STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		157090	B. WI	NG		11/18/2020	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			VERMONT ST, SUITE 110		
HERITAG	SE HOME HEALTH	I SERVICES LLC			IAPOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0000							
Bldg. 00	conducted of this M health agency, by the Health, in accordan	paredness Survey was Medicare and Medicaid home he Indiana State Department of nce with 42 CFR 484.102.  9, 11-10, 11-12, 11-13, 11-16, 020	E 00	000	N 518 Patient Rights #1 Agency has now added the State Dept of Health Advance Directives 11/1/2018 to the SC packets effective 11/20/2020. #2 Agency will follow up in the QAPI meetings every quarter ensure this deficiency does no	DC to	
	Facility #: 005294				occur in the future. #3 Clinical Director and Administrator will directly mon		
	CCN #: 157090			and be responsible for #1 and #4 Deficiency has already bee	#2.		
	Total Active Censu	S:			corrected by 11/20/2020.		
	Unduplicated Skille months: 426	ed patients admitted prior 12					
	Skilled patients Home Health	Aide only: 107 0					
	Total Patient Clinic	al Records Reviewed:					
	4	ds with Home Visit:  Records without Home Visit:  stient Records:					
	Home Health Servi have been in compl Preparedness Requ	Preparedness survey, Heritage ces, LLC, was found not to liance with the Emergency irements for Medicare ders and Suppliers, 42 CFR					

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

TITLE

(X6) DATE

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157090	B. WI	NG		11/18/	2020
	ROVIDER OR SUPPLIER			429 E. \	ADDRESS, CITY, STATE, ZIP COD /ERMONT ST, SUITE 110 APOLIS, IN 46202	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	484.102, for home h	nealth agencies.					
E 0013	Quality Review Con 3 403.748(b), 416.5	mpleted on 12/03/2020 by Area 4(b) 418 113(b)					
_ 00.0	, ,	5(b), 483.475(b), 483.73(b),					
Bldg. 00	484.102(b), 485.6 485.727(b), 485.9 491.12(b), 494.62 Development of E (b) Policies and pr develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) of communication pla section. The polici	25(b), 485.68(b), 20(b), 486.360(b), (b) P Policies and Procedures ocedures. [Facilities] must					
	and procedures. To develop and imple preparedness policion the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policibe reviewed and until the procedures. The policibe reviewed and until the procedures of the preparedness policiber of the preparedness policiber of the preparedness policiber of the preparedness policiber on the preparedness policiber of the prep	cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least annually.  ties at §494.62(b):] Policies The dialysis facility must ement emergency cies and procedures, based					
	on the emergency (a) of this section,	plan set forth in paragraph risk assessment at of this section, and the					

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AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157090	(X2) MULTIPLE A. BUILDING B. WING	e construction 6 <u>00</u>	(X3) DATE SURVEY COMPLETED 11/18/2020
	PROVIDER OR SUPPLIER		STRE 429 INDI		
(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 APPRODEFICIENCY)	BE COMPLETION
	section. The police be reviewed and users These emered not limited to, fire, failures, care-relate supply interruption	an at paragraph (c) of this sies and procedures must updated at least every 2 regencies include, but are equipment or power sed emergencies, water and natural disasters he facility's geographic			
	failed to develop a part staffing to meet the needed during an erroutbreak.  The Finding include Review of the record the agency's emerge to evidence staffing 19 emergency.  During an interview p.m., the Director of in their policy and part staffing 19 emergency.	ency preparedness plan failed strategies during an COVID- on 11/16/2020 2:15 p.m.,at f Nursing was unable evidence procedure where the agency trategies in the event of an gency's emergency	E 0013	E 0013 Development of EF Policies and Procedures Updated policy and proced POC has now been update last update as of 2018. Approach our local staffing agencies to fulfill agency st needs. If they are not able we will partner agency will patients to local HH agenci SNFs. Administrator will be responder #1 and #2. New policy is already in plate of 12/1/2020. Completion of 12/1/2020.	ure ad from  affing to fulfill transfer es and nsible
E 0021 Bldg. 00	[(b) Policies and p develop and imple preparedness poli on the emergency (a) of this section, paragraph (a)(1) of communication pla	for Follow up Staff/Pts. rocedures. The HHA must ement emergency cies and procedures, based r plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this cies and procedures must			

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AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157090	(X2) MUI A. BUII B. WIN	DING	nstruction <u>00</u>	(X3) DATE COMPI 11/18	LETED
	PROVIDER OR SUPPLIER			429 E. \	DDRESS, CITY, STATE, ZIP COD /ERMONT ST, SUITE 110 APOLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
G 0000	years.] At a minim procedures must a (3) The procedure staff and patients are needed, in the interruption in serve emergency. The local officials of ar that they are unable Based on record reversailed to develop an ensuring staffing to when needed during COVID-19 Outbread The Finding included Review of the record the agency's emergency.  During an interview p.m., the Director of in their policy and procedures are must as a minimum to the policy and procedures of the procedure of the procedure of the policy and procedures must a minimum to the procedure of the p	view and interview, the agency distribution in the needs of the patients of an emergency, such as a sk.  ed:  ed on 11/13/2020 at 12:00 p.m., ency preparedness plan failed a strategies during an COVID-  or on 11/16/2020 at 2:15 p.m., at f Nursing was unable evidence procedure where the agency strategies in the event of an agency's emergency	E 002	21	E 0021 HHA-Procedures for R Staff/Pts  Agency will partner with the s and local officials with an upd list of patient's in acute distrest Agency will also look into increasing the network of volunteers assisting with the situations if and when as need Policy also states a complete run-down of each drill.  4 table top exercises, 1 exercity per quarter, updated materials from district 5 is now in the Elbinder. Exercises will be revise in each QAPI.  Administrator and EMG Contribution Deficiency has been corrected of 12/1/2020. Completion dat 12/1/2020.	tate ated ass.  EMG ded.  ise s MG ewed roller. d as	12/01/2020
Bldg. 00	State Re-licensure s	Federal Recertification and survey in conjunction with a fection Control in relation to	G 000	00	N 518 Patient Rights #1 Agency has now added the State Dept of Health Advance Directives 11/1/2018 to the So	<b>;</b>	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		157090	B. WING		11/18/2020	
			CERT	ET ADDRESS CITY OF THE TID COD		
NAME OF I	PROVIDER OR SUPPLIE	ER		ET ADDRESS, CITY, STATE, ZIP COD		
LIEDITA		1050/1050/10		E. VERMONT ST, SUITE 110		
HERITAG	GE HOME HEALTH	H SERVICES LLC	INDI	ANAPOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S DI AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	COMPLETION	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	the COVID-19 par	ndemic. A complaint		packets effective 11/20/2020	).	
		also conducted in conjunction		#2 Agency will follow up in the		
	_	This was a full extended survey,		QAPI meetings every quarte	l l	
		d to the administrator on		ensure this deficiency does	l l	
	11-12-2020, at 11:			occur in the future.		
				#3 Clinical Director and		
	Complaint #· IN (	00273503; Substantiated; no		Administrator will directly mo	poitor	
	deficiencies were			and be responsible for #1 ar		
	actionolog well (			#4 Deficiency has already be		
	Survey Dates: 11-	-9, 11-10, 11-12, 11-13, 11-16,		corrected by 11/20/2020.	Sell	
	11-17, and 11-18-2			Corrected by 11/20/2020.		
	11-17, and 11-10-2	2020				
	Facility #: 005294					
	Tacinty π. 003274					
	CCN: 157090					
	CCN. 13/090					
	Medicaid #: 2008	05010				
	Medicald #. 2006	03010				
	Conque un duntiont	ted for prior 12 months: 426				
	Census undupnear	ed for prior 12 months. 420				
	Current census: Si	Irillad nationts:				
	Current census. S.	kined patients.				
	Indianapolis paren	at 66				
	indianapons paren					
	Martinsville branc	h 41				
	Wiai tilisville branc	11 41				
	Total Skilled patie	ents: 107				
	Total Skilled patie	10/				
	Datianta who racei	ved home health aide only				
		al services only: 0				
	services or persona	at services only: 0				
	Home Visits with	Clinical Record Review: 4				
	110me visits with	Chinical Recold Review: 4				
	Clinical massed	riory only Activo				
	Clinical record rev	view only Active: 3				
	Clinical record rev	view Closed: 3				
	Cimical record rev	view Closed: 3				
	Total Clinical Rec	ords Reviewed: 10				
	Total Clinical Rec	oras keviewea: 10				
			1			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/18/2020			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202				
(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 APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE		
IAU	This deficiency refleaccordance with 410 for additional State  Based on the Conditional State  Social Security Act, for the following conditional Security Act, for the following conditional State  CFR 484.100, Complete Local Law. Therefore 1891(a)(3)(D)(iii) on precluded from open home health aide transverse evaluation programs 11-18-2020, and conditional State St	ects State Findings cited in O IAC 17. Refer to State Form	TAG		DATE		
G 0416 Bldg. 00		acy notice to all patients					
	Based on record rev failed to notify patie Assessment Informa start of care for 10 (whose clinical record The findings included 1. Review of a poli revised April 2017, "Purpose Each patiparticipant in his/he		G 0416	G-0416 OASIS Privacy Notice Agency did not have this form the SOC binders at the time of state audit. Agency has now added the OASIS Statement Patient Privacy Rights to the packets effective 11/20/2020. Form has been uploaded for review.  Clinical Director will oversigh both locations to ensure that the SOC binders are made for use/delivery, the OASIS	t when		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		T	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/18/2020		
NAME OF P	ROVIDER OR SUPPLIER				RESS, CITY, STATE, ZIP COD		
HERITAC	GE HOME HEALTH	SERVICES LLC			OLIS, IN 46202		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TA		DEFICIENCY)		DATE
	_	esponsibilities as described			atement of Patient Privacy		
		informed verbally and in			ghts form is included in ev	•	
		nitial evaluation visit, in			OC binder for clinician/pati		
		ng care to the patient, of the			erbal and written review an	d	
		anization policy regarding			plementation at time of		
	-	disclosure of medical			Imission. OASIS Stateme		
		ing, patient privacy rights			atient Privacy Rights form		
		tion of the Outcome and			viewed with all clinician st		
		ation Set (OASIS): 1. The			andatory meeting on 12/10		
	_	I that OASIS information will			review the content of the		
		e purpose of the collection. 2.			nd initiating discussion with		
	The right to have the information kept confidential			-	atient/caregiver at Admissi		
	3. The right to be informed that OASIS information will not be disclosed except for				ASIS Statement of Patient rivacy Rights form was ma		
		allowed by the Federal					
		e right to be informed that the		7.	atient #2, 4, 8, 6, 9, 10, 1, 3	5, 5,	
	_	ita, OASIS Outcome-Based		' '			
	Quality Improveme						
		ality Monitoring (OBQM),			ne Administrator and Clinic	eal.	
	-	orted Quality Measure reports			rector of Home Health Ca		
		accreditation surveyors as			ervices will be responsible		
		data may be used to identify			onitoring these corrective	101	
		rmance improvement activities			ctions to ensure that this		
		se to answer questions 6. The			eficiency is corrected and v	vill not	
	_	, and request changes on			cur.	1101	
	his/her assessment				eficiency has already beer	1	
					prrected by adding this for		
	2. The Admission I	Packet for new patients was			orm has been uploaded for		
		rsing supervisor on 11-9-2020,			view) to ALL current SOC	-	
	at 11:30 A.M.	•			nders as of 11/20/2020 for		
					plementation. Correction		
	During an inte	rview on 11-13-2020, at 9:44			11/20/2020.		
	_	ing supervisor, the supervisor					
	verified the content	s of the agency binder					
	presented was the a	dmission information given to					
	_	of care intake since 2019,					
	-	pervisor assumed the role of					
	nursing supervisor,	-					
		rm patients of their OASIS					
		nursing supervisor indicated					

