/E NI IRSING AND	HEALTHCARE SERVICES, INC			ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
			<u>, L</u>				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
		arthritis, hypertension and					
	hyperlipidemia.	, J1					
	31 1						
	C. The med	lication section indicated the					
	patient was taking Gabapentin 600 mg						
	(medication used	d for diabetic neuropathy -					
	numbness / tingl	ling pain in patient					
	extremities) thre	e times a day, Metformin					
	(treatment for diabetes) Tradjenta (treatment						
	for diabetes), Hydroxyzine as needed						
	(treatment for anxiety/sleep), Cymbalta						
	(treatment for de	epression), Seroquel					
	(treatment for de	epression), Metoprolol					
	(treatment for hi	gh blood pressure),					
	Amlodipine (trea	atment for high blood					
	pressure), Nexiu	ım (treatment for stomach					
	acidity), Proair (treatment for COPD), Qvar					
	(treatment for Co	OPD), Xalatan (treatment					
	of glaucoma), A	lphagan (treatment for					
	glaucoma), Mure	o (treatment for corneal					
	edema), Polyvin	yl (treatment for eye redness					
	1	ion), Zofran (treatment for					
	nausea), iron sur	oplement, and low dose					
	aspirin. No pain	n medication(s) were					
	identified.						
		nal limitations indicated					
	endurance and a	mbulation, and goal that the					
	patient would no	ot experience any falls over					
	the next 60 days						
	E. Page 3 of	f the same plan of care					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 34 of 77

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017		
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL DESCRIPTION OF THE OPEN ATTOM		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION	
	indicated in the of 11/7/17, indicated be independent a continued to set medications but medication remit to demonstrate of sugar, lived with patient of the agunable to care for F. Review of assessment dated patient was continued to demonstrate of the agunable to care for formal for the patient of the agunable to care for the patient was continued to demonstrate of the agunable to care for the patient of the agunable to care for assessment dated patient was continued to the patient had severtion, clear be cough, full range weakness and we with a current reassessment indicated back pain that we "gabapentin / programme p	CY MUST BE PRECEDED BY FULL RESC IDENTIFYING INFORMATION 60 day summary dated ing the patient would tried to as much as he / she can, up his / her own would benefit from inders. The patient was able obtaining his / her own blood a ex spouse who was also a ency (patient #9) and was or the patient. of the comprehensive nursing d 11/7/17, indicated the inent, no ears / nose / throat neurological, genitourinary, integumentary impairments, hortness of breath during reath sounds but productive e of motion but had some alks with a cane, a diabetic ading of 214, pain rated the patient had lower as chronic - took in (as needed) pain, and the			(EACH CORRECTIVE ACTION SHOULD BE	TE		
	chronic pain ran scale of 1 - 10 w pain). The pain	ed the patient complained of ging from a 6 to a 10 (on a ith 10 being the worst assessment failed to include						
	(stabbing, throbb	pain the patient was having bing, sharp). No further o elaborate the findings.						

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 35 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017		
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
(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)	ΓE	(X5) COMPLETION DATE	
	dated 11/7/17, in visual impairme	of a fall risk assessment ndicated the patient had nt and pain affecting level of						
	function, scored a total of 4, in which a score of 4 or more was considered at risk for falling.							
	the comprehensi include a duration by the home hea	failed to be supported by tve assessment, failed to on of services to be provided alth aide, and failed to tions for the prevention of						
	9/28/17, was rev clinical record in certification per	record of patient #12, SOC riewed on 11/30/17. The included a plan of care for the fiod of 9/28/17 to 11/26/17, ing orders / information:						
	to 3 times a wee per week throug to assist with all living) such as b hair care, dressin incontinence car	k, not to exceed 6 hours hout the certification period, ADLs (activities of daily eathing (bed / tub / shower), ng, nail care (no clipping), re, meal prep, light ransfers and medication						
	_	ciple diagnoses were age debility with secondary						

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 36 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			LDING	nstruction <u>00</u>	(X3) DATE COMPL 12/04 /	ETED	
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC		9840 W	DDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	behaviors, chron	specified dementia without nic obstructive pulmonary					
	disease, unspecified systolic congestive heart, essential hypertension, diverticulitis with perforation, anemia, hypothyroidism,						
	and mixed incontinence.						
	C. Medications included Calcium, Ferrous Sulfate, Synthroid (for Trazodone						
	(for sleep and / or behaviors), Amlodipine (for hypertension), Hydralazine (for						
	hypertension), Tylenol (for pain or fever) and Ensure Supplements (nutrition supplements).						
		of the same plan of care tient was hard of hearing, the					
	patient had good	I days and bad, the patient mily member for answers to					
	balance was uns	a cane in the home, gait and teady, high fall risk, fell a					
	breath easily wh	out injury, gets short of ile exerting self such as and walking more that 20 to					
	40 feet. The pat	ient had chronic pain in his / t does not get greater than 6					
	on a scale of 1 -	10 and took Tylenol as aghter would set up the					
	would benefit from	tion box and the patient om medication reminders.					
	_	ber reported the patient ee 3 days a week with a					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 37 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017			
		ROVIDER OR SUPPLIER E NURSING AND I	HEALTHCARE SERVICES, INC		9840 W	DDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
PR	A) ID REFIX 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
		shower, needs di in / out of the sho washing, assistant the patient declin with incontinent and needs help w by assistance with falls, need assistant and meal prep. To to say the patient one works while	rect assistance with transfer ower, direct assistance with nee with a "sink bath" when nes a shower, assistance / peri care, wears depends with clean up, needs stand the walking due to frequent ance with light housekeeping. The plan of care continued to lived with family members, the other was disabled and tient did not have willing or					
		initial and admit 9/28/17, indicate pain, intensity 4 onset was blank, needed) tylenol, incontinent and owas alert to self, cardiovascular as limits, musculos the patient had liright shoulder, as of breath with exstatus (skin), and indicated the pat dementia, COPE HTN, diverticulii	of the comprehensive nursing ting assessment dated d the patient had right hip - 10, duration was chronic, relief measures was prn (as regular diet, feeds self, diaper was checked, patient had dementia, ssessment within normal keletal assessment indicated mited range of motion to the ssist with a cane, shortness tertion, fair integumentary I the nursing narrative itent a diagnoses of 0, debility, incontinence, tis, CHF, "has balance August", hard time upon					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 38 of 77

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

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 JAPOLIS, IN 46256	
(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
		inusual findings. No further o elaborate the findings.			
	the comprehensi include a duration by the home heat. 4. The findings with the Director and Alternate Act 3:45 PM, and all acknowledged at comprehensive at the plan of care, and #11 was revadministrative stall acknowledged.	of patient #12 was reviewed or of Nursing, Administrator, administrator on 11/30/17 at administrative staff and agreed the assessment did not support. The findings of patient #9 iewed with the same aff on 12/1/17 at 4:30 PM,			
	Client Assessme indicated " Pu about the client's functional and pass appropriate to make care, treatabased on informations.	olicy titled "Comprehensive ent" revised on 5/1/15, rpose To collect data is health history, (physical, sychological) and their needs of the home care setting. To ment or service decisions ation developed about each d the individual's response			

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 39 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					,	3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING				COMPLETED 12/04/2017	
			B. W1		A DE DE COMPANION	12/04/	2017	
NAME OF PRO	OVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400			
ADAPTIVE	NURSING AND I	HEALTHCARE SERVICES, INC			APOLIS, IN 46256			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE	
		olicy titled "Plan of					2,1,1,2	
I		ed on 3/21/12, indicated "						
	the medical plan of care shall included							
I	•	frequency and duration of						
v	visits, nutritional	requirements any safety						
n	neasures to prote	ect against injury any						
О	other appropriate	e items "						
N OF 44		\\4\\ P \						
	110 IAC 17-14-1(a Scope of Services							
	•	(1)(B) Except where						
S	services are limite	d to therapy only, for						
		ce in the home health						
	setting, the registe ollowing:	ered nurse shall do the						
	•	valuate the patient's nursing						
n	needs.							
			N 0:	541	N541 The Administrator/decigned with	:11	02/16/2018	
					The Administrator/designee will provide an in-service to all inte			
		review and interview, the			employees including Clinical			
	•	e failed to accurately			Managers by 1/16/18. The			
I	J 1	s's dialysis access and failed			in-service will include educatin Clinical Managers on how to	ıg		
	-	ssible dialysis access sites in			implement appropriate infectio	n,		
		reviewed of a patient with			and checking for bruit and thril			
d	dialysis in a sam	ple of 3. (#9)			Clinical Managers will also educate Home Health Aides, o	on		
_F	Findings include:				site maintenance and what to			
					report to clinicians. These			
1.					Lintonyontions will be added to t	ho.		
1	1. The clinical re	ecord of patient #12, start			interventions will be added to to clients plan of care. Aide care			