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		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157090	B. W	ING		11/18/	/2020
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ERMONT ST, SUITE 110		
HERITAC	GE HOME HEALTH	SERVICES LLC			APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	clinicians used the start of care binder provided to						
	educate patients and their representatives of their						
		t did not contain patient					
	OASIS rights.						
	3. Review of the clinical record of patient #2,						
		care date of 11-3-2020, and					
	failed to evidence C	OASIS patient rights, as					
	required by policy,	had been provided to patient					
	#2 or their represen	tative.					
	4 D ' C4 1	1					
		linical record of patient #4,					
	evidenced a start of care date of 11-3-2020, and failed to evidence OASIS patient rights, as						
		had been provided to patient					
	#4 or their represen						
	#4 of their represent	tative.					
	5. Review of the cl	linical record of patient #8, a					
		enced a start of care date of					
	· ·	o evidence OASIS patient					
		by policy, had been provided					
	to patient #8.						
	6. Review of the cl	inical record for patient #6 was					
	completed on 11/16	5/2020 and evidenced a start of					
	· · ·	10/7/2020. The clinical record					
		he patient or the patient's					
	_	received notification of OASIS					
	patient rights, as rec	quired by policy.					
	7. Review of the cl	inical record for patient #9 was					
		6/2020 and evidenced a SOC of					
	_	nical record failed to evidence					
		atient's representative had					
		n of OASIS patient rights, as					
	required by policy.						
	9 D: - C4 - 1	:::-1					
		linical record for patient #10					
	_	1/16/2020 and evidenced a The clinical record failed to					
	evidence the patient						
	evidence the patient	i or the patient's					

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		157090	B. W	ING		11/18/	2020
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	rc	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	representative had re patient rights, as req	eceived notification of OASIS					
		inical record of patient #1,					
		care date of 10-11-2020, and					
	failed to evidence O	ASIS patient rights, as					
	required by policy, l	had been provided to patient					
	#1 or their represent	tative.					
		elinical record of patient #3,					
		care date of 10-4-2020, and					
		ASIS patient rights, as					
	required by policy, had been provided to patient						
	#3 or their representative.						
	11 Review of the c	elinical record of patient #5,					
		care date of 09-17-2020, and					
		ASIS patient rights, as					
		had been provided to patient					
	#5 or their represent	tative.					
		elinical record of patient #7,					
		care date of 10-22-2020, and					
		ASIS patient rights, as					
		had been provided to patient					
	#7 or their represent	tative.					
G 0434	484.50(c)(4)(i,ii,iii,i						
Blda 00	Participate in care						
Bldg. 00	3	nformed about, and care in advance of and					
		where appropriate, with					
	respect to	where appropriate, with					
	(i) Completion of a	ıll assessments;					
		furnished, based on the					
	comprehensive as	sessment;					
		nd revising the plan of care;					
	• •	s that will furnish the care;					
	(v) The frequency						
		omes of care, including					
	patient-identified g	joals, and anticipated risks					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157090	B. Wl	NG		11/18/	/2020
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹		429 E. \	VERMONT ST, SUITE 110		
HERITAG	SE HOME HEALTH	SERVICES LLC		INDIAN	IAPOLIS, IN 46202		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	and benefits;						
	(vii) Any factors that could impact treatment effectiveness; and						
		in the care to be furnished.					
	(VIII) Arry Crianges	in the care to be furnished.	G 0	434	G 434 Participate in Care		12/14/2020
	Based on record rev	view and interview, the agency		7.57	a to the artisipate in Gard		12/14/2020
		ritten notice to patients of the			Agency is revising and revam	the	
	-	uency of anticipated visits			SOC package. New package		
		services for 10 (Patients # 1-10)			include but not limited to,		
	of 10 patients whos	e clinical records were			disciplines that will participate	in	
	reviewed.				the patient's care and state the		
					purposed frequency of clinical		
	The findings included:				visits.		
	1 D ' C 1'				10% of all SOCs will be audite		
	_	icy, "Rights/Responsibilities,"			weekly until agency has reach	ed	
	_	evidenced the policy stated, ignate someone to act as			100%.	_	
	-	ve. This representative, on			Clinical Director, Administrator and Office Administrator		
	_	t, may exercise any of the			Clinical Director has already		
	_	the policies and procedures			initiated to follow through		
		organization The patient			purchasing new consent forms	2	
	_	erbally and in writing during the			from Med Pass. As of this dat		
		sit, in advance of furnishing			we should have a revised SO		
		The admitting clinician will			package with an updated SOC		
	_	at or his/her representative with			package within 2-4 weeks. W		
	a written copy of th	e Patient Rights "			waiting for revised SOC packa		
					agency has added the require	d	
	2. The Admission l	Packet for new patients was			consent in the current SOC		
	-	rsing supervisor on 11-9-2020,			package as of 12/14/2020.		
		iew of the patient start of care			Completion date of 12/14/2020	٥.	
		ntained a document titled					
		Rights," which evidenced					
	-	ealth Services supports the					
		on of Home Care Bill of Rights					
		me care patients as follows:					
		dvise the patient in advance of					
	_	will furnish care, and the					
	irequency of visits	proposed to be furnished "					
	During an inte	rview on 11-13-2020, at 9:44					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		ì í	ILDING	instruction 00	(X3) DATE COMPL 11/18/	ETED		
		ROVIDER OR SUPPLIER			429 E. \	ADDRESS, CITY, STATE, ZIP COD /ERMONT ST, SUITE 110 APOLIS, IN 46202		
PF	(4) ID REFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		verified the content presented was the a patients at the start when the nursing sunursing supervisor, requirement to inform and frequency of provided in writing of visits proposed to representative.  3. Review of Herita "Informed Consent No. 1-002.1 Joint Consent No. 1-002.1 Joint Consent Informed Consent No. 1-002.1 Joint Conse	ing supervisor, the supervisor is of the agency binder dimission information given to of care intake since 2019, apervisor assumed the role of verified the policy run patients of the disciplines, apposed visits prior to a stated clinicians checked the finotification without having the disciplines and frequency to the patient or patient age Home Health policy titled age Home Health policy titled age Home Health policy dommission Home Health.  "Procedure 1. During the follow up visitswill be verbally and / or in writing ) the services and disciplines wolved in the care of the approximate the patient dated 11-3-2020, at some services that the policy of such services that the pol					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		(X2) MULTIPLE C A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/18/2020			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	consent failed to no spouse representation	by, and home health aide. The stify the patient and the patient we in writing of the frequency posed visits prior to furnishing					
	evidenced a consensigned by the patier which indicated " the services and frethe Agency will procare evidenced disc 2 times a week for (HHA) 2 times a week for 8 weeks; pweek for 1 week, thoccupational therapweek, then 2 times week for 1 week; at (SLT) evaluation th#1 had received car and occupational th The consent failed patient spouse represent consent failed to patient spouse represent failed to the signal of th	inical record of patient #4, t document dated 11-3-2020, nt's spouse representative,  I have been informed of all quency of such services that ovide " Patient #2 plan of iplines of skilled nursing (SN) 9 weeks; home health aide eek for 1 week, then 3 times a physical therapy (PT) 2 times a ten 1 time a week for 2 weeks; by (OT) 1 time a week for 1 a week for 1 week, then 1 time a nd speech language therapy the week of 11-16-2020. Patient the visits from nursing, physical, erapy, and home health aide. To notify the patient and the esentative in writing of the tion of proposed visits prior to					
	closed record, evided dated 9-6-18, signed indicated " I have services and freque Agency will provide evidenced disciplin week, 2 times a week for 3 weeks; Patient #4 had receiphysical, and occup	inical record of patient #8, a enced a consent document d by the patient, which e been informed of all the ncy of such services that the e " Patient #8 plan of care es of PT 1 time a week for 1 ek for 2 weeks, then 1 time a DT 1 time a week for 6 weeks. ived care visits from nursing, pational therapy. The consent patient in writing of the					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  157090		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/18/2020	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	frequency and durate furnishing services.  7. Review of the classification of the classification of the classification of the completed on 11/16 agency shall advise disciplines that will frequency of visits and " I have been of all the services at that the Agency will was signed by the plan of care (POC) for skilled nursing (week for the complement for three moneded (PRN) for completed on the completed on the consent failed to ever of services of anticipation of the classification of the consent document " included the statem the patient in advantage furnish care, and that to be furnished" of my rights, and of of such services that The document was daughter/Power of a the consent of the sooc POC date.	tion of proposed visits prior to inical record for patient #6 was /2020 and revealed a start of 10/7/2020. The clinical record t document "Home care bill of ded the statement " the the patient in advance of the furnish care, and the proposed to be furnished " en informed of my rights, and and frequency of such services 1 provide " The document atient on 10/7/2020. The SOC dated 10/7/2020 revealed orders SN) once a week times one etion of the SOC, then once a anths and twice weekly as atheter complication (sic),		TAG	DEPICIENCY		DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157090	B. W	ING		11/18/	2020
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				/ERMONT ST, SUITE 110		
HERITAC	GE HOME HEALTH	SERVICES LLC			APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n twice a week for four weeks,					
		k times one week, zero times a					
		ek, then once a week times two					
		failed to evidence the type					
		rvices of anticipated care					
	visits to be provided	l.					
	0.00 1 0.1 1						
		inical record for patient #10					
		1/18/2020 and revealed a SOC					
		The clinical record revealed the					
		Home care bill of rights" that					
		ent "the agency shall advise					
	1 -	ce of the disciplines that will					
		e frequency of visits proposed					
		and "I have been informed					
		all the services and frequency					
		t the Agency will provide"					
		signed by the patient on C POC dated 7/22/2020 revealed					
		a week times one week, then					
		e weeks and social worker					
		I treat." The consent failed to					
	1 '	nd frequency of services of					
	anticipated care visi						
	_	cal record for patient #1, start					
		1/2020, orders evidenced SN- 1					
		eeks/ PT- 1 day a week for 1					
	1	k for 7 weeks/OT - 2 days a					
		ST- referral order / HHA-referral					
		sent forms signed by the					
		sion. Review of the Consent					
		or Disclosure of Information					
		ne care to be furnished based					
		ve assessment and the					
ı		anticipated upon admission.					
	11 Review of clini	cal record for patient #3, start					
		4/2020, orders evidenced : SN- 2					
	` ′	weeks /PT- 2 times a week for 2					
		order, included consent forms					
	"CORS / S I - ICICITAI	order, meraded consent forms					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157090	B. W	ING		11/18/	2020
NAME OF B	ADOLUDED OD CLUDDI IED			STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>		429 E. \	/ERMONT ST, SUITE 110		
HERITAC	SE HOME HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46202		
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		t upon admission. Review of					
		thorization for Disclosure of o establish the care to be					
	furnished based on						
	assessment and the	-					
	anticipated upon ad						
	and parent upon up						
	12. Review of clini	cal record for patient #5, start					
		7/2020, orders evidenced : SN 1					
		eek, 2 days a week for 2 weeks					
	-	or 6 weeks; included consent					
		patient upon admission.					
		ent and Authorization for					
		nation failed to establish the					
		based on the comprehensive					
	assessment and the						
	anticipated upon ad	mission.					
	13. Review of clini	cal record for patient #7, start					
		2/2020, orders evidenced : SN 1					
		eek, 2 days a week for 3 weeks,					
	-	weeks/PT- 1 day a week for 1					
	week, 2 days a weel	k for 6 weeks/OT - 3 days a					
	week for 3 weeks, 2	days a week for 3					
	weeks/HHA- 2 days	s a week for 4 weeks, included					
	_	ed by the patient upon					
	admission. Review						
		isclosure of Information failed					
		to be furnished based on the					
	-	essment and the frequency of					
	visits anticipated up	on aumission.					
	14. The findings fo	r the above patients were					
	_	Director of Nursing and					
		/10/20 at 3:00 p.m., in which					
		es and disciplines anticipated					
		ally during admission.					
		/// / · · · · · · ·					
	410 IAC 17-12-3(a)	(1)(A)(B)					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		A. BU	(X2) MULTIPLE CONSTRUCTION (X3) DATE S  A. BUILDING 00 COMPLI  B. WING 11/18/2			ETED	
		157090	B. W		_	11/10/	2020
	PROVIDER OR SUPPLIEI GE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COI		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG			DATE
	410 IAC 17-12-3(a 410 IAC 17-12-3(b	)(2) )(2)(D)(i)(AA)(BB)					
G 0528	484.55(c)(1)						
	` ' ` '	cial, functional, cognition					
Bldg. 00		ent health, psychosocial,					
	functional, and co						
			G 0	528	G 0528-Health, Psychosocial	·,	12/16/2020
	Based on record re	view and interview, the			Functional, Cognition		
	_	essment failed to be accurate			(Patient #1)		
	•	e assessment of all patients			By educating and training all		
		s, psychosocial status, and			clinical staff to follow through,		
		cluding dialysis access site			document and communicate v	vith	
		2 (Patient #1 and 7) of 7 active			the team members when they		
		nd 1 (Patient #9) of 3 closed			observe any clinical status		
	records reviewed.				changes and/or additional ser		
					needs that needs to be addres	ssed	
	The findings include	led:			by HHA. The comprehensive assessment should include all		
	1. Review of the cl	inical record of patient #1,			current and past medical histo	ry	
	evidenced a compr	ehensive assessment which			and any concerns identified sh	nould	
	indicted (M1740) (	Cognitive, behavior, and			be discussed with the		
		m that are demonstrated at			patient/patient representative	and	
		None of the above behavior		the physician responsible fo		he	
	_	chosocial WNL (Within Normal			POC. This deficiency was		
		prehensive assessment of the			reviewed with all clinical staff		
		Behavioral Status failed to			12/9/2020 and 12/16/2020 wit		
	-	he patient's current health			verbal understanding. Patient		
		le relevant cognitive health,			was discussed with the clinica		
	psychosocial, funct	tional, and cognitive status			team that was providing direct		
	<b>.</b>	11/10/2020			care to the patient on 11/23/20		
	_	w on 11/12/2020 at 9:25 A.M.,			Case Manager and OT decide		
		ted patient #1 has significant			MSW was not indicated at this	,	
		s currently living with a family sidence can not accommodate			time because the caregiver	.,	
		obility concerns, and may be in			declined needs assessment b	y	
		ork consult to assess for			MSW.	t all	
	community resource				Agency will provide consistent		
	community resourc				staff mandatory meetings and trainings every 3-6 months.		
	2 Review of the o	linical record of patient #7,			The Administrator and Clinical	 	
l	2. Review of the C	innear record or patient $\pi$ $i$ ,	- 1		I THE AUTHINISHARDI AND CHINICA	1	

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PRINTED: 01/11/2021

DEPARTMEN' CENTERS FOI		ORM APPROVED MB NO. 0938-039				
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MIJI TIPI I	E CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			PLETED
AND I EAR	or condition	157090	B. WING	<u> </u>		8/2020
		137090	b. wing		11/10	3/2020
NAME OF I	PROVIDER OR SUPPLIER	3		EET ADDRESS, CITY, STATE, ZIP COD		
TWINE OF I	NO VIDER OR SOLVEIE	•	429	E. VERMONT ST, SUITE 110	)	
HERITA	GE HOME HEALTH	SERVICES LLC	INDI	IANAPOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		ILD BE ROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY		DATE
	limited review for c	coordination of care with an end		Director of Home Health	Care	
	stage renal disease	provider, and dialysis access,		services will be responsib	ole for	
	assessment and care	e, evidenced a start of care		monitoring these correcti	ve	
	date of 10-22-20, a	and contained a plan of care for		actions to ensure that this	s	
	the certification per	riod of 10-22-2020 to 12-2-2020		deficiency is corrected ar	าd will not	
	_	1 day a week for 1 week, 1		recur.		
	days a week for 3 w	veeks, 1 day a week for 3		Correction date of 12/16/	2020.	
	weeks/ PT-1 day we	eek a 1 week, 2 days a week for				
		Under the narrative section, an		(Patient #7)		
	end stage renal dise	ase (ESRD) provider was		When agency is treating	an active	
	identified for coord			dialysis patient, agency v		
				contact the dialysis center		
	Review of a resumn	otion of care comprehensive		inquire where, what days		
	_	0-22-20, performed by RN,		times that patient is recei		
		to evidence patient #7 had a		dialysis and add this info	-	
		ty fistula access site. The		into the patient's profile p		
		ialysis access fistula failed to		clinical review. When ag	-	
		ice or absence of bruit and		treating a dialysis patient	-	
	_	describe the condition of the		access site and surround		
	site and surrounding			access site will be assess	•	
	·	5		supportive assessment		
	During the interview	w on 11-18-2020 at 3:00 P.M.,		documentation noted in t	he	
		nursing, the above findings		patient's visit note(s).		
		en queried for further pertinent		Deficiencies was discuss	ed with	
		nation, or documentation, the		all employees on 12/9/20		
	_	stated having nothing further		12/16/2020 with verbal		
	to present for review			understanding.		
	_	al record review was completed		Agency will provide cons	istent all	
		revealed a SOC date of		staff mandatory meetings		
		ses included autonomic		trainings every 3-6 month		
	_	al knee osteoarthritis,		Clinical Director to hold a		
		pation, tubular adenoma of the		meeting with all nursing s		
		ndrome, and obstructive sleep		each case conference or		
	apnea (OSA).	, <b>r</b>		bi-weekly basis. Patient		
	F (- 211).			dialysis center was conta		
	On 8/28/2020 at 9·4	11a.m., a physician's office sent		chart was updated to add		
		e agency with the admitting		supportive information as		
		J		, cappoints intormation at		1

diagnosis listed as "constipated/pain and

had presented to her physician's office for "

pressure." The referral revealed that the patient

when and times the patient

attends dialysis. RN was also

contacted regarding the lack of

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		157090	B. W	'ING		11/18/	2020
)	NOTABLE OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
NAME OF P	PROVIDER OR SUPPLIER	t		429 E. \	VERMONT ST, SUITE 110		
HERITAC	GE HOME HEALTH	SERVICES LLC		INDIAN	IAPOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	RECTION (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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	evaluation of constipation" and "she has				clinical documentation in rega		
	•	ating and takes numerous			to the fistula site assessment		
		as (sic) small amounts of loose			surrounding tissue assessmer		
		e has a hx (history) of tubular			11/23/2020. Education provid		
		lyp)" The referral form also			as to what the site assessmer	nt	
	-	lical history that included left			documentation should obtain.		
		ophy, sinus node dysfunction,			The Administrator and Clinical		
	and pacemaker place	ement.			Director of Home Health Care		
					services will be responsible fo	r	
		comprehensive assessment			monitoring these corrective		
		vealed the nursing review of the			actions to ensure that this		
	-	as incomplete and failed to			deficiency is corrected and wil	I not	
evidence documentation related to bowel,				recur.			
	constipation, or care	diac problems.			All clinical staff have been		
					communicated to follow throug	- I	
	-	liscussed with the Director of	on this concern on 12/9/2020 and				
	- ' '	2:26 p.m. on 11/18/2020, in			12/16/2020. Completion date	of	
		l no further information or			12/16/2020.		
	documentation to pr	rovide.					
					(Patient #9)		
	410 IAC 17-14-1 (a	1)			SOC comprehensive assessm		
					will include all current and pas		
					medical history and any conce		
				identified should be discussed			
					with the patient/patient		
					representative and the physici	an	
					responsible for the POC.		
					Comprehensive assessment		
					should contain supportive		
					information in relation to the		
					admission diagnosis including		
					specific interventions and goa	IS	
					related to the admission		
					diagnosis. All clinical staff wa	S	
					educated on 12/9/2020 and		
					12/16/2020 regarding the		
					deficiency with verbal		
					understanding. RN was		
					contacted on 11/23/2020 to		
					discuss the deficiency. Patier	nt	

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

PRINTED: 01/11/2021 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
		157090	B. WIN	IG		11/18/	/2020
NAME OF F	DOLUBER OF GUIDNIE			STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIE	К		429 E. \	VERMONT ST, SUITE 110		
HERITAC	SE HOME HEALTH	H SERVICES LLC		INDIAN	APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	<u> </u>	DATE
					has already been discharged t	rom	
					agency. 100% compliance is estimated to be achieved in 1		
					month or before.		
					Agency will provide consistent	· all	
					staff mandatory meetings and	ali	
					trainings every 3-6 months.		
					Clinical Director to hold addition	onal	
					meeting with all nursing staff a		
					each case conference on a		
					bi-weekly basis.		
					The Administrator and Clinical		
					Director of Home Health Care		
					services will be responsible for	r	
					monitoring these corrective		
					actions to ensure that this		
					deficiency is corrected and wil	I not	
					recur.		
					All clinical staff have been communicated to follow through	ah.	
					on this concern on 12/9/2020.	-	
					staff mandatory meeting is	ΛII	
					scheduled for 12/16/2020.		
					Completion date of 12/16/2020	0.	
					,		
G 0530	484.55(c)(2)						
		and care preferences					
Bldg. 00	•	ngths, goals, and care					
	-	uding information that may					
		nstrate the patient's					
	. •	achievement of the goals					
		patient and the measurable					
	outcomes identific	ed by the HHA; ecord review, the agency failed	0.05	20	G 530-Strengths, Goals, and (	Caro	12/17/2020
		ent's care preferences and	G 05	30	Preferences	Jaie	12/16/2020
	_	n of care in 1 (Patient #9) of 3			Patient #9		
		viewed in a sample of 10.			By educating and training all		
					clinical staff to ensure evidence	e of	
	Findings include:				patient stated strengths and ca		
					preferences are documented i		