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 40 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. WI	ING		12/04/	2017
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t			ESTPOINT DRIVE, SUITE 400		
ΔΠΔΡΤΙ\	/F NURSING AND I	HEALTHCARE SERVICES, INC			APOLIS, IN 46256		
71071111	TE NORONO 7 NAD	TIE/LETTIO/(IXE GERVIGES, IIVO	,	IIVDI/IIV	711 OLIO, 114 40200		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					to Clinical Managers.		
	A. The clini	ical record contained a plans			Administrator/designee will en		
	of care dated 8/8/17 to 10/6/17 and				orientation of newly hired Clini		
	10/7/17 to 12/5/1	17 which indicated the			Managers will include: educati	-	
	10/7/17 to 12/5/17, which indicated the patient had a diagnosis of End Stage Renal				Clinical Managers to implemer appropriate interventions relate		
	1 *	•			maintenance and protection of		
		receiving dialysis 3 times a			clients dialysis access site suc		
	week.				as bleeding precautions, signs		
					and symptoms of infection, and		
	B. Review of	of the comprehensive			checking for bruit and thrill.		
	nursing assessments dated 10/5/17 and				Clinical Managers will also		
	11/2/17, indicated the patient had a PICC				educate Home Health Aides of		
					site maintenance interventions	;	
		y inserted central catheter) to			related to maintenance and		
	the right chest w	all			protection of clients dialysis		
					access site such as bleeding	mo	
	C. Accordir	ng to Cleveland Clinic			precautions, signs and sympto of and what to report to Clinica		
	website (www.m	nyclevelandclinic.org), a			Managers. These interventions		
		efined as "A thin, soft,			be added to the clients plan of		
					care. Aide care plan will includ		
		n intravenous (IV) line.			signs/issues to report to		
	l '	n as IV medications, can be			registered nurse. To begin		
	be given through	a PICC. Blood for			immediately and be on-going.		
	laboratory tests of	can also be withdrawn from					
	a PICC A PIC	CC can also spare your			Clinical Managers will also be		
		vessels from the irritating			educated to attempt to coordin		
	effects of IV me	_			care with client's dialysis center	er	
	effects of TV file	dications			and these attempts will be		
					documented on the care coordination sheet.		
		were reviewed with the			Administrator/designee to		
	Director of Clini	cal Services, Administrator,			complete by 1/16/18.		
	and Alternate Ac	dministrator on 12/1/17 at					
	4:30 PM and the	e Director of Clinical					
	•	ed she was aware that the			100% of all clinical records will	be	
					audited weekly for the next 2		
		e identified and documented			months by the Homecare		
	the dialysis inacc	curately, but at the time of			Consultant to ensure complian	ce	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 41 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED	
			B. WI	NG		12/04/	2017
	ROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC		9840 W	ADDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DECLEDED IN 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)		DATE
	question the form				with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited quarterly Administrator or designee. Any clinical record that does not m 100% compliance will be audit weekly until that threshold is not a The Administrator or designee be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	y by y eet eed net. will	
N 0542 Bldg. 00	services are limite purposes of practi setting, the register following: (C) Initiate the plarevisions. Based on record Registered Nurse development of a supported by the and failed to include provided in 3 (#9, 11 and 12) Findings include	(1)(C) Except where d to therapy only, for ce in the home health ered nurse shall do the an of care and necessary review and interview, the erailed to ensure that the che plans of care were comprehensive assessment and a duration of services to out of 3 records reviewed.	N 05	542	N542 The Administrator/designee w provide an in-service to all interemployees by 1/16/18. The in-service will include the follow the clinicians will be educated that the duration of services not to be included on the verbal or when and also on the plan of control of the verbal or when and also on the plan of control of the verbal or when and also on the plan of control of the verbal or when and also on the plan of control of the verbal or when and also on the plan of control of the verbal or when and also on the plan of control or with plan of correction. Clinical records that meet 100%	ernal wing: I eeds eder care. I be	02/16/2018
		was reviewed on 12/1/17.			compliance after the 2 month		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 42 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. W	ING		12/04/	2017
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ESTPOINT DRIVE, SUITE 400		
AD ADTIV	/E NITIDOING AND	HEALTHCARE SERVICES INC			IAPOLIS, IN 46256		
ADAPTN	/E NURSING AND	HEALTHCARE SERVICES, INC		INDIAN	IAPOLIS, IN 40250		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The clinical reco	ord included a plan of care			period will be audited quarterly	by by	
	for the certification period of 10/7/17 to				Administrator or designee. Any	/	
		e following orders /			clinical record that does not m		
		c following orders /			100% compliance will be audit		
	information:				weekly until that threshold is m		
	A. Home health aide 2 hours a day, 2 to 3 hours a week, not to exceed 6 hours				The Administrator or designee	will	
					be responsible for monitoring		
					these corrective actions to ens		
		h the certification period to			that this deficiency is corrected	מ	
	1	•			and will not recur.		
		DLs (activities of daily living)			The Administrator/designee wi		
	such as bathing	(bed / tub / shower), hair			provide an in-service to all inte	emai	
	care, dressing, nail care (no clipping), incontinence care, meal prep, light				employees, which refers to Clinical Managers by 1/16/18.		
					The in-service will review		
		ransfers and medication			coordination of care with other		
		ansiers and medication			healthcare providers. Clinical		
	reminders only.				Managers should conduct		
					coordination of care at a minin	num	
	B. The prin	ciple diagnoses were			of once per month to ensure n		
	seguelae of othe	r cerebrovascular (stroke)			duplication of services. Clinica		
	_	diagnoses of end stage renal			Managers will be in-serviced to		
	1	-			contact other providers providi	ng	
	disease, essentia				care to client and document		
	athlersclerotic h	eart disease, hyperlipidemia			services, dates, and times the	y	
	and anemia.				are in the home. The in-service		
					also review with Clinical Mana	gers	
	C The natio	ent's medications included			to follow up and document		
	_				physician appointments to ens	ure	
	1 1	gh cholesterol), metoprolol			possible changes in orders or		
	` `	l pressure), Seroquel			condition of patient are		
	(treatment of sch	nizophrenia, bipolar and			documented and staff in the ho	ome	
	depression), pan	toprazole (treat high levels			is educated.	ш	
	of stomach acid) Isosorbide (treat high blood pressure and chest pain), Carbidopa-Levodopa (treat high blood				The Administrator/designee will ensure orientation of newly hir		
					internal staff, including Clinical		
					Managers, includes: review		
					coordination of care with other		
	pressure), Iron (anemia supplement),				healthcare providers, Clinical		
	Epogen (anemia	treatment during dialysis),			Managers should conduct		
	1 5 (1	<i>3 </i>	1				