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPL	ETED
		157090	B. WING	G		11/18/	/2020
			<u> </u>				
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
					/ERMONT ST, SUITE 110		
HERITAC	GE HOME HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	Patient #9 clinical r	record review was completed on			OASIS and Evaluations for PC	DC	
		certification period of 8/31/2020			development.		
	to 10/29/2020, with SOC date of 8/31/2020.				Audits to be performed by the	QΑ	
		l autonomic neuropathy,			clinician at time of POC	~.	
	_	arthritis, spondylosis,			completion to ensure patient		
		ar adenoma of the colon, sick			stated strengths and care		
		d obstructive sleep apnea			preferences are documented		
	(OSA).	a costation to steep aprica			within the chart.		
	(00/1).				Clinical Director and Administr	ator	
	Review of the intel	te referral form, dated 8/28/2020,					
		9 was referred to the agency			will be responsible for A and B All clinical staff have been	·.	
		physician (PCP) for skilled			communicated to follow through	vh.	
		es for the management of			•	•	
		dominal pain and pressure,			on this concern on 12/9/2020.	All	
					staff mandatory meeting is		
	and for physical the	erapy (PT) for inability to walk.			scheduled for 12/16/2020.	•	
	D . C.1	1 1 ' 14 (PT)			Completion date of 12/16/2020	J.	
		al physical therapy (PT)					
		vas completed by employee G					
		enced four goals were					
		ng improvement of strength of					
		mproved balance, improved					
	_	fety training. The PT reported					
		ving goals were the inability to					
		and knee pain. Patient #9					
	_	" be able to walk further					
		failed to evidence patient					
		care preferences were					
		velopment of the plan of care					
	goals.						
	Davier C. DT.	it commissed has a sureland of					
		it completed by employee G on					
	· · · · · · · · · · · · · · · · · · ·	evidence documentation of					
	patient #9 stated str	rengths and care preferences.					
	Daview of the disch	narge PT visit, completed by					
		10/7/2020, failed to evidence					
	_	atient #9's stated strengths					
	and care preference	es.	1				
	Tl C 1'	diamand anida da Director					
	The findings were o	discussed with the Director of					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	ULTIPLE CO JILDING	onstruction 00	(X3) DATE SURVEY COMPLETED
		157090	B. W	ING		11/18/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
		2:26 p.m. on 11/18/2020, in I no further information or covide.				
G 0536	484.55(c)(5)					
Bldg. 00	currently using in a potential adverse including ineffectiv side effects, signif	dications the patient is order to identify any effects and drug reactions, we drug therapy, significant icant drug interactions, rapy, and noncompliance				
	Based on clinical re interview, the agence medications were re effects, drug reaction side effects, significal duplicative drug the	cord review and staff by failed to ensure all eviewed for potential adverse ens, ineffective drug therapy eant drug interactions, and erapy for 1 (Patient #7) of 7 ds reviewed and 1 (Patient #10)	G 0	536	G-0536 A Review of All Curre Medications (Patient #10) The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will recur.	12/10/2020
	was completed on 1 of care (SOC) date skilled nursing (SN)	inical record for patient #10 1/18/2020 and revealed a start 7/22/2020. Orders included twice a week times one week, mes five weeks for medication			All clinical staff have been communicated to follow throug on this concern on 12/9/2020. staff mandatory meeting is scheduled for 12/16/2020. Completion date of 12/16/2020 If agency is treating a patient that attends dialysis, Intake	All D.
	list of medications t taking, but failed to medications were re any potential advers interactions, ineffec side effects, and dup	he patient was currently reveal evidence that the econciled in order to identify se effects, drug reactions and tive drug therapy, significant plicative drug therapy.			Coordinator will contact the dialysis center to request a list administered medications at dialysis for the RN case manager's review. The RN will add these medications to the medication profile in the patient chart and perform a medication reconciliation and drug interaction.	II nt's n

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/18/2020	
	PROVIDER OR SUPPLIER  BE HOME HEALTH SERVICES LLC	429 E. \	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 IAPOLIS, IN 46202		
(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	
	Nursing (DON) at 2:17 pm on 11/18/2020, she agreed that there was no evidence of medication reconciliation in the patient's clinical record.  2. Review of the clinical record for patient #7 on 11-18-2020, evidenced a start of care 10-22-2020, and contained a plan of care for the certification period 10-22-2020 to 12-2020. The plan of care diagnoses included end stage renal disease.  Review of the comprehensive assessment dated 10-22-2020, evidenced patient went to in-center dialysis facility in the admission documentation.  During a telephone interview with the Non-Employee DD a dietitian at patient #7's dialysis center on 11-15-20 at 1:15 p.m., Non-Employee DD stated patient #7 received the following medications patient #7 may need while at the dialysis center for hemodialysis and: Nifedipine (anti-hypertensive to treat high blood pressure) XR 60 mg (milligrams), Calcitriol (treat for low calcium and psoriasis), Sevelamer (lowers the amount of phosphorus in the blood), Erythropoietin (to treat low red blood cells), Iron (to treat iron deficiency anemia), Active vitamin D (supplement), Phosphorus binder (help to pass excess phosphorus out of the body), B-complex Vitamin (supplement), Folic acid (supplement), and Antihistamine (treatment of allergies).		review within 5 days of the admission. Patient #7-Dialysis center has been contacted wit administered dialysis medicati added and reconciled on the medication profile in the patier chart.  Audits to be performed by the clinician at the time of the POC completion to ensure all active medications (home and dialys are included on the medication profile and reconciled within 5 days of the SOC/ROC. All dialysis POCs will be audited the month or until 100% compliant achieved.  The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will recur.  All clinical staff have been communicated to follow throug on this concern on 12/9/2020. staff mandatory meeting is scheduled for 12/16/2020. Completion date of 12/16/2020.	hons hons hit's QA C ss) hor 1 ce is	
G 0572	484.60(a)(1)				
Bldg. 00	Plan of care Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		157090	B. W	NG		11/18	/2020
	PROVIDER OR SUPPLIER		<u>,                                      </u>	429 E. \	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 IAPOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	signed by a doctor of medicine, osteopathy,						
		within the scope of his or					
		certification, or registration.					
	1	rs a patient under a plan of					
		e completed until after an					
		e physician is consulted to					
	1 ''	or modifications to the					
	original plan.		$G_0$	572	G-0572 Plan of Care		12/16/2020
	Based on clinical re	cord review and interview, the	100	312	(Patient #9)		12/10/2020
		sure the plan of care (POC)			SOC comprehensive assessm	ent	
		pecific measurable outcomes			will include all current and pas		
		ient #9) of 3 closed patient			medical history and any conce		
	records reviewed in a sample of 10.				identified should be discussed		
		1			with the patient/patient		
	Findings include:				representative and the physici	an	
					responsible for the POC.		
	Patient #9 clinical r	ecord review was completed on			Comprehensive assessment		
	11/16/2020 for the	certification period of 8/31/2020			should contain supportive		
	to 10/29/2020, with	SOC date of 8/31/2020.			information in relation to the		
	Diagnoses included	autonomic neuropathy,			admission diagnosis including		
		arthritis, spondylosis,			specific interventions and goal	ls	
	_	r adenoma of the colon, sick			related to the admission		
	· ·	d obstructive sleep apnea			diagnosis. All clinical staff wa	s	
	(OSA).				educated on 12/9/2020 and		
					12/16/2020 regarding the		
		te referral form, dated 8/28/2020,			deficiency with verbal		
	_	9 was referred to the agency			understanding. RN was		
		physician (PCP) for skilled			contacted on 11/23/2020 to	_	
		anagement of constipation and			discuss the deficiency. Patien		
	_	pressure, and for physical			has already been discharged	rom	
	therapy (PT) for ina	waik.			agency.	· all	
	Daview of the DOC	for the certification period of			Agency will provide consistent		
		2020, revealed SN goals			staff mandatory meetings and		
		rid-19 screening prior to skilled			trainings every 3-6 months.  Clinical Director to hold addition	nal	
		ided, patient and caregiver			-		
		anding of the signs and			meeting with all nursing staff a each case conference on a	ııı <del>C</del> ı	
	_	-19, being free from injury,			bi-weekly basis.		
	1	er verbalizing understanding of			The Administrator and Clinical		
	Patient and caregive	or verbanizing understanding or					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 157090		(X2) MULTIPLE C A. BUILDING B. WING	OONSTRUCTION OO	(X3) DATE SURVEY COMPLETED 11/18/2020	
	ROVIDER OR SUPPLIER SE HOME HEALTH		429 E.	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 NAPOLIS, IN 46202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
G 0574 Bldg. 00	the individualized eremain free from signespiratory distress, verbalize understand regimen, patient will compliance, home established by physical have no hospitalizate program will be established by established by physical program will be established by physical program will be established goals rediagnosis of constipe pressure.  During an interview (DON) on 11/18/202 the plan of care and 410 IAC 17-13-1 (at 484.60(a)(2)(i-xvi) Plan of care must The individualized the following:  (i) All pertinent dia (ii) The patient's monopromote status;  (iii) The types of sequipment require (iv) The frequency made;  (v) Prognosis;  (vi) Rehabilitation (vii) Activities perricix) Nutritional require (x) All medications	mergency plan, patient will gns and symptoms of patient and caregiver will ding of the medication I maintain regular diet exercise program will be ical therapist, the patient will ions, and a home exercise ablished by the occupational  coals failed to evidence specific, lated to the admitting ation and abdominal pain and  with the Director of Nursing 20 at 2:26 P.M., the DON stated goals were adequate.  )  include the following plan of care must include  gnoses; pental, psychosocial, and ervices, supplies, and d; and duration of visits to be  potential; itations; mitted; uirements;		Director of Home Health Car services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and we recur.  All clinical staff have been communicated to follow through this concern on 12/9/2020 12/16/2020. Completion dat 12/16/2020.	e for vill not ugh D and
	· , -,	i J	- 1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/18/2020		
	PROVIDER OR SUPPLIER			429 E. V	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 APOLIS, IN 46202		
(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)	ATE	(X5) COMPLETION DATE
	emergency depart re-admission, and to address the und (xiii) Patient and contraining to facilitate (xiv) Patient-specieducation; measure identified by the Hook (xv) Information redirectives; and (xvi) Any additional physician may chook Based on record reversity failed to ensure the orders the patient's restrictions 1 (Patient received dialysis the 10 patients.  The finding include Review of the clinical care date of 10-22-2 for the certification 12-2020, diagnosis stage renal disease. evidence a fluid resal as part of patient #7 Review of coordina 10-22-2020, eviden (Director of nursing employee L. The efforts and the patient with the patient for the certification 12-21-2020, eviden (Director of nursing employee L. The efforts and the patient for the patie	riew and interview, the agency plan of care included care fluid intake and diet int #7) of 1 patient who eatments, in a total sample of included care fluid intake and diet int #7) of 1 patient who eatments, in a total sample of included, in a total sample of included, but not limited to, end included	G 0	574	G-0574 Plan of Care Must Include the Following (Patient #7) Intake Coordinator to coordinate services with active dialysis of to include diet, fluid restriction and all medications. This information will be added to the patient's chart for clinical reviet the RN Case Manager. Patie #7-Renal diet requirement and restrictions were added to the patient's chart.th, 2021. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and wirecur.  All clinical staff have been communicated to follow throu on this concern on 12/9/2020, mandatory staff meetings were completed on 12/16/2020. Completion date of 12/16/2020.	enter as ne ew by nt d fluid e or	12/16/2020

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		157090	B. WI	NG		11/18/	2020
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	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
G 0576 Bldg. 00	During a telephone of PM, Non-Employee in-center dialysis far have a low sodium, 32-ounce fluid intaked on 11-17-2020, at 3 findings and stated prestrictions should have plan of care.  410 IAC 17-13-1(a)  484.60(a)(3)  All orders recorded All patient care orders, must be resulted in the care orders, must be resulted in the care orders in the care order order significant included:  1. Review of a policundated, evidenced medications, treatment patients must be order must include the signed with the full receiving the order and order order orders in the care or	interview on 11-17-2020 at 2:30 p. DD, a Dietitian at patient #7's cility, stated patient #7 was to diabetic, renal diet with a ste restriction per 24 hours.  3:30 PM, the DON verified the patient #7's fluid and dietary have been documented on the content #7's fluid and dietary have been documented on the dietary failed to include all patient are orders and failed to be to verify to ensure services 2 (Patients #1 and 5) of 7 dis reviewed in a sample of 10.  The policy stated, "All ents, and services provided to dered by a physician. The he date, specific order, be name and title of the person and be sent to the physician ditionally, an order or verified when: There is a	G 03		="" b=""> ="" b=""> /b> /b> Agency went by the last ordereceived from the hospital, however there was confusion with an older order and the newest order of disciplines requested. Patient #1-Update referral order contains referration for SN/PT/OT. Clarified with MD on 11/23/2020, ST and Hiservices were not indicated at this time. Patient #5 All lab orders will be initiated by the Clinical Director to ensure labs are performed when ordered and	ed al HA	12/01/2020
	question or discrepa prescription. Some	one other than the physician			lab results are received and uploaded into the patient's		