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 43 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		12/04/	/2017
			<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			ESTPOINT DRIVE, SUITE 400		
ADAPTIV	E NURSING AND I	HEALTHCARE SERVICES, INC		1	APOLIS, IN 46256		
(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
	Hectorol (high parathyroid treatment during				coordination of care at a minin		
	dialysis), and Venofer (anemia treatment				of once per month to ensure n		
	during dialysis).				duplication of services, Clinica		
	during diaryolo).				Managers are to contact other		
	D. Safety measures included but not				providers providing care to clie and document services, dates		
	1				and times they are in the home		
	limited to respira	atory precautions.			and Clinical Managers are to	-	
					follow up and document physic	cian	
	E. Nutrition	al requirements indicated			appointments to ensure possib		
	the patient was o	on a low nutritional status,			changes in orders or condition	of	
	renal diet, low so	odium, and fluid restrictions.			patient are documented and		
	renar diet, fow sourdin, and fidid restrictions.				external staff, the hourly		
	E Eumotion	al limitations included but			caregivers working in the hom		
					educated. To begin immediate	ely	
	not limited to pa	ralysis.			and be on-going. The Administrator/designee w	:11	
					in-service Clinical Managers o		
	G. Plan of c	eare indicated the patient			ensuring the plan of care is		
	had dialysis 3 tir	nes a week.			supported by the documentation	on in	
					the comprehensive assessme		
	H The patie	ent goals included no falls			Clinical Managers to include,		
	-	ess over the next 60 days.			when applicable, the following		
	and no weight to	ss over the flext oo days.			patient has dialysis access site	e –	
					where is the site, who is		
	_	the same plan of care			responsible to monitor the acc		
	included a 60 da	y summary dated 10/5/17,			site; names of physicians that may give orders; duration of a		
	indicating the pa	tient's dialysis site located			services; fluid restriction amou		
	on the right side	of the chest was intact,			for a 24 hour period; does pati		
	· ·	d "help hands on help",			have paralysis or weakness	- : : •	
		unsteady on his feet which			specific to one side of body; fa	ıll	
					interventions; description of pa	ain;	
		ke him a high fall risk, had a			onset of pain; diet restrictions;		
	fistula that was placed in the right arm and				weight loss interventions and	_	
	had a vascular appointment in November,				name of other agencies provid	ling	
	continued to hav	e dialysis three times a			health care services including	ما م ما	
	week on Tuesda	y, Thursday, and Saturday,			when services are being provi	uea.	
	<u> </u>	ued to prepare the patient's			To be done by 1/16/18. The Administrator/designee w	ill	
	or spease contin	aca to propure the putients	l		The Auministrator/designee w	111	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 44 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
			B. WI	NG		12/04/2017	
			┶	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ESTPOINT DRIVE, SUITE 400		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC			APOLIS, IN 46256		
(X4) ID	SUMMARY	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 APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	medication, bene	efited from medication			ensure orientation of newly him	ed	
	reminders, conti	nued to live with ex spouse			Clinical Managers includes:		
	(patient #11) wh	o was also a patient of the			ensuring the plan of care is supported by the documentation	on in	
	agency, had a fa	mily member that checked			the comprehensive assessmen		
		ten, no willing caregivers.			Clinical Managers to include,		
	on the patient of	ten, no wining ouregivers.			when applicable, the following:	: if	
	J D	f the community and in a second			patient has dialysis access site		
		of the comprehensive nursing			where is the site, who is		
		d 10/5/17, indicated the			responsible to monitor the acc	ess	
	patient was on a	renal diet with 1000			site; names of physicians that		
	milliliters fluid r	restriction under the feeding			may give orders; duration of ai		
	tube section. Ne	eurological assessment			services; fluid restriction amou for a 24 hour period; does pati-		
	indicated the pat	ient was alert to person,			have paralysis or weakness	CIII	
	_	unequal hand grasps, left			specific to one side of body; fa	II	
	*	normal cardiovascular			interventions; description of pa		
					onset of pain; diet restrictions;		
		nad a blood pressure of			weight loss interventions and		
		skeletal assessment			name of other agencies provid	ing	
	_	tient had limited range of			health care services including	ما ما	
	motion, ambulat	ion with a cane, had some			when services are being provided to be services are being provided to be when the services are services.	iea.	
	tremors, shortne	ss of breath with exertion,			on-going.		
	smokers, PICC 1	ine to the right chest for			5.1 g5.1.g.		
	dialysis, intact a	nd last changed on 10/3/17					
	1 -	alysis and location in the					
	comments section						
	documentation to	o elaborate the findings.					
		of the fall risk assessment					
	dated 10/5/17, ir	ndicated the patient had					
	visual impairme	nt, pain affecting level of					
	function, impair	ed functional mobility, scored					
	_	hich a score of 4 or more					
		at risk for falling.					
	was considered (at 115k 101 laining.					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 45 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
			B. WING		12/04/2017	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
ΔΠΔΡΤΙ\	/F NURSING AND	HEALTHCARE SERVICES, INC		VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256		
	1	<u> </u>	<u> </u>	T		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	-	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	L. Revi	ew of the nutritional risk				
	assessment date	d 10/5/17, indicated the				
	patient scored a 30, in which a score 30 to					
	55 points was considered a medium					
	nutritional risk v	with recommendations to				
	provide education	on, appropriate dietary				
	instructions, cor	nsult with dieticians as				
	needed, consult	with physician and discuss				
	need for dietary	supplements and to				
	continue to mon	itoring and provided				
	instructions as in	ndicated. The comment				
	section indicated	d the patient was not to have				
	potassium, green	n vegetables, a renal diet				
	with 1000 millil	iter fluid restriction. The				
	form also indica	ted the meals were not only				
	prepared by the	spouse and the home health				
		ceived prepared and				
	delivered meals	from a community service.				
	_	cy document titled "Nursing				
		te" dated 9/1/17, indicated				
	_	an appointment with a				
		17. The clinical record				
		ced documentation of				
		th the surgeon's office in				
	_	w up / possible change in				
	•	t condition and failed to				
		ices being provided by the				
	shared agency a	long with dates and times.				
		cy document titled "Nursing				
	Supervisory No	te" dated 9/25/17, indicated				

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 46 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/04/2017	
ADAPTIV	ROVIDER OR SUPPLIER 'E NURSING AND I	HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256	
(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
	Practitioner for "	n appointment with a Nurse [physician name" and the			
	patient was recei	ving services from another ncy.			
		cy document titled "Nursing e" dated 10/5/17, indicated			
	on 11/7/17, dialy	vascular lab appointment rsis on Tuesday, Thursday,			
	-	d was receiving services me health agency.			
	Care Coordination 11/2/17, indicate have another age help care for the activities of daily	by document titled "Patient on" dated 10/5/17 and d the patient continued to ency come into the home to patient's instrumental valuing and that the agency eservices being provided by			
	Adaptive.	31			
	the comprehensi include the perso the patient's dialy	failed to be supported by we assessment, failed to on / facility responsible for ysis access, failed to			
	observe, physicia management of t dialysis, failed to	the dialysis accesses to an responsible for the he patient's hypertension / b include the names of			
	from, failed to in	rders may be accepted clude a duration of services y the home health aide,			

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 47 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
			B. WI	NG		12/04/	/2017
e o e				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER			9840 W	ESTPOINT DRIVE, SUITE 400		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC	_	INDIAN	APOLIS, IN 46256		
(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 APPROPRIA [*] DEFICIENCY)	ΓE	COMPLETION
TAG		Also answer of Control		TAG	BEIGHALI		DATE
		the amount of fluids					
		hour period, failed to					
		y if the patient had paralysis					
		kness, and failed to include					
	interventions for	the prevention of falls and					
	weight loss as w	rell as diet restrictions. The					
	plan of care also	failed to include the name					
	of the shared age	ency, the services being					
	provided and wh	nen those services would be					
	provided.						
	•						
	2 The clinical r	record of patient #11, SOC					
		riewed on 12/1/17. The					
	•						
		ncluded a plan of care for the					
	1	dod of 11/10/17 to 1/8/18,					
	with the following	ng orders / information:					
	A. Home he	ealth aide 2 hours a day, 2					
	to 3 times a weel	k, not to exceed 6 hours					
	per week through	hout the certification period,					
	^ -	ADLs (activities of daily					
		athing (bed / tub / shower),					
		ng, nail care (no clipping),					
		re, meal prep, light					
		ransfers and medication					
	reminders only.						
	R The prin	ciple diagnoses were					
	_	•					
		ive pulmonary disease					
		condary diagnoses of type					
		arthritis, hypertension and					
	hyperlipidemia.						

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 48 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	00	COMPL	ETED
			B. WIN	NG		12/04/	2017
NAME OF B	DROWINED OR CUINDLIED		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER				ESTPOINT DRIVE, SUITE 400		
ADAPTIV	E NURSING AND I	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	Birtolikery		DATE
	C The mad	ication section indicated the					
		ng Gabapentin 600 mg					
	_	for diabetic neuropathy -					
	· ·	ing pain in patient					
		e times a day, Metformin					
	· · · · · · · · · · · · · · · · · · ·	abetes) Tradjenta (treatment					
	`	droxyzine as needed					
		xiety/sleep), Cymbalta					
	`	epression), Seroquel					
	`	epression), Metoprolol					
	`	gh blood pressure),					
	`	atment for high blood					
		m (treatment for stomach					
	l *	treatment for COPD), Qvar					
		OPD), Xalatan (treatment					
	`	lphagan (treatment for					
		o (treatment for corneal					
		yl (treatment for eye redness					
		on), Zofran (treatment for					
	1	oplement, and low dose					
		medication(s) were					
	identified.						
	D. Function	al limitations indicated					
		mbulation, and goal that the					
		ot experience any falls over					
	the next 60 days.	•					
	Lie lielle oo days.	•					
	E. Page 3 of	f the same plan of care					
	_	60 day summary dated					
		ng the patient would tried to					
	1	C - F	1				