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i f		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED
		157090	B. W	ING		11/18/2020
N. M. C. C. C.	DROLUDED OF CLUBY			STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>		429 E. Y	VERMONT ST, SUITE 110	
HERITAC	GE HOME HEALTH	SERVICES LLC		INDIAN	IAPOLIS, IN 46202	<del>-</del>
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	`	licensed independent			chart by the Intake	
		norized prescriber or his/her			Coordinator. Patient #5-all la	abs
	_	s the order or prescription.			have been obtained per	
	_	r, illegible, or unclear. The n reviewed may be the original			current orders. Verified MD	
		n, a facsimile copy (if permitted			has received the lab results	
		et transcription of a verbal			of 11/23/2020 with no further lab orders.	
	order or prescription	-			Agency to cross check	
	order or prescription	и			different orders for services	if
	2 Review of the cli	nical record of patient # 1,			more than 1 referral order is	"
		care date of 10-11-20, and			sent. The Clinical Director w	dil
		care for the certification period			initiate a lab binder to monitor	
		9-20, with skilled nursing (SN,)			all lab orders and verify	
	physical therapy (PT,) occupational therapy (OT,)				completion of labs obtained	
		, 1			per active order. This will be	
	Review of the refer	ral order, dated 10-05-20,			monitored daily by the Clinic	
	revealed physical th	erapy (PT,) occupational			Director. Deficiency was	
	therapy (OT,) speed	th therapy (ST,) and home			discussed with all employee	s
	health aide (HHA,)				on 12/9/2020 and 12/16/2020	
					with verbal understanding to	)
		on 11/13/20 at 3:00 PM, the			ensure this deficient practice	e
	l '	Jursing) verified all disciplines			will not recur.	
		n the plan of care. No other				
	information was pro	ovided.			The Administrator and Clinic	al
					Director of Home Health Care	
		inical record of patient # 5,			services will be responsible	for
		care date of 9-17-20, and			monitoring these corrective	
		care for the certification period			actions to ensure that this	
		5-20, with skilled nursing (SN,)			deficiency is corrected and v	will
		rehensive assessment / OASIS			not recur.	
		care coordination noted dated			All protocols are in place as	
		idence that Employee C,			12/1/2020. Completion date	OΤ
	performed lab draw	on aumission.			12/1/2020.	
	Review of referral of	order, dated 9-10-20, revealed				
	home care order for	SN and labs.				
	During an interview	on 11/13/20 at 3:15 PM, the				
	DON (Director of N	Jursing) verified the SN perform				
	labs draws during v	isits but acknowledged order				

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPLETED		
		157090	B. W	B. WING		11/18/	11/18/2020	
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD			
LIEDITAG		055)//050110			VERMONT ST, SUITE 110			
HERITAG	SE HOME HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46202			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	clarification should	have been documented for						
	admission labs.							
G 0580	484.60(b)(1)							
	Only as ordered b	y a physician						
Bldg. 00	Drugs, services, a	nd treatments are						
	administered only	as ordered by a physician.						
			G 0	580	G 0580 Only as Ordered by a		12/09/2020	
		view and interview, the agency			Physician			
		vices were furnished only after			(Pt#1, 2, 4, 6, 8)			
		an's order for disciplines,						
		duration of visits, and care			New Admission Order is now			
		its #1 2, 4, 6, 8) of 7 active			available in Kinnser. After the			
		iewed and 1 (Patient #9) of 3			SOC has been completed, the	<del>)</del>		
	closed patient recor	ds was reviewed.			SOC clinician will create an			
					Admission Order to include:			
	The findings includ	ed:			RVTO, time of VO given, name			
					physician representative provi	-		
		cy, "Physician Orders,"			the order, discipline requested			
		the policy stated, "All			frequency and duration orders			
		ents, and services provided to			focus of care. This order will be	эе		
		lered by a physician. The			sent to the MD for signature			
	•	ited via telephone or in writing			immediately following.			
		rsigned by the physician in a			This is a new process in place	!		
	-	When the nurse or therapist			based on the state auditor's			
		der from the physician, he/she			findings. New admission order	· IS		
		r as given and then read the			now active for use for all new			
	_	sysician verifying that the			SOCs. All staff has been			
	-	e order heard it correctly and			educated and trained.	-11		
	-	r correctly. The verbal order			Ongoing in-services including	all		
	_	order was taken and verified s on the form and signing the			staff mandatory in-service on			
		ast include the date, specific			12/16/2020 to go over new	l bo		
		th the full name and title of the			process. 10% of all charts will audited to ensure process is ir			
		e order and be sent to the			compliance until 100% accura			
	physician for signat				is achieved.	Су		
	physician for signat				Clinical Director and Administr	rator		
	2 Review of the al-	inical record of patient #2,			will monitor to ensure that the	atoi		
		care date of 11-3-2020, and			deficient practice will not occu	r		
		care for the certification period			Deficiency corrected as of	1.		
	Contained a plan of	care for the certification period	1		Deliciency corrected as Of			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157090	B. W	ING		11/18/	2020
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
LIEDITAC	SELIOME LIEM TH	0507/1050110			VERMONT ST, SUITE 110		
HERITAG	GE HOME HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46202		
(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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	of 11-3-2020 to 1-1	-2021, with skilled nursing (SN,)			12/9/2020, however to be		
	physical therapy (P	Γ,) occupational therapy (OT,)			monitored on an on going bas	is.	
	home health aide (HHA,) and speech language						
	therapy (SLT.)	,, 1			Deficiency-HHA provided care	<b>.</b>	
	15 ( )				without the agency having		
	Review of the start	of care comprehensive			obtained a specific VO.		
		dated 11-3-2020, conducted			All HHA's have been educated	d not	
		(RN) employee H, evidenced			to provide any services until a		
		essment "Orders for			plan and an order is in place in		
		tment SN-2 week 9 for wound			chart before providing any pat		
	*	ded] visits for soiled or			care services.		
		PT-2 wk 1, 1 wk 2; OT- 1 wk 1;			So far, no similar problems ha	Ve	
		Eval [sic evaluate] and treat			been found in other charts.	<b>V</b> O	
		); MSW-Eval and treat to assist			However, agency to review all	НΗΔ	
		ng term care] planning HHA-2			charts and will address this iss		
	-	and ADL [activities of daily			if more deficiencies are found.		
	_	All frequency orders are			Weekly audits will be performed		
		uthorization approval "			on 25% or more of HHA charts		
	-	an contacted Re [sic			ensure a care plan and an ord		
	-	e start of care] report findings			obtained before HHA services		
		POC [sic plan of care] I/G [sic			initiated. Audited to be continu		
	-	HHA [sic home health aide]			until 100% compliance is	ueu	
	_	ch therapy] & MSW [sic			accomplished.		
		ter] Evals." [sic evaluations]			Clinical Director and Administr	otor	
	illedical social work	terj Evais. [sie evaluations]					
	Daview of the plan	of care and the SN visit notes			to monitor and ensure the defi		
	-				practice will not occur. Deficie	HICY	
		are was provided on 11-5,			corrected as of 12/9/2020.		
		which consisted of "SN to clean			Completion date of 12/9/2020.		
		d cleaner and pat fry. Apply					
		and cover with foam dressing,					
		imes a week; right heel: SN to					
		ound cleanser and cover					
		dressing twice weekly, may					
		change dressing. WOUND					
	-	ck wound, left buttock wound					
		clean wounds with wound					
	cleanser and pat dry. Apply hydrogel to wound						
		foam dressing, change					
	-	veek. May teach family to					
	change dressing."	The RN provided wound care					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00		COMPLETED	
		157090	B. W	ING		11/18/	2020	
NAME OF D	PROVIDER OR SUPPLIER	<u>.</u>	-	STREET A	DDRESS, CITY, STATE, ZIP COD			
					/ERMONT ST, SUITE 110			
HERITAC	GE HOME HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46202			
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	ined a specific verbal order,						
		sician signature having been y developed plan of care to						
	authorize all plan of							
	authorize an plan of	care orders.						
	Review of the PT e	valuation, dated 11-4-2020, by						
	employee I, evidend	eed a check mark before						
	1 -	Re: Plan of Care, Goals,						
		n and Direction." Review of						
		ailed to evidence a specific						
		Torders for care. Review of videnced the PT had furnished						
		a care visit on 11-9-2020. The						
	_	e without having obtained a						
	_	r, and prior to the physician						
	_	en received on the fully						
	developed plan of c	are to authorize all plan of care						
	orders.							
	D:							
		valuation, dated 11-6-2020, by ced a check mark before						
		Re: Plan of Care, Goals,						
	1	n and Direction." Review of						
		ailed to evidence a specific						
	verbal order with O	T orders for care. Review of						
		videnced the OT had						
		es during a care visit on						
		T provided OT care without						
		pecific verbal order, and prior						
		ring signed and returned the nof care to authorize all plan						
	of care orders.	i of care to authorize all plan						
	or care oracis.							
	Review of HHA vis	it notes evidenced the HHA						
	had made care visits	s on 11-6, 11-9, 11-11, 11-13,						
	and 11-16-2020; to	include the provision of hands						
		ning. Review of the clinical						
		lence a verbal order had been						
		ical record for HHA services.						
	The HHA had provi	ided HHA care without the						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPI	LETED
		157090	B. W	ING _		11/18	/2020
			_	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			VERMONT ST, SUITE 110		
HEDITAC	GE HOME HEALTH	I SEDVICES I I C			APOLIS, IN 46202		
HEINHAG		I SERVICES LEG		INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ined a specific verbal order,					
		sician signature having been					
	received on the fully developed plan of care to						
	authorize all plan of	f care orders.					
		of care failed to evidence the					
		had signed the written plan of					
		8-2020, when the clinical record					
	review was comple	ted.					
	2 D . C	1. 1 10					
		linical record for patient #4,					
		f care date of 9-1-2020, and					
		care for the certification period					
		220, with orders for PT 2 times a					
		OT 2 times a week for 1 week,					
		for 4 weeks, and SLT 2 times a					
	week for 4 weeks.						
	Daviesy of the recer	rtification OASIS, dated					
		T, employee G, evidenced a					
	1	"Physician Notified Re: Plan of					
		ency, Duration and Direction."					
		s for Disciplines and					
		nced PT 2 wk 4, effective					
		k 1, 1 wk 4, effective 11-1-2020;					
	and ST 2 wk 4, effe						
							1
	Review of the clinic	cal record failed to evidence a					
		ers for PT, OT, ST care.					
		es for PT evidenced the PT had					
	furnished PT servic	ees during a care visit on 11-3,					
		and 11-16-2020. OT care visits					
		, 11-4, 11-9, and 11-16-2020; the					
		ervices on 11-6 and 11-12-2020.					
		T had furnished care without					
		specific verbal order, and prior					
	_	ving signed and returned the					
		n of care to authorize all plan					
	of care orders.	1					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157090	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/18/2020
HERITAC	PROVIDER OR SUPPLIEF		429 E.	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 IAPOLIS, IN 46202	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF Review of the plan attending physician care orders on 11-1 review was comple  4. Review of the cl evidenced a start of contained a plan of	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION of care failed to evidence the had signed the written plan of 8-2020, when the clinical record red. inical record for patient #8, care date of 9-6-18, and care for the certification period , with orders for SN, PT, and OT	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	assessment, dated 9 AA, a registered nu attending physician the completion of the and identified paties clinical record faile for SN, PT, and OT furnished care on 9 The PT furnished care OT furnished care of OT furnished care of	of care OASIS/comprehensive 16-18, by former employee 16-18, by former employee 17-18, failed to evidence the 18-18 had been contacted related to 18-18 needs. Review of the 19-18 needs. Review of the 19-18 needs order orders. The SN 19-18, 9-25, and 9-30-2018 needs on 9-19 and 10-5-18. The 19-18 needs of 9-25-18. The SN, PT, and 19-18 needs of 9-25-18 needs of			
	attending physician developed plan of c 5. Review of patier start of care (SOC) care (POC) for 10/7 revealed orders for week for one week for three months an needed) for catheter therapy (PT) once a of 10/12 (sic) and o	of care evidenced the had signed the fully are on 10-8-2018.  In #6 clinical record revealed a date of 10/7/2020, and a plan of 1/2020 to 11/16/2020. The POC skilled nursing (SN) once a (for SOC) then once a month d twice a week PRN (as complication, physical week for one week, eval week ccupational therapy (OT) once k then twice a week for three			