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 49 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC		9840 W	DDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(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)	ΓE	(X5) COMPLETION DATE
TAG	be independent a continued to set medications but medication remit to demonstrate of sugar, lived with patient of the agunable to care for assessment dated patient was context / mouth / head, reardiovascular, it the patient had sexertion, clear be cough, full range weakness and we with a current reassessment indicate of the sexes of the context of the patient had sexes and we with a current reassessment indicate of the context of the con	as much as he / she can, up his / her own would benefit from nders. The patient was able obtaining his / her own blood a ex spouse who was also a ency (patient #9) and was		TAU			DATE
	"gabapentin / prinarrative indicate chronic pain ran scale of 1 - 10 w pain). The pain a description of (stabbing, throble documentation to the prinarrative indicate in the prinarrative indicate in the prinarrative indicate in the prinarrative indicate in the prinarrative indicate	n (as needed) pain, and the ed the patient complained of ging from a 6 to a 10 (on a with 10 being the worst assessment failed to include pain the patient was having bing, sharp). No further o elaborate the findings.					
	dated 11/7/17, in	ndicated the patient had					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 50 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPL	ETED
			B. WIN	G		12/04/	2017
			'	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ESTPOINT DRIVE, SUITE 400		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC		INDIANA	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	nt and pain affecting level of					
	· ·	a total of 4, in which a					
	score of 4 or mo	re was considered at risk					
	for falling.						
	The plan of care	failed to be supported by					
	the comprehensi	ve assessment, failed to					
		on of services to be provided					
		lth aide, and failed to					
	l -	tions for the prevention of					
	falls.	tions for the prevention of					
	laiis.						
	2 The aliminal m	and of notions #12 COC					
		record of patient #12, SOC					
		riewed on 11/30/17. The					
		ncluded a plan of care for the					
	certification peri	od of 9/28/17 to 11/26/17,					
	with the following	ng orders / information:					
	A. Home he	ealth aide 2 hours a day, 2					
		k, not to exceed 6 hours					
		hout the certification period,					
		ADLs (activities of daily					
		`					
	1	athing (bed / tub / shower),					
		ng, nail care (no clipping),					
		re, meal prep, light					
	1	ansfers and medication					
	reminders only.						
	B. The prin	ciple diagnoses were age					
	1	debility with secondary					
		specified dementia without					
	-						
	penaviors, enron	ic obstructive pulmonary					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 51 of 77

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC		9840 W	ADDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(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 APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	disease, unspecinheart, essential havith perforation and mixed incomincluded Calcium Synthroid (for Torriver), A hypertension), Haypertension), Torriver and Ensure Supplements). C. Page 2 or indicated the patronic patient had good looked to the far questions, used a balance was unsmonth ago without petting dressed a getting dressed a great patient had good looked to the far questions, used a balance was unsmonth ago without petting dressed a getting dressed a great patient had good looked to the far questions, used a balance was unsmonth ago without petting dressed a great patient had good looked to the far questions, used a balance was unsmonth ago without petting dressed a great patient had good looked to the far questions, used a balance was unsmonth ago without petting dressed a great petting dressed a great patient had good looked to the far questions, used a balance was unsmonth ago without petting dressed a great petting	cy MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION fied systolic congestive hypertension, diverticulitis , anemia, hypothyroidism, htinence. Medications m, Ferrous Sulfate, Crazodone (for sleep and / mlodipine (for			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
	on a scale of 1 - needed. The day patient's medicar would benefit from The family memore needed assistance	t does not get greater than 6 10 and took Tylenol as aghter would set up the tion box and the patient com medication reminders. The inher reported the patient are 3 days a week with a direct assistance with transfer					
		ower, direct assistance with nee with a "sink bath" when					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 52 of 77

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED	
			B. WIN			12/04/	2017
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
ADAPTIV	E NURSING AND	HEALTHCARE SERVICES, INC			ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	•		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	i E	DATE
	the patient declin	nes a shower, assistance					
	with incontinent	/ peri care, wears depends					
	and needs help v	with clean up, needs stand					
	by assistance wi	th walking due to frequent					
	falls, need assist	ance with light housekeeping					
	and meal prep.	The plan of care continued					
	to say the patien	t lived with family members,					
	one works while	the other was disabled and					
	therefore, the pa	tient did not have willing or					
	able caregivers i	n the home.					
	D. Review	of the comprehensive					
	nursing initial ar	nd admitting assessment					
	dated 9/28/17, ir	ndicated the patient had					
	right hip pain, in	ntensity 4 - 10, duration was					
	chronic, onset w	as blank, relief measures					
	was prn (as need	led) tylenol, regular diet,					
	feeds self, incon	tinent and diaper was					
	checked, patient	was alert to self, had					
	dementia, cardio	ovascular assessment within					
	normal limits, m	usculoskeletal assessment					
	indicated the pat	tient had limited range of					
	_	ght shoulder, assist with a					
	cane, shortness of	of breath with exertion, fair					
	integumentary st	tatus (skin), and the nursing					
	narrative indicat	ed the patient a diagnoses of					
	dementia, COPE), debility, incontinence,					
	HTN, diverticuli	itis, CHF, "has balance					
	· ·	August", hard time upon					
		inusual findings. No further					
		o elaborate the findings.					
		Č					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 53 of 77

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLI A. BUILDINC B. WING	E CONSTRUCTION G 00	(X3) DATE SU COMPLET 12/04/20	TED
	PROVIDER OR SUPPLIER E NURSING AND I	HEALTHCARE SERVICES, INC	9840	EET ADDRESS, CITY, STATE, ZIP CO O WESTPOINT DRIVE, SUI IANAPOLIS, IN 46256		
(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 A	IOULD BE	(X5) COMPLETION DATE
	the comprehensi	failed to be supported by ve assessment and failed to n of services to be provided lth aide.				
	with the Director and Alternate Ac 3:45 PM, and all acknowledged ar comprehensive at the plan of care. and #11 was reviadministrative st all acknowledged	The findings of patient #9 iewed with the same aff on 12/1/17 at 4:30 PM,				
	Client Assessme indicated " Pu about the client's functional and ps as appropriate to make care, treatr based on informations.	olicy titled "Comprehensive nt" revised on 5/1/15, rpose To collect data health history, (physical, sychological) and their needs the home care setting. To ment or service decisions ation developed about each d the individual's response				
	Treatment" revis	olicy titled "Plan of ed on 3/21/12, indicated " an of care shall included				

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 54 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
			B. WI			12/04	/201/
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC		9840 W	ADDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(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
	the following visits, nutritiona	frequency and duration of I requirements any safety sect against injury any					
N 0543 Bldg. 00	services are limite purposes of practi setting, the registe following:	(1)(D) Except where ed to therapy only, for ice in the home health ered nurse shall do the priate preventive and	N 0:	543	N543 The Administrator/designee v		02/16/2018
	Registered Nurs appropriate prev were put into pla a fall and nutrition records reviewed. Findings include 1. The clinical records of 4/10/17, The clinical records rectificat.	review and interview, the e failed to ensure that entative nursing measures are with patient identified as onal risk in 3 out of 3 d. (#9, 11 and 12) e: record of #9, SOC (start of was reviewed on 12/1/17. ord included a plan of care ion period of 10/7/17 to be following orders /			provide an in-service to all interemployees, including Clinical Managers by 1/16/18. The in-service will review intervent for fall and nutritional risk assessments. The in-service winstruct Clinical Managers that there clearly needs to be documented education taking place between the Clinical Managers and the Home Heal Aides working in the home and client in regards to implementithis information in to the care the patient, as well as care coordination with other provide and family to support nutrition intervention. Administrator/designee will en	ions will t Ith d ing for ers risk	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 55 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
			B. WI	NG		12/04/	2017
		L		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	t .		9840 W	ESTPOINT DRIVE, SUITE 400		
ADAPTIV	'E NURSING AND	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG		in al	DATE
					orientation of newly hired Clini Managers includes: having	icai	
	A. Home health aide 2 hours a day, 2				interventions for fall and nutriti	onal	
	to 3 hours a wee	k, not to exceed 6 hours			risk assessments that indicate		
	per week through	h the certification period to			issues in those areas; that the	re	
	assist with all Al	DLs (activities of daily living)			clearly needs to be documente	ed	
		(bed / tub / shower), hair			education taking place betwee		
		ail care (no clipping),			the Clinical Managers and the		
	_	e, meal prep, light			Home Health Aide and client i	n	
					regards to implementing this information in to the care for the	20	
		ansfers and medication			patient, as well as care	ie	
	reminders only.				coordination with other provide	ers	
					and family to support nutrition		
	B. The prin	ciple diagnoses were			intervention. To begin immedia	ately	
	sequelae of other	r cerebrovascular (stroke)			and be on-going.		
	with secondary of	diagnoses of end stage renal					
	disease, essentia	l hypertension,			100% of all clinical records wil	l be	
		eart disease, hyperlipidemia			audited weekly for the next 2 months by the Homecare		
	and anemia.	out alboure, ily pering rue illu			Consultant to ensure compliar	nce	
	and anomia.				with plan of correction. Clinica		
	G G G				records that meet 100%		
	_	leasures included but not			compliance after the 2 month		
	limited to respira	atory precautions.			period will be audited quarterly	-	
					Administrator or designee. An clinical record that does not m	-	
	D. Nutrition	nal requirements indicated			100% compliance will be audit		
	the patient was o	on a low nutritional status,			weekly until that threshold is n		
	renal diet, low so	odium, and fluid restrictions.			The Administrator or designee		
					be responsible for monitoring		
	E. Function	al limitations included but			these corrective actions to ens	sure	
	not limited to pa				that this deficiency is corrected	d	
	not minica to pa	141,515.			and will not recur.		
	•	ent goals included no falls					
	and no weight lo	oss over the next 60 days.					
	G. Page 2 o	f the same plan of care					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 56 of 77