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i '		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		157090	B. W	ING		11/18	/2020
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
					/ERMONT ST, SUITE 110		
HEKITAC	GE HOME HEALTH	SEKVICES LLC		INDIAN	APOLIS, IN 46202		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG			DATE
	The POC was digital	ally signed by the admitting					
	nurse on 10/7/2020	in the EMR field "Nurse					
		of Verbal SOC Where					
		OC was signed by the primary					
		on 10/30/2020. Review of					
		ed to evidence verbal orders					
		written down, read back and the attending physician for					
		or orders for SN, PT, and OT.					
	8	,,					
	The patient received	d OT services on 10/8, 10/13,					
		, and 10/27/2020, without the					
		ined specific SOC orders and					
	-	physician's signature on the					
	POC.						
	The patient received	d SN services on 10/28/2020,					
	-	having obtained specific SOC					
		obtaining a physician's					
	signature on the PO	C.					
	6 Davis	at #0 alimical magard1-1 -					
	-	nt #9 clinical record revealed a 020, and a POC for the					
		of 8/31/2020 to 10/29/2020.					
		orders for SN once a week for					
		e a week for one week then					
	twice a week for for	ur weeks, and OT once a week					
		(sic) times a week for one week					
	and once a week for	r two weeks.					
	The POC was disite	ally signed by the admitting					
	_	, in the EMR field "Nurse					
		of Verbal SOC Where					
	Applicable."						
		cal record failed to evidence					
	-	lisciplines, frequency, and care					
		and OT. At the date of survey					
	exit, the plan of car	e had not been signed by the					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		157090	B. WI	NG		11/18	/2020
		l .	<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			VERMONT ST, SUITE 110		
HEDITA	GE HOME HEALTH	SERVICES LLC			APOLIS, IN 46202		
HEIMIA				INDIAN	Al OLIO, IIV 40202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	attending physician						
	•	nt #1 clinical record revealed a					
	start of care (SOC) date of 10/11/2020, and a plan						
		0/11/2020 to 12/09/2020. The					
		rs for skilled nursing (SN) once					
		x, physical therapy (PT) once a					
		and then twice a week for					1
		ccupational therapy (OT)					
	twice a week for eig	gnt week.					
	The DOC 41-14	ally signed by the admitting					
	_	0 in the EMR field "Nurse					
		of Verbal SOC Where					
	-	OC was not signed by the					
		ler (PCP). Review of physician					
	1	ence verbal orders had been					
		own, read back and verified,					
	and sent to the atter						
		or orders for SN, PT, and OT.					
	Souther signature is	101 01 01 01 01 01 01 01					
	The patient received	d OT services on 10/12, 10/20,					
	_	s, and 11/03/2020, 11/04/2020					
	without the agency	having obtained specific SOC					
	orders and prior to	obtaining a physician's					
	signature on the PC	OC.					
	The patient received	d SN services on 10/19/2020,					
	10/26/2020, 11/02/2	202 without the agency having					
	obtained specific So	OC orders and prior to					
	obtaining a physicia	an's signature on the POC.					
		at 3:50 P.M., the nursing					
	_	d the clinical records for the					
	_	elation to start of care					1
	•	de physician authorization of					
		o patients. The nursing					
	^	the above findings and					
		y had begun/continued					
	-	atients based on the clinician					
	assessments and co	ordination of care with the					1

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  157090		A. BUILDING  B. WING	00	COMPLETED 11/18/2020	
	ROVIDER OR SUPPLIER		429 E. \	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 APOLIS, IN 46202	
(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
G 0590 Bldg. 00	physician's office af considered to satisfy obtained verbal order frequencies, and spesupervisor indicated followed the agency verbal orders be door verified, dated and so care orders for discible sent to the attend countersignature. To confirmed the composition of the nursing supervitable physician's plan of cootained days to we furnished, and was to the referral order has request for further pexplanation, or door supervisor stated the vendor had represent Signature and Date care] where applicate and the fully develosigned by the attendiverbal order to authorize was not requested.  410 IAC 17-13-1 (al. 484.60(c)(1)  Promptly alert relevant to the satisfactory of the prophysician(s) to any condition or needs.	ther assessments, which they the requirement of having ters for disciplines, terific care orders. The nursing the agency clinicians had not to policy above, which required toumented, read back and trigned, must contain specific plines with frequencies, and ing physician for the nursing supervisor trehensive assessments were cian for countersignature. sor verified the attending trare signature was often teks after services had been the next physician order after def been received. Upon tertinent information, the nursing te electronic clinical record the diffield locator "Nurse of Verbal SOC [sic start of tole" was signed by a nurse, the ped plan of care was later ting physician, a separate torize the furnishing of the furnishing of the patient's  The nursing the agency clinicians had not to policy above, which required to plines with requeries, and the nursing supervisor the nursing the nursing the next physician order after the next physician record the diffield locator "Nurse to provide the furnishing of the nursing the nurse, the nursing the nurse, the nursing the nursing the nurse, the nursing the nursing the nurse, the nursing the nursing the nurse, the nursing the nursing the nurse, the nursing the nursing the nurse, the nursing the nurse, the nursing the nursing the nurse, the nursing the nurse, the nursing the nurse, the nursing the nursing the nurse, the nursing the nurse, the nursing the nurse	TAG		DATE
	the plan of care sh	ould be altered.	G 0590	/b>	12/16/2020

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157090	B. W	NG		11/18/	/2020
				·			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					VERMONT ST, SUITE 110		
HERITA	GE HOME HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLYDED ON AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		view and interview, the agency			(Patient#9)		
		attending physician was			(i diloneso)		
		e in the patient's condition that			If a patient is being discharge	d for	
	_	rision to the plan of care (POC)			non-compliance, the DC discip		
	for 1 (Patient #9) of 3 closed patient records				will discuss concerns with the	J0	
	reviewed in a sample of 10.				patient/Pt representative, Cas	<b>e</b>	
	reviewed in a sample of 10.				Manager, Physician and Clinic		
	Findings include:				Director in advance prior to Do		
	i mangs merade.				All clinicians have been instru		
	Review of the clinic	cal record for patient #9 was			to document evidence as to w		
		5/2020, for the certification			we feel the patient is	ııy	
	_	to 10/29/2020, with SOC date			non-compliant, evidence barri	are	
	•	Diagnoses included autonomic			related to patient being compli		
	_	al knee osteoarthritis,			and efforts made to overcome		
		pation, tubular adenoma of the			identified barriers. Patient #9	•	
		androme, and obstructive sleep			been discharged from the age		
	-	ent #9 was referred to the				-	
		ary care physician (PCP) for			The Clinical Director spoke to		
					discharging clinician about the	•	
	- '	) for management of			deficiency on 11/23/2020.	_	
	_	dominal pain and pressure,			Clinician stated the patient and		
	and for physical the	erapy (PT) for inability to walk.			her daughter agreed for the D		
	Daviass of a mbrosia	ionla and an data d 0/2/2020 tha			take pace because she did no	L	
		ian's order dated 9/3/2020 the			want to perform the HEP as		
		equest to delay initial PT			directed and the patient did no		
		/2020. On 9/9/2020 the patient's			want to work on any further go		
		nested that the initial PT			with therapy. MD was notified		
		eduled. Initial PT evaluation			the agency DC by the dischar	ging	
	•	0/14/2020. Subsequent visits			clinician with MD approval to		
	were completed on	10/2/2020 and 10/7/2020.			perform the DC.		
	D C DT :	1 . 10/14/2020			01: 1 5: 1 31 1:		
		it note dated 9/14/2020			Clinical Director will audit eve	-	
		goals were including			discharge chart discharged as	i	
	_	ength of lower extremities,			non-compliant for 1 month to		
	_	improved gait, and transfer			ensure documentation contain	IS	
		reported limitations to			the barriers related to patient		
		re the inability to stand fully			being compliant and efforts ma		
	upright and knee pain Patient stated goals were to				to overcome any identified bar	riers	
	" be able to walk	turther"			is discharged based on		
					non-compliance concerns to		
	Review of a PT visit note dated 10/2/2020				ensure there is supportive		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMP		COMPL	ETED
		157090	B. W	NG		11/18/	2020
				CTD FET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP COD		
LIEDITA	DE LIGNE LIENT TH	050/4050110			VERMONT ST, SUITE 110		
HERITAG	GE HOME HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46202		
(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' DEFICIENCY)	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	evidenced Employe	e G's documentation regarding			documentation that shows		
	patient #9's respons	e to treatment " unsure of			evidence Based on further cha	ırt	
	how often patient is	compliant with HEP (home			reviews, agency has not occur	red	
	exercise program).	Goals remained unchanged			the same deficiency yet. 100		
	from the PT evaluat	tion on 9/14/2020." The PT			compliance to be achieved on		
	visit note failed to e	evidence what the HEP was,			1/15/2021 or before.		
	failed to evidence w	why employee G felt that the					
		ppliant with the HEP, and failed			Ongoing chart review during (	QAPI	
	to evidence barriers	related to patient being			every 3 months. Ongoing		
	compliant with the				in-services including all staff		
					mandatory in-service on 12/9/2	2020	
	Review of PT visit	note dated 10/7/2020 evidenced			and 12/16/2020 to go over this	;	
	employee G's docur	mentation regarding patient			deficiency to prevent this		
	#9's response to treatment " self-limiting				deficiency in the future.		
	behavior affecting p	patient's ability to have more			j		
	independence in mo	obility " and " patient was					
	1 -	nt with physical therapy and did			The Administrator and Clinical		
		ficient compliance during			Director of Home Health Care		
	sessions to justify for	urther skilled care " Goals			services will be responsible for	-	
	remained unchange	d from the PT evaluation on			monitoring these corrective		
	9/14/2020. The PT	visit note failed to evidence			actions to ensure that this		
	what the HEP was,	failed to evidence why			deficiency is corrected and wil	not	
	employee G felt pat	tient #9 was not compliant with			recur. Completion date of		
	the HEP, and failed	to evidence barriers related to			12/16/2020.		
	patient being compl	liant with the HEP and efforts					
	made to overcome a	any identified barriers. One					
	goal was documente	ed as being met: transfer					
	safety training. Goa	als of improving strength of					
	the lower extremitie	es, improving gait, and					
	improving balance	were documented by employee					
	G as not being met.						
	Review of the clinic	cal record failed to evidence					
	documentation that	employee G had notified the					
		abilities to meet goals, failed to					
	evidence documentation of efforts to modify						
	interventions in order to obtain desired outcomes,						
	and failed to evidence documentation of a consult						
	with the PCP prior	to discharging the patient due					
	_	nation patient #9 was unable					
	w agency's determin	nation patient #3 was unable	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		157090	B. W	NG		11/18/	2020
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			429 E. \	VERMONT ST, SUITE 110		
HERITAG	SE HOME HEALTH	SERVICES LLC	_	INDIAN	APOLIS, IN 46202		
(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)	ΓΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	to achieve goals.						
	During an interview	with the DON on 11/18/2020					
	-	t #9's discharge from therapy					
	-	l lack of documentation of					
		pliance were reviewed as well					
		nentation of attempts to					
		rder to meet the patient's					
	needs. The DON st	ated the documentation of the					
	physical therapist du	uring visits on 9/14/, 10/2, and					
	10/7 were adequate.						
	410 IAC 17-13-1(a)	(2)					
G 0598	484.60(c)(3)(ii)						
0 0000	Discharge plans of	ommunication					
Bldg. 00		elated to plans for the					
J	• •	e must be communicated to					
		entative, caregiver, all					
		orders for the HHA plan of					
	care, and the patie	· · · · · · · · · · · · · · · · · · ·					
	practitioner or other	er health care professional					
	who will be respon	nsible for providing care and					
	services to the pat	tient after discharge from					
	the HHA (if any).						
			G 0	598	G-0598 Discharge Plans		12/16/2020
		riew and interview, the agency			Communication		
		sions to the discharge plan			If patient is being discharged for		
		to the patient and/or			non-compliance, the dischargi	-	
		ry care physician (PCP) prior atient in 1 (Patient #9) of 3			clinician will discuss compliand	е	
		ds reviewed in a sample of 10.			concerns and any barriers to compliance of POC with		
	ciosed patient record	ds reviewed in a sample of 10.			the patient/Pt Representative i	f	
	Findings include:				applicable, Case Manager and		
	i mamga meraac.				Clinical Director and Physician		
	Review of the clinic	cal record for patient #9 was			prior to discharge. This will be		
		/2020 for the certification			evident by documentation in		
	-	to 10/29/2020, with SOC date			the patient's chart. All cliniciar	าร	
	-	iagnoses included autonomic			have been instructed to docum		
	neuropathy, bilatera	l knee osteoarthritis,			evidence as to why we feel the	•	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		157090	B. W	ING		11/18/	2020
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			VERMONT ST, SUITE 110		
HERITAG	SE HOME HEALTH	SERVICES LLC			IAPOLIS, IN 46202		
			1		,		are.
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		a LSC IDENTIFYING INFORMATION pation, tubular adenoma of the	-	TAG	patient is non-compliant, evide	nnoo	DATE
					•		
	colon, sick sinus syndrome, and obstructive sleep apnea (OSA). Patient was referred to the agency				barriers related to patient bein	-	
		physician (PCP) for skilled			compliant and efforts made to		
		anagement of constipation and			overcome any identified		
	- · ·	-			barriers. This deficiency was		
		pressure, and for physical			discussed with all clinicians or		
	therapy (PT) for ina	ionity to wark.			12/16/2020 at all staff mandat	-	
	Davious cf411' '	cal magain for matical #0			post survey in-service. Based		
	Review of the clinical record for patient #9				further chart reviews, agency		
	evidenced that the patient received three PT visits				not occurred the same deficie	•	
	on 9/14/2020 for admission, 10/2/2020 for a				finding. All clinicians must rep		
	follow-up visit, and on 10/4/2020 for a discharge				and document non- compliand		
	visit.				concerns with the treating teal		
	D: £41- DT :-	Later 1			prior to discontinuing service(s	•	
		nitial evaluation note dated			there is a non-compliance con		
		d documentation by employee			that arises, the clinician will no	otity	
		n as "To self-care when goals			the Case Manager,		
	met."				Clinical Director and		
	D:				Physician immediately after	l	
		it note evidenced a follow up			discussing the concerns with t		
	-	by employee G on 10/2/2020.			patient and Pt Representative	•	
		nented "poor compliance with  I minimal self-initiation			applicable) to work with the pa		
					to identify barriers and modify	ıne	
		expect to discharge patient hysical therapy during next			POC to meet the patient's	on	
	-	ation failed to evidence that			identified goals. Documentation evidence of this communication		
		aregiver were notified of plans			will be added to the chart for	71.1	
		aregiver were notified of plans alled to evidence the PCP			review. If a patient is discharge	and .	
	having been notified					<del>je</del> u	
	naving occir nounce	u.			from the agency due to non-compliance, a complete of	hart	
	Review of a PT vici	it note dated 10/7/2020			audit will be performed by the	ııaıı	
		nt was discharged on			Clinical Director to ensure		
	•	oyee G. Documentation failed			documentation supports evide	nce	
		patient and/or caregiver and			of identified barriers, attempts		
	PCP were notified p	-			made to over come the barrier		
	1 C1 were nounted p	onto to discharge.			and evidence of reporting find		
	The findings were discussed with the Director of				to the Physician. The Clinical	-	
	The findings were discussed with the Director of Nursing (DON) at 2:26 p.m. on 11/18/2020, in				Director spoke to the discharg		
	- ' '	l no further information or			clinician about the deficiency	_	
	documentation to pr				11/23/2020. Clinician stated t		
	aocumentation to pi	ioviuc.	1		T TIZSIZUZU. CIINICIAN SIALEO L	i i C	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157090	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/18/2020				
	ROVIDER OR SUPPLIER		429 E.	STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202					
(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 APPROPRI DEFICIENCY)	5.112				
				patient and her daughter agree for the DC to take pace because he did not want to perform the HEP as directed and the pating did not want to work on any figoals with therapy. MD was notified of the agency DC by discharging clinician with MD approval to perform the DC. Clinical Director will audit ever discharge chart discharged a non-compliant for 1 month to ensure documentation contains the barriers related to patient being compliant and efforts in to overcome any identified by its discharged based on non-compliance concerns to ensure there is supportive documentation that shows evidence Based on further charviews, agency has not occur the same deficiency yet. 10 compliance to be achieved on 1/15/2021 or before. The Administrator and Clinical Direction of Home Health Care services be responsible for monitoring these corrective actions to enthat this deficiency is corrected and will not recur. Completic date of 12/16/2020.	use he ent urther the ery s ns nade arriers  nart urred 0% n rector s will nsure ed				
G 0608	484.60(d)(4) Coordinate care d								
Bldg. 00	needs, and involve	elivery to meet the patient's e the patient, representative piver(s), as appropriate, in f care activities.							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157090	B. W	ING _		11/18/2020	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2			VERMONT ST, SUITE 110		
HERITAC	GE HOME HEALTH	SERVICESTIC			IAPOLIS, IN 46202		
HEINHA				וואטואוו	, ii OLIO, III 70202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
			G 0	608			12/09/2020
		ecord review and interview, the			/b>		
	-	ordinate care delivery to meet			(Patient#7)		
	-	and involve the patients,					
	-	caregiver(s), as appropriate, in			RN Case Manager to coordin		
		care activities ( Patient #7) 1 of			services with active dialysis ce		
	-	l who receive dialysis in a			to include dialysis location and		
	sample of 10.				telephone number, frequency	•	
					of dialysis. This information w		
	The finding include	ed:			be added to the patient's char	t for	
					a clinical review. Intake		
	Review of the clinical record of patient #7, start of				coordinator will call the dialysi	S	
	care date of 10-22-2020 evidenced a plan of care				center to request the following	l	
	for the certification period of 10-22-2020 to				information upon referral		
		included end stage renal		acceptance and document in the			
	-	of care failed to evidenced			chart for RN Case Manager		
		e with a dialysis center for			review: Name of dialysis cent	er,	
	-	eives dialysis on Monday,			location, telephone number, d	ays	
	Wednesday and Fri	day.			and times the patient attends		
					dialysis, renal diet specifics, fl	uid	
		cal record of patient #7, and			restrictions, and request a		
		nts dated 10-18-20, revealed the			medication list for RN review.		
	-	modialysis on Monday,			Patient #7-dialysis center was		
		at the in-center dialysis			called on 11/23/2020 to reque	st	
	facility.				information regarding the dialy		
					location, what days and times	the	
	_	v, on 11/18/20 at 3:15 PM, the			patient attends dialysis, and		
		nursing) no additional			medication list from dialysis		
	_	ven and indicted patient's #7			center. All of the following cor	ntent	
		ted with their (Monday,			has been added to the patient	's	
	Wednesday, Friday	) dialysis schedule.			chart.		
					Clinical Director will audit will		
	410 IAC 17-12-2 (ł	n)			every new dialysis admission	-	
					POC development for 1 month	n to	
					ensure the contents as stated		
					above are included in the pati	ent's	
					chart and dialysis medications	are	
					included on the medication pro	ofile	
					and reconciled with the home		

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	OF CORRECTION	IDENTIFICATION NUMBER  157090	A. BUILDING B. WING	00	COMPLETED  11/18/2020
	ROVIDER OR SUPPLIER		429 E.	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 IAPOLIS, IN 46202	
(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
				medications. Audits will continuation until 100% compliance per modis achieved. 100% compliance estimated to be achieved in 1 month or before. Agency will provide consistent all staff mandatory meetings and train every 3-6 months. Clinical Director to hold an additional meeting with all nursing staff a each case conference on a bi-weekly basis.  All clinical staff have been communicated to follow through on this concern on 12/9/2020. mandatory staff meetings were 12/16/2020.  The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will recur.  Deficiency corrected as of 12/9/2020 however, to be monitored on an ongoing basi during QAPI.  Completion date of 12/9/2020	nue onth e is ings ings after gh All e on al r
G 0682	484.70(a) Infection Prevention	on			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 157090 B. WING 11/18/2020 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 429 E. VERMONT ST, SUITE 110 HERITAGE HOME HEALTH SERVICES LLC INDIANAPOLIS, IN 46202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 00 Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. G 0682 12/16/2020 Based on observation, policy review, and After discussing further with the interview, the agency failed to ensure policies and Case Manager/employee, it was procedures were put into place for Pre-Covid an isolated incident where screening of visitors and failed to ensure they employee was nervous during the followed their policies and procedures in audit visit and did not follow screening patients upon arrival of a home visit for through with the Heritage Policy 1 of 4 home visits conducted. and Procedure of the COVID-19 questionnaire/prescreening The finding included: assessment. The Clinical Director has discussed this specific 1. Record review of the agency's undated policy employee and feels confident that titled, "Heritage Home Health COVID-19 Staff this will not happen again. Clinical Prevention Plan," revealed staff are to perform Director will audit 10 visit notes COVID-19 Prescreening assessment questions as weekly to ensure the covid well as check patient's temperature at the questionnaire and patient/caregiver beginning of the any patient visits. responses are documented in the chart until 100% compliance is 2. Upon entering the agency on 11/09/2020 at 9:30 achieved. Clinical Director will AM, the agency failed to evidence some form of also monitor the infection signage posted at the entrance with visitation prevention practices when restrictions and screening procedures, attending home supervisory visits instructions to individuals seeking medical care with clinicians ensuring the with symptoms of respiratory infection to covid-19 questionnaire is asked to immediately put on a mask and keep it on during the patient/caregiver prior to any their assessment, cover their mouth/ nose when hands-on care is provided. coughing or sneezing, use and dispose of tissue, Clinical Director will also ensure and perform hand hygiene after contact with the clinician is abiding by the respiratory secretions. The agency failed to universal precaution policy actively screen visitors, check for fevers, signs including hand washing, practicing and/or symptoms of respiratory infections, and good bag technique and wearing other criteria such as travel or exposure to appropriate protective wear per COVID-19. agency policy. 3. During a home observation visit on 11/12/2020 After reviewing more charts, this