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

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC		9840 W	DDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC 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	regulatory of included a 60 data indicating the part on the right side continued to need continued to material fistula that was proceed to the continued to have week on Tuesda. H. Review nursing assessment the patient was of milliliters fluid in tube section. Not indicated the part place and time, it is sided weakness, assessment but he sided weakness, as a sided we	ex usummary dated 10/5/17, attent's dialysis site located of the chest was intact, and "help hands on help", unsteady on his feet which ke him a high fall risk, had a placed in the right arm, we dialysis three times a y, Thursday, and Saturday. Of the comprehensive ent dated 10/5/17, indicated on a renal diet with 1000 restriction under the feeding eurological assessment tient was alert to person, unequal hand grasps, left normal cardiovascular had a blood pressure of oskeletal assessment tient had limited range of cion with a cane, had some ss of breath with exertion, of the fall risk assessment had not, pain affecting level of ed functional mobility, scored which a score of 4 or more at risk for falling.		TAG			DATE
	I		1				

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 57 of 77

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
(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)	ΓE	(X5) COMPLETION DATE	
TAG	J. Review of assessment dated patient scored a 55 points was consult instructions, conneeded, consult need for dietary continue to mon instructions as in section indicated. The plan of care interventions for weight loss. 2. The clinical result of the section indicated in the certification per with the following the section indicated as times a weeper week throught to assist with all living) such as better the section in t	of the nutritional risk d 10/5/17, indicated the 30, in which a score 30 to onsidered a medium with recommendations to on, appropriate dietary asult with dieticians as with physician and discuss supplements and to itoring and provided indicated. The comment		TAG			DATE	
	incontinence car	re, meal prep, light ransfers and medication						

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 58 of 77

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

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256	
(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
	chronic obstructi (COPD) with sec	ciple diagnoses were we pulmonary disease condary diagnoses of type arthritis, hypertension and			
	endurance and a	al limitations indicated mbulation, and goal that the t experience any falls over			
	indicated in the 6	f the same plan of care 60 day summary dated ng the patient would tried to as much as he / she can.			
	assessment dated patient had short exertion, clear be cough, full range weakness and wa	of the comprehensive nursing I 11/7/17, indicated the ness of breath during reath sounds but productive of motion but had some alks with a cane, pain ated the patient had lower as chronic.			
	dated 11/7/17, in visual impairment function, scored	of a fall risk assessment dicated the patient had not and pain affecting level of a total of 4, in which a re was considered at risk			

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 59 of 77

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
			B. WING		12/04/2017	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC		VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256		
(X4) ID	Г	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	The plan of care failed to include interventions for the prevention of falls.					
	2 The clinical s	record of patient #12, SOC				
		viewed on 11/30/17. The				
	·	ncluded a plan of care for the				
		iod of 9/28/17 to 11/26/17,				
	with the followi	ng orders / information:				
	A. Home h	ealth aide 2 hours a day, 2				
	to 3 times a wee	k, not to exceed 6 hours				
	per week throug	hout the certification period,				
		ADLs (activities of daily				
	, o,	oathing (bed / tub / shower),				
	hair care, dressi	ng, nail care (no clipping),				
	incontinence car	re, meal prep, light				
	housekeeping, to	ransfers and medication				
	reminders only.					
	D. The	ain1a diamanana arraya				
	_	ciple diagnoses were age				
	1	debility with secondary				
	_	specified dementia without				
		nic obstructive pulmonary				
	_	fied systolic congestive				
		nypertension, diverticulitis				
		, anemia, hypothyroidism,				
	and mixed incor	ntinence.				
	C. Page 2.c	of the same plan of care				
	_	tient was hard of hearing, the				
	_	d days and bad, the patient				
	Patront mad 5000	and and out, the putient				

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 60 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017		
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	questions, used a balance was uns month ago without breath easily who getting dressed a 40 feet. The pather right hip that on a scale of 1 needed. D. Review nursing initial ardated 9/28/17, in right hip pain, in right hip pain, in	mily member for answers to a cane in the home, gait and teady, high fall risk, fell a but injury, gets short of ile exerting self such as and walking more that 20 to ient had chronic pain in his / t does not get greater than 6 10 and took Tylenol as of the comprehensive and admitting assessment adicated the patient had attensity 4 - 10, duration was					
	chronic, onset was blank, relief measures was prn (as needed) tylenol, incontinent, patient had dementia, musculoskeletal assessment indicated the patient had limited range of motion to the right shoulder, assist with a cane, shortness of breath with exertion, and the nursing narrative indicated the patient a diagnoses of dementia, COPD, debility, incontinence, HTN, diverticulitis, CHF, "has balance endurance fell in August" [SIC] hard time upon assessment. The plan of care failed to include interventions for the prevention of falls.						
	with the Directo	r of Nursing, Administrator,					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 61 of 77

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

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2017				
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
(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)	ILD BE COMPLETION			
	3:45 PM, and all acknowledged are care should have the prevention of patient #9 and # same administra PM, all acknowledged plans of care should interventions for weight loss due to the following the medical plans the following visits, nutritional	dministrator on 11/30/17 at administrative staff administrative staff administrative staff administrative staff administrative staff and agreed that the provided and agreed with the staff on 12/1/17 at 4:30 edged and agreed that the buld have included the prevention of falls and to nutritional risks. Dick titled "Plan of sed on 3/21/12, indicated " an of care shall included frequency and duration of a requirements any safety ect against injury any e items "						
N 0546 Bldg. 00	services are limited purposes of practices setting, the register following: (G) Inform the phappropriate medical	(1)(G) Except where d to therapy only, for ce in the home health ered nurse shall do the ysician and other al personnel of changes in						
	the patient and far	ition and needs, counsel mily in meeting nursing and ticipate in inservice						

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 62 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) I	MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. I	BUILDING <u>00</u>	COMPLETED	
B. V	WING	12/04/2017	
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD	•	
	9840 WESTPOINT DRIVE, SUITE 400		
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC	INDIANAPOLIS, IN 46256		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE PROPERTY)	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION	TAG DEFICIENCY)	DATE	
programs, and supervise and teach other nursing personnel.			
1	0546 <u>N546</u>	02/16/2018	
	The Administrator/designee will	02/10/2010	
Based on record review and interview, the	provide an in-service to all interna	ı	
Registered Nurse failed to evidence that a	staff including Clinical Managers		
patient was educated on a new medication	employees by 1/16/18. The		
order upon a return home from the hospital	in-service will include educating Clinical Managers that		
in 1 out of 1 record reviewed of a patient	whenever they obtain knowledge	of	
resumed after hospitalization in a sample of	a new medication, they will provid		
3. (#9)	education to the patient, documer	ıt	
	this education as well as patient response to education.		
Finding included:	The Administrator /designee will		
i maing included.	ensure orientation of newly		
1. The clinical record of patient #9 was	hired Clinical Managers includes:		
*	whenever they obtain knowledge		
reviewed on 12/1/17. The clinical record	a new medication, they will provid education to the patient, documer		
contained an order dated 11/6/17, which	this education as well as patient		
indicated services to resume on 11/2/17	response to education. To begin		
from a hospitalization and the patient was	immediately and be on-going.		
started on Meclizine 12.5 mg tablets by	100% of all clinical records will be audited weekly for the next 2		
mouth up to 3 x a day as needed for	months by the Homecare		
dizziness. Review of the comprehensive	Consultant to ensure compliance		
nursing assessment dated 11/2/17, the	with plan of correction. Then		
assessment failed to indicate if the patient	quarterly will be audited by		
was educated on the new medication.	Administrator or designee. The Administrator or designee will		
was educated on the new medication.	be responsible for monitoring thes		
2 50 50 2 2 2 2	corrective actions to ensure that		
2. The Director of Clinical Services was	this deficiency is corrected and wil	ı	
interviewed on 12/1/17 at 4:30 PM,	not recur.		
acknowledged the documentation errors and	Update: The agency will ensure the admitting nurse reviews the plan of		
agreed that the patient should have been	care to ensure its accuracy. The		
educated on the new medication, patient	Director of Nursing and		
response to the education, and	Compliance/designee will also		
documentation of the education.	review all plan of care to ensure		
documentation of the education.	accuracy. Once 100% accuracy is achieved Director of Nursing and		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 63 of 77

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

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/04/2017			
	ROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
(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		
				Compliance/designee will audit 25th of plans of care quarterly. The agency will ensure that patien needs will be met by coordinating care with the patients physician an with all other companies providing care to the patient. The Director of Nursing and Compliance/designee will instruct Clinical Managers on how to coordinate care and document in patient's chart. The agency will work to prevent the reoccurrence of missed visits by providing caregivers that are able to meet the clients needs. Director of Nursing and Compliance/designee will monitor missed visits to ensure visits are made up when possible.	ts d		
N 0547 Bldg. 00	services are limite purposes of practic setting, the register following: (H) Accept and can chiropractor, podia	(1)(H) Except where d to therapy only, for ce in the home health ared nurse shall do the arry out physician, atrist, dentist and					
	agency failed to put verbal orders admission assess	review and interview, the ensure the Registered Nurse in writing after an ment in 1 out of 1 record tient admitted to services in	N 0547	N547 The Administrator/designee w provide an in-service to all into employees including Clinical Managers by 1/16/18. The in-service will include education that Clinical Managers will obt a separate written verbal order follows the verbal order that w taken during a phone call with	ernal on ain r that as		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 64 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
			B. WI	NG	G		12/04/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	ROVIDER OR SUPPLIER	R	9840 WESTPOINT DRIVE, SUITE 400					
ADAPTI\	F NURSING AND	HEALTHCARE SERVICES, INC	INDIANAPOLIS, IN 46256					
7 (1) (1)		TIE/RETITIO/RICE GETTVIGEG, IIVG		11077	711 0210, 117 10200			
(X4) ID	SUMMARY	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 APPROPRIAT	ΓE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY		DATE	
	Findings include	2.			physician's office after the			
					comprehensive assessment. T	his		
	1 The clinical r	record of #12_SOC (start of			verbal order will include the			
	1. The clinical record of #12, SOC (start of				findings of the comprehensive			
		as reviewed on 11/30/17.			assessment, and orders for ho			
	Review of the ac	dmitting comprehensive			The written verbal order will be			
	assessment dated	d 9/28/17, indicated that the			separate from the plan of care			
	physician was no	otified and new orders were			will be maintained in the clinica	∄I		
		rt service w/ (with) personal			record.			
		` ' *			The Administrator/designee wi ensure orientation of newly hir			
	care and light housekeeping for the next 60				Clinical Managers includes:	eu		
	days." The clinical record failed to evidence a written verbal order.				Clinical Managers will obtain a			
					separate written verbal order t			
					follows the verbal order that wa			
	2 The Director	of Clinical Services,			taken during a phone call with			
					physician's office after the			
		nd Alternate Administrator			comprehensive assessment. T	his		
	were interviewed	d on 11/30/17 at 3:45 PM.			verbal order will include the			
	The Alternate A	dministrator indicated the			findings of the comprehensive			
	plan of care was	used as physician order.			assessment, and orders for ho			
	F	r y			The written verbal order will be	;		
					separate from the plan of care	and		
					will be maintained in the clinica	al		
					record. To begin immediately a	and		
					be on-going.			
					100% of all clinical records will	be		
					audited weekly for the next 2			
					months by the Homecare			
					Consultant to ensure complian			
					with plan of correction. Clinical			
					records that meet 100%			
					compliance after the 2 month			
					period will be audited quarterly	-		
					Administrator or designee. Any			
					clinical record that does not me			
					100% compliance will be audit			
					weekly until that threshold is m			
					The Administrator or designee	WIII		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 65 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/04/2017			
	ROVIDER OR SUPPLIER E NURSING AND	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
(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 APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
N 0563	410 IAC 17-14-1(c				be responsible for monitoring these corrective actions to ens that this deficiency is corrected and will not recur.		
Bldg. 00	listed in subsectio (2) review the plate severity of the path but at least every Based on record agency failed to comprehensive of accurate, consist amount of information care in 2 out of 2 sample of 3. (#9) Findings included 1. The clinical recare) of 4/10/17, A. Review of nursing assessment the patient was of milliliters fluid retube section. Notindicated the path place and time, up as well as well as the patient was of milliliters fluid retube section. Notindicated the path place and time, up as well as wel	The appropriate therapist n (b) of this rule shall: n of care as often as the ient's condition requires, two (2) months; review and interview, the ensure that the 60 day reassessments were ent and contained adequate mation to support the plan of 2 records reviewed in a 2 and 11)	N 03	563	N 563 The Administrator/designee will provide an in-service to a internal employees including Clinical Managers by 1/16/18 which will include instructing Clinical Managers that the comprehensive assessment must be accurate, consistent and contain adequate information to support the plof care such as, where applicable, information regarding patients functional status to support the need of assistance with activities of daily living and instrumental activities of daily living, accurately identify the patient catheter access site for dialy the person / facility responsi for the management of the patient's dialysis permacatheter site, an assessment of the fistula, consistent assessment of the patient's vision between the	an If siss,	02/16/2018

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 66 of 77

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 12/04/2017				
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
			9840 WESTPOINT DRIVE, SUITE 400				
ADAPIN	E NURSING AND	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	
TAG				TAG	comprehensive assessment	DATE	
		nad a blood pressure of			and the fall risk assessment,		
	•	oskeletal assessment			consistent assessment of the		
	_	tient had limited range of			patient's diet between the pla	an	
	•	ion with a can, had some			of care and the nutritional		
	tremors, shortne	ss of breath with exertion,			assessment, and consistent		
	smokers, PICC line to the right chest for dialysis, intact and last changed on 10/3/17 with name of dialysis and location in the comments section. Skin assessment indicated no skin impairments.				with the comprehensive		
					assessment indicating weakness and limited mobili	tv	
					versus the plan of care	,	
					indicating paralysis, identify		
					the patient's hypertension,		
	Ears/Nose/Throat/Mouth/Head assessment				depression, iron deficiency,		
		impairments. No further			stroke and the medications		
		o elaborate the findings.			used for the treatment of hypertension, depression, ire	on	
		o elaborate the initings.			deficiency, and stroke,		
	D D :	C4 C11 : 1			accurately identify visual		
		of the fall risk assessment			impairment / glaucoma,		
		ndicated the patient had			identification of the patient's		
	_	nt, pain affecting level of			hypertension, COPD,	a i n	
		ed functional mobility scored			depression, description of pa and accurate identification o	l l	
	a 6, in which a s	core of 4 or more was			pain medication(s) used to tr		
	considered at ris	k for falling.			the back pain, neuropathy,		
					adequate diabetic assessme	nt	
	C. Review	of the nutritional risk			that include a diabetic foot		
	assessment dated	d 10/5/17, indicated the			exam and history of blood sugars since last nursing vis	sit	
		30, in which a score 30 to			and report abnormal findings	l l	
	_	onsidered a medium			and the medications used fo	l l	
	_	vith recommendations to			the treatment of hypertensio	n,	
					COPD, depression, neuropat	hy,	
	provide education, appropriate dietary instructions, consult with dieticians as needed, consult with physician and discuss				and diabetes.		
					The Administrator/designed		
					The Administrator/designee will ensure orientation of		
	need for dietary supplements and to				newly hired Clinical Manager	rs	
		itoring and provided			will include instructing Clinic		
	instructions as indicated. The assessment				Managers that the		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 67 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETE			LETED	
			B. WI	NG		12/04	/2017
NAME OF I	PROVIDER OR SUPPLIE	D	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
			9840 WESTPOINT DRIVE, SUITE 400				
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	regulatory or LSC identifying information indicated the patient had a skin impairment.			TAG			DATE
	_	-			comprehensive assessment must be accurate, consister		
	The comment section indicated "no				and contain adequate		
	* •	reen veggies, renal, fluid			information to support the p	olan	
	restriction 1,000) ml [milliliters]."			of care such as, where		
	D. Review of the plan of care for the certification period of 10/7/17 to 12/5/17,				applicable, information		
					regarding patients functions		
					status to support the need of assistance with activities of		
	_	home health aide 2 hours a			daily living and instrumenta		
	day, 2 to 3 hours a week, not to exceed 6 hours per week through the certification period to assist with all ADLs (activities of				activities of daily living,		
					accurately identify the patie	nt's	
					catheter access site for dial	ysis,	
					the person / facility respons	ible	
	"	ch as bathing (bed / tub /			for the management of the		
		re, dressing, nail care (no			patient's dialysis		
	clipping), incon	tinence care, meal prep, light			permacatheter site, an assessment of the fistula,		
	housekeeping, to	ransfers and medication			consistent assessment of the	ne	
	reminders only.	The principle diagnosis was			patient's vision between the	_	
	sequel of other of	cerebrovascular (stroke)			comprehensive assessment		
	_	diagnoses of end stage renal			and the fall risk assessment	-	
	disease, essentia				consistent assessment of the	_	
		eart disease, hyperlipidemia			patient's diet between the p	lan	
		e patient's medications			assessment, and consistent	t	
		•			with the comprehensive	•	
	1	(treat high cholesterol),			assessment indicating		
		at high blood pressure),			weakness and limited mobil	lity	
	. `	nent of schizophrenia,			versus the plan of care		
		ression), pantoprazole (treat			indicating paralysis, identify	/	
	high levels of st	omach acid), Isosorbide			the patient's hypertension, depression, iron deficiency,		
	(treat high blood	d pressure and chest pain),			stroke and the medications	•	
	Carbidopa-Levodopa (treat high blood pressure), Iron (anemia supplement), Epogen (anemia treatment during dialysis),				used for the treatment of		
					hypertension, depression, in	ron	
					deficiency, and stroke, ,		
	Hectorol (high parathyroid treatment during				accurately identify visual		
		,			impairment / glaucoma,		
	dialysis), and Venofer (anemia treatment		1		identification of the patient's	S	İ

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 68 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
			B. WING 12/04/2017				
N. 1	ADOLUBED OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	<u>C</u>	9840 WESTPOINT DRIVE, SUITE 400				
	E NURSING AND I	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION		TAG		DATE	
during dialysis). Safety measures included					hypertension, COPD, depression, description of pa	ain	
		respiratory precautions.			and accurate identification o		
	Nutritional requi	rements indicated the patient			pain medication(s) used to tr		
	was on a low nut	tritional status, renal diet,			the back pain, neuropathy,		
	low sodium, and	fluid restrictions.			adequate diabetic assessme	nt	
	Functional limita	ations included but not limited			that include a diabetic foot		
	to paralysis. Pla	n of care indicated the			exam and history of blood	:4	
		sis 3 times a week. The			sugars since last nursing vis and report abnormal findings		
patient goals included no falls and no weight loss over the next 60 days.					and the medications used fo	•	
					the treatment of hypertension		
	loss over the next of days.				COPD, depression, neuropat	hy,	
					and diabetes.		
	_	f the same plan of care					
	· ·	y summary dated 10/5/17,			Update: The agency will ensure the admitting nurse reviews the plan or		
	which indicated	that the patient's dialysis site			care to ensure its accuracy. The	'	
	located on the rig	ght side of the chest was			Director of nursing and		
	intact, continued	to need "help hands on			Compliance/designee will also		
	help", continued	to be unsteady on his feet			review all plans of care to ensure		
	which continued	to make him a high fall risk,			accuracy. Once 100% accuracy is achieved Director of Nursing and		
	had a fistula that	was placed in the right arm			Compliance/designee will audit 259	%	
		ar appointment in			of plans of care quarterly.		
		inued to have dialysis three			The agency will ensure that wations		
	· ·	Tuesday, Thursday, and			The agency will ensure that patient needs will be met by coordinating	ıs	
					care with the patients physician an	d	
		use (patient #11) continued			with all other companies providing		
		tient's medication,			care to the patient. The Director of		
		nedication reminders,			Nursing and Compliance/designee will instruct Clinical Managers on		
		with ex spouse who was			how to coordinate care and		
	also a patient of	the agency, had a family			document in patient's chart. The		
	member that che	ecked on the patient often,			agency will work to prevent the		
	no willing caregi	ivers.			reoccurrence of missed visits by		
	_				providing caregivers that are able t meet the clients needs. Director of		
	The comprehensive assessment failed to be				Nursing and Compliance/designee		
	_				will monitor missed visits to ensure		
	accurate, consistent and contained adequate				visits are made up when possible.		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 69 of 77

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

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017	
	PROVIDER OR SUPPLIEI	R HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	such as adequate the patients function need of assistant living and instructiving, inaccurate catheter access a facility responsitive patient's dial assessment of the arm, inconsistent vision between the plant assessment and inconsistent assessment, and comprehensive a weakness and limplan of care indicassessment faile hypertension, destroke and the material treatment of hypertension, destroke and the material treatment of hypertension, and the material treatment of hypertension and treatment of hypertension and the material trea	o support the plan of care en information in regards to extional status to support the ce with activities of daily imental activities of daily ely identified the patient's site for dialysis, the person / ble for the management of ysis permacatheter site, an ite fistula in the patient's right assessment of the patient's either comprehensive the fall risk assessment, essment of the patient's diet in of care and the nutritional inconsistent with the assessment indicating mitted mobility versus the cating paralysis. The diet to identify the patient expression, iron deficiency, nedications used for the pertension, depression, iron stroke. The comprehensive ent dated 11/7/17, indicated continent, no ears / nose / thead, neurological,			To begin immediately and be on-going. 100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultant to ensure compliance with plan of correction. Then quarterly will be audited by Administrator or designee. The Administrator or designee will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.			

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 70 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2017				
		ROVIDER OR SUPPLIER E NURSING AND I	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
	(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)	ΓE	(X5) COMPLETION DATE	
		impairments, the breath during ext but productive co but had some we cane, a diabetic versus 214, pain assess had lower back programmerative indicate chronic pain rang scale of 1 - 10 we pain). The pain	ertion, clear breath sounds ough, full range of motion eakness and walks with a with a current reading of ment indicated the patient pain that was chronic - took in (as needed) pain", and the ed the patient complained of ging from a 6 to a 10 (on a ith 10 being the worst assessment failed to include pain the patient was having						
		(stabbing, throbbing, sharp). No further documentation to elaborate the findings. B. Review of a fall risk assessment dated 11/7/17, indicated the patient had visual impairment and pain affecting level of function, scored a total of 4, in which a score of 4 or more was considered at risk							
		C. The clinical record included a plan of care for the certification period of 11/10/17 to 1/8/18, with orders for home health aide 2 hours a day, 2 to 3 times a week, not to exceed 6 hours per week throughout the certification period, to assist with all ADLs (activities of daily living) such as bathing (bed / tub / shower), hair care, dressing, nail							

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 71 of 77

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

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/04/2017	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP COD	
ADAPTIV	/E NURSING AND	HEALTHCARE SERVICES, INC		VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		g), incontinence care, meal	TAG		DATE
	prep, light housekeeping, transfers and				
		nders only. The principle			
		hronic obstructive			
	pulmonary disea	se (COPD) with secondary			
	diagnoses of typ	e 2 diabetes, polyarthritis,			
	hypertension and	d hyperlipidemia. The			
	medication section	on indicated the patient was			
taking Gabapentin 600 mg (medication used					
	for diabetic neuropathy - numbness / tingling				
	pain in patient extremities) three times a day,				
	Metformin (treatment for diabetes)				
	Tradjenta (treatn	nent for diabetes),			
	Hydroxyzine as	needed (treatment for			
		Cymbalta (treatment for			
		oquel (treatment for			
		toprolol (treatment for high			
		Amlodipine (treatment for			
		sure), Nexium (treatment for			
	J /	, Proair (treatment for			
	/	reatment for COPD),			
	`	ent of glaucoma), Alphagan			
		aucoma), Muro (treatment			
		na), Polyvinyl (treatment for			
		eye lubrication), Zofran			
	*	nusea), iron supplement, and			
	•	. No pain medications were ional limitations indicated			
		mbulation, and goal that the			
		ot experience any falls over			
	the next 60 days	•			
	the heat ou days	•			

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 72 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/04/2017		
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC				ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(X4) ID		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	
		f the same plan of care				
		60 day summary dated				
	11/7/17, indication	ng the patient would tried to				
	be independent a	as much as he / she can,				
	continued to set	up his / her own				
	medications but	would benefit from				
	medication remin	nders. The patient was able				
	to demonstrate o	btaining his / her own blood				
	sugar, lived with	ex spouse who was also a				
	patient of the age	ency (patient #9) and was				
	unable to care for the patient.					
	•	ive assessment failed to				
	•	amount of information to				
		of care, such as adequate				
		egards to the patients				
		to support the need of				
		ctivities of daily living and				
		vities of daily living,				
		fying visual impairment /				
	_	fication of the patient's				
		OPD, depression,				
	description of pa					
		pain medication(s) used to				
	-	in, neuropathy, adequate				
		ent that included a diabetic				
		story of blood sugars since				
	last nursing visit and report abnormal					
	_	medications used for the				
		ertension, COPD,				
	depression, neur	opathy, and diabetes.				

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 73 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/04/2017				
	PROVIDER OR SUPPLIER	HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
(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)	ſE	(X5) COMPLETION DATE	
N 0606 Bldg. 00	therapist in therap the initial visit to the make a supervisor (30) days, either weights is present or abse assess relationship whether goals are Based on record agency failed to conducted a super observance of car relationship between the between the composition of the contained a plan period of 10/7/12 for the Registere supervisory visit	A registered nurse, or y only cases, shall make the patient's residence and y visit at least every thirty when the home health aide not, to observe the care, to pos, and to determine the being met. The review and interview, the the ensure the Registered Nurse the envisory visit that included are and assessing the the patient and the term in 2 out of 3 records at 11) and failed to conduct that every 30 days in 1 out of the ed. (#11)	N 00	606	N606 The agency's supervisory note will be updated as of 1/2/18 to include observation of Home Health Aide providing direct care to the patient at a minimum of every 60 days. We do have a sup not dated 10/5/17 which we will upload as a supporting document for patient #11. The agency's supervisory note will be updated as of 1/2/18 to include observation of Home Health Aide providing direct care to the patient at a minimum of at least every 30 days. 100% of all clinical records will be audited weekly for the next 2 months by the Homecare Consultan to ensure compliance with plan of correction. Clinical records that meet 100% compliance after the 2 month period will be audited quarterly by Administrator or designee. Any clinical record that does not meet 100% compliance will be audited weekly until that threshold is met. The Administrator or designee will	t	02/16/2018	

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 74 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2017		
	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
OVIDER OR SUPPLIER E NURSING AND HEALTHCARE SERVICES, INC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION A. Review of an agency form titled "Nursing Supervisory Note" dated 11/2/17, included care coordination (such as level of services, advance directives, plan of care reviewed and appropriate, changes to the treatment, other agencies in the home), chart (current plan of care in the chart and reviewed, home chart reviewed, emergency plan reviewed, grievance and branch numbers available, current medication profile in chart and updated, medication reconciliation complete, and goals reviewed), Patient / caregiver (verbalizing satisfaction with services, involved and agreed with plan of care, any changes in caregiver involvement, patient / caregiver education provided if necessary), environment (patient area / room clean and organized, DME and supplies match plan of care, oxygen safety observed, medications stored appropriately), assessment (vital signs obtained including oxygen saturations), and pain assessments. The form was signed by the home health aide. The supervisory visit			(X5) COMPLETION DATE		
n aide. The supervisory visit e observance of care and the he relationship between the home health aide. record for patient #11 was /1/17. The clinical record					
Case Version Grant Contract Co	HEALTHCARE SERVICES, INC Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION Y of an agency form titled rvisory Note" dated 11/2/17, coordination (such as level of the directives, plan of care appropriate, changes to the r agencies in the home), chart if care in the chart and the chart reviewed, emergency grievance and branch able, current medication profile dated, medication complete, and goals tent / caregiver (verbalizing the services, involved and an of care, any changes in vement, patient / caregiver ided if necessary), patient area / room clean and the and supplies match plan of affety observed, medications fately), assessment (vital signs ding oxygen saturations), and	D HEALTHCARE SERVICES, INC Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION To fan agency form titled rvisory Note" dated 11/2/17, coordination (such as level of ace directives, plan of care appropriate, changes to the r agencies in the home), chart of care in the chart and e chart reviewed, emergency grievance and branch able, current medication profile dated, medication complete, and goals and of care, any changes in vement, patient / caregiver ided if necessary), coatient area / room clean and ate and supplies match plan of aftety observed, medications atacly), assessment (vital signs aling oxygen saturations), and atts. The form was signed by the aide. The supervisory visit the observance of care and the atther relationship between the thome health aide. Tecord for patient #11 was 20/1/17. The clinical record on of care for the certification	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256 Y STATEMENT OF DEFICIENCIE PINCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION OF an agency form titled rvisory Note" dated 11/2/17, coordination (such as level of the directives, plan of care propropriate, changes to the r agencies in the home), chart of care in the chart and e chart reviewed, emergency grievance and branch tible, current medication profile dated, medication complete, and goals ent / caregiver (verbalizing the services, involved and am of care, any changes in vement, patient / caregiver ided if necessary), watient area / room clean and E and supplies match plan of aftety observed, medications intelly), assessment (vital signs ding oxygen saturations), and tas. The form was signed by the aide. The supervisory visit the observance of care and the the relationship between the thome health aide. PREFIX TAG PROVIDENT ALANGE CORRECTION INDIANAPOLIS, IN 46256 ID PROVIDENT ALANGE CORRECTION SIDELLY CRUSCAMEPERENCED TO THE APPROPRIATE TAG De responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Administrator/designee will in-service all agency by 1/16/18 on the requirement for Clinical Managers to make an aide supervisory visit at least every 30 days, whether aide is present or no to observe the care aide is providing, to assess relationship between aide and patient and to determine if goals are being met.		

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 75 of 77

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		B. WIN	1G		12/04/	2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					ESTPOINT DRIVE, SUITE 400		
ADAPTI\	/E NURSING AND	HEALTHCARE SERVICES, INC		INDIAN	APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG.			(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	F				
TAG		R LSC IDENTIFYING INFORMATION ed Nurse "to perform		TAG	DEFICIENCE		DATE
		ts per state regulations RN					
	1 2						
		signs and pulse oximetry at					
	this time."						
	A 771 11	1					
		ical record failed to evidence					
		visory visit note between					
	9/7/17 to 11/2/1′	<i>1</i> .					
	D. D	6 (41.1					
		of an agency form titled					
		visory Note" dated 11/2/17					
	•	luded care coordination					
	`	Services, advance					
	directives, plan of care reviewed and						
		appropriate, changes to the treatment, other					
		nome), chart (current plan of					
		and reviewed, home chart					
	_	gency plan reviewed,					
	_	ranch numbers available,					
		on profile in chart and					
	•	tion reconciliation complete,					
		ved), Patient / caregiver					
		sfaction with services,					
	_	involved and agreed with plan of care, any					
	changes in caregiver involvement, patient /						
	caregiver education provided if necessary),						
	environment (patient area / room clean and						
	organized, DME and supplies match plan of						
	care, oxygen safety observed, medications stored appropriately), assessment (vital signs obtained including oxygen saturations), and						
	pain assessments	s. The form was signed by					

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 76 of 77

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

PRINTED: 02/12/2018 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/04/2017		
NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
(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 CROSS-REFERENCED TO THE APPROFILE OF THE PROPERTY OF T		ATE	(X5) COMPLETION DATE
	the home health aide. The supervisory visit failed to include observance of care and the assessment of the relationship between the patient and the home health aide. 3. The findings were reviewed with the Director of Clinical Services, Administrator, and Alternate Administrator on 12/1/17 at 4:30 PM, and indicated the case manager / registered nurse should have been observing care provided by the home health aide during joint visits.						

State Form Event ID: 11IK12 Facility ID: 014118 If continuation sheet Page 77 of 77