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	T OF DEFICIENCIES  OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157090	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/18/2020
	ROVIDER OR SUPPLIER		429 E.	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 JAPOLIS, IN 46202	
(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
	agency's policies an the COVID-19 pres toward the end of the During an interview the DON (Director of COVID-19 prescree	or on 11/13/2020 at 11:30 AM, of Nursing) stated the ening assessment questions erformed at the beginning of		deficiency has not been found other employees. The Clinical Director will continue to monit audits and during home supervisory visits to ensure 10 compliance on ongoing basis.  All clinical staff have been communicated to follow through on this concern on 12/9/2020. staff mandatory meetings tool place on 12/16/2020. 100% compliance is expected as of 12/16/2020.  The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this	or  00%  gh All  C
				deficiency is corrected and wi recur. Completion date of 12/16/202	
G 0708 Bldg. 00	Development and care in partnership	evaluation of plan of care evaluation of the plan of o with the patient, any), and caregiver(s);			
	Based on record revenue that the patie were included in the	riew, the agency failed to ent and patient's caregiver e re-evaluation of the plan of tient #9) of 3 closed patient	G 0708	="" span=""> /b>(Patient#9) Agency must show evidence that the patient/Pt representative and physicial were included in Evals and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLET	
		157090	B. W	ING		11/18/20	)20
NAME OF T	PROVIDER OR SUPPLIER	-	-	STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
NAME OF F	NOVIDER OR SUPPLIER	<u> </u>			VERMONT ST, SUITE 110		
HERITAC	GE HOME HEALTH	SERVICES LLC		INDIAN	IAPOLIS, IN 46202		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	F' 1' ' 1 1				Re-evaluations when		
	Findings include:				developing the POC in-regar	ds	
	D-4:4 #0 -1::1				to setting patient specific		
		ecord review was completed on certification period of 8/31/2020			goals. Interventions must		
		Start of care (SOC) date of			reflect the goals set. If a		
					patient is unable to meet the		
	8/31/2020. SOC OASIS (outcome and assessment information set) listed diagnoses including				goals set due to non-compliance or functional	,	
	autonomic neuropathy, bilateral knee				inabilities and or barriers, the		
	osteoarthritis, spondylosis, constipation, tubular				evaluating clinician will	<b>`</b>	
	adenoma of the colon, sick sinus syndrome, and				discuss concerns with the		
	obstructive sleep apnea (OSA). Patient was				patient/Pt representative, Ca	se	
	referred to the agency by the primary care				Manager, Physician and		
	physician (PCP) for skilled nursing (SN) for				Clinical Director in advance		
	1 * • · · ·	stipation and abdominal pain			prior to initiated new goals a	nd	
	_	or physical therapy (PT) for			interventions or discharging		
	inability to walk.				services if required. All		
	·				clinicians have been instruct	ted	
	Review of a PT visi	t note dated 9/14/2020,			to document evidence as to		
	revealed the PT esta	ablished four goals during the			why we feel the patient is		
		g improvement of strength of			non-compliant, evidence		
		mproved balance, improved			barriers related to patient		
		fety training. PT reported			being compliant and efforts		
		ving goals were the inability to			made to overcome any		
		and knee pain. The note			identified barriers on 12/9/20		
		nt #9 goals were to "be able			and 12/16/2020. Patient #9		
	to walk further"				has been discharged from the		
	Daview of a DT	t note dated 10/2/2020			agency. The Clinical Directo	or [	
		as completed on 10/2/2020, by			spoke to the discharging	,	
		oyee G documented regarding			clinician about the deficiency on 11/23/2020. Clinician stat		
		treatment "unsure of how			the patient and her daughter		
		pliant with HEP (home exercise			agreed for the DC to take page		
		mained unchanged from the PT			because she did not want to		
		2020. Employee G's visit note			perform the HEP as directed		
		yhy employee G felt the patient			and the patient did not want		
	was non-compliant and also failed to evidence				work on any further goals wi		
	employee G having spoken with the patient and/or				therapy. MD was notified of		
		d to compliance and			the agency DC by the		
	progression toward	-			discharging clinician with Mi	D	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157090	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/18/2020	
	PROVIDER OR SUPPLIER		429 E.	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 NAPOLIS, IN 46202		
(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 APPROPRI DEFICIENCY)	DATE	
	evidenced the PT di on 10/7/2020, by er documented regardi treatment " self- patient's ability to h mobility " and " compliant with phy demonstrate sufficie sessions to justify fi The clinical record documentation of th work with the paties determine barriers t The findings were conversed.	the PT's/ agency's attempts to not and/or caregiver to ocompliance.  Liscussed with the Director of 12:26 p.m. on 11/18/2020, in In of further information or revoide.		approval to perform the DC Clinical Director will audit every discharge chart discharged as non-compliar for 1 month to ensure documentation contains the barriers related to patient being compliant and efforts made to overcome any identified barriers is discharged based on non-compliance concerns the ensure there is supportive documentation that shows evidence Based on further chart reviews, agency has recurred the same deficient yet.  Clinical Director will audit therapy Re-evaluations were to ensure deficiency does not recur. Clinical Director will continue audits until 100% compliance has been achieved. 100% compliance estimated to be achieved or before 1/15/2021 before.  Ongoing chart review during QAPI every 3 months. Ongoin-services including all state mandatory in-service on 12/9/2020 and 12/16/2020 to over this deficiency in the future.  The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this	not cy sis nor ng poing ff go ent .	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157090	B. W	ING		11/18/	/2020
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			VERMONT ST, SUITE 110		
HERITAC	SE HOME HEALTH	SERVICESTIC			IAPOLIS, IN 46202		
HEINITAG	DE HOWE HEALTH			INDIAN			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					deficiency is corrected and wil		
					recur. Deficiency was correcte		
					as on 12/9/2020. Completion	date	
					of 12/16/2020.		
0.0740	404.75(1.)(0)						
G 0716	484.75(b)(6)						
Dida 00	Preparing clinical						
Bldg. 00	Preparing clinical	notes;		716	CO716 Proposing Clinical Net	.00	12/16/2020
	Događ an ragard ray	view and interview, the	G 0	/16	G0716 Preparing Clinical Not		12/16/2020
	Physical Therapist f				(Pt #1)All visit notes must show		
		their visit notes all teaching			evidence of the skilled teachin and the patient/caregiver resp	-	
		er response to the teaching for			to the teaching. Clinical Direct		
		active records reviewed in a			has discussed this deficiency		
	sample of 10.	ictive records reviewed in a			all clinicals with assured	VVILII	
	sample of 10.				understanding of the deficienc	<b>^</b> \/	
	Findings include:				and how to prevent re-occurre	-	
	i manigs merade.				in the future.	1100	
	During a home visit	t with employee E, (OT,)			Based on further chart reviews	s	
	-	ist, on 11-12- 20 at 10:15 AM,			agency has not occurred the	٠,	
		ed with patient #1 their long			same deficiency yet.		
		ed for a podiatrist referral.			Clinical Director to audit 25%	of all	
		could not afford to go.			visits weekly to ensure deficie		
	Patient #1, who slee	eps on a pull out couch at the			does not reoccur. Auditing to	,	
		ussed with employee E about			continue until 100% is achieve	∍d.	
	DME (durable med	ical equipment), and stated			Ongoing chart review during C	QAPI	
	"This noodle on the	side of the bed railing is wore			every 3 months. Ongoing		
	out."				in-services including all staff		
					mandatory in-service on		
		record on 11-17-20 at 2:30 PM,			12/16/2020 to go over this		
		ote failed to evidenced patient			deficiency to prevent this		
		odiatry suggestion, reason for			deficiency in the future. Clinic		
	_	d failed document patient #1			Director and Administrator will	I	
	durable medical equ	ipment request.			monitor to ensure that the		
					deficient practice will not occu	r.	
		w on 11-17-20, at 3:15 PM, the			Deficiency corrected as of		
	_	stated the physical therapist			12/9/2020, however to be		
		I have been document in the			monitored on an on going bas	is	
	visit narrative.				during QAPI.	_	
					Completion date of 12/16/2020	0.	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		157090	B. WI	NG		11/18/	2020
				CED FEE	ADDRESS STEW STATE STR COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
LIEDITAC	SELIOME LIEM TU	0507/1050110			VERMONT ST, SUITE 110		
HERITAG	SE HOME HEALTH	SERVICES LLC		INDIAN	IAPOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	410 IAC 17-14-1(c)	0(5)					
G 0798	484.80(g)(1)						
	Home health aide	assignments and duties					
Bldg. 00	Standard: Home	health aide assignments					
	and duties.						
	Home health aide	s are assigned to a specific					
		ered nurse or other					
	appropriate skilled	l professional, with written					
	patient care instru	ctions for a home health					
	aide prepared by that registered nurse or other appropriate skilled professional (that is,						
		speech-language					
	pathologist, or occ	cupational therapist).					
			G 0	798	/b>		12/09/2020
	Based on record rev	view and interview, the			(Patient #7)		
	Registered Nurse fa	iled to ensure they included					
	dietary and fluid res	striction on a home health aide			All HHA care plans must inclu	ıde	
	care plan for 1 (Pati	ent #7) of 1 patient record			diet and any applicable fluid		
	review of a patient	receiving dialysis treatments			restrictions. The Clinical Dire	ctor	
	and home health aid	le services in a sample of 10.			has discussed this deficiency	with	
					all clinicians to ensure all HHA	١	
	The finding include	d			care plans must have dietary a	and	
					fluid restrictions noted on the	care	
	Review of the clinic	cal record of patient #7, start of			plans. Patient #7-HHA care p	lan	
		2020 evidenced a plan of care			has been updated by adding t	he	
	for the certification	period of 10-22-2020 to			patient's fluid restrictions and		
	12-2020, diagnoses	included end stage renal			renal diet on 11/23/2020.		
	disease. The home	health aide care plan failed to					
		requirement fluid restriction			Based on further chart		
	as part of patient #7	's renal diet requirement.			reviews, the agency has not h	ad	
					the same deficiency yet. Age	псу	
		tion of care note dated			to continue auditing charts wit		
		ced team conference with DON			HHA services to assure deficie	ency	
		g), employee K, employee J and			is not found.		
		entry failed to evidence patient					
		sis, sodium, diabetic, renal			Clinical Director to audit 25%	or	
		e restriction of 32 ounces per			more of all HHA care plans to		
	24 hours as part of a	renal diet.			ensure deficiency does not		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157090	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 11/18/2020
	PROVIDER OR SUPPLIER		429 E.	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 IAPOLIS, IN 46202	
(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)	BATTE
	PM, Non-Employee in-center dialysis fa have a low sodium,	interview on 11-17-2020 at 2:30 e DD, a Dietitian at patient #7's cility, stated patient #7 was to diabetic, renal diet with a see restriction per 24 hours.		reoccur. Auditing to continue 100% is achieved. Ongoing of review during QAPI every 3 months. 100% compliance is estimated to be achieved on obefore 1/15/2021 or before.	chart
	findings and stated	8:30 PM, DON verified the patient #7's fluid and dietary nave been documented on the re plan.		Ongoing in-services including staff mandatory in-service on 12/16/2020 to go over this deficiency to prevent this deficiency in the future.	g all
	410 IAC 17-14-1(m			The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will recur.  Completion date of 12/9/2020	or II not
G 0848 Bldg. 00	Condition of partice Federal, State, and regulations related patients.  The HHA and its start furnish services in applicable federal regulations related	Federal, State, Local Law sipation: Compliance with d local laws and d to the health and safety of staff must operate and compliance with all state, and local laws and d to the health and safety of r local law provides			
	licensing of HHAs licensed.	, the HHA must be	G 0848	G0848	12/04/2020

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLI	ETED
		157090	B. W	ING		11/18/	2020
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			VERMONT ST, SUITE 110		
HERITAC	GE HOME HEALTH	SERVICES LLC			APOLIS, IN 46202		
(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
	Based on record rev	view, observation, and			Change of Information along v	vith	
	interview, the home	health agency failed to			change in officers ( share		
	disclose a change to	the ownership structure of			purchase and sale as of June		
	the agency at the tir	ne the changes were made			2020) have been submitted to		
	(See G 852;) failed	to disclose to the state agency,			ISDH as of 11/17/20. The rene	ewal	
	the names and addre	esses of all persons involved			application for state license is		
	when the agency ha	d a change in ownership			currently pending with ISDH. A	All	
		4;) failed to disclose a change			the requested or required		
		ctor, and managing agent of the			documents have been		
		at the time the changes were			summited to ISDH ( Attn to		
	· · · · · · · · · · · · · · · · · · ·	and failed to operate a home			Director of Home Health Divisi	ion	
		with a valid state license by			under ISDH) including renewa	ı	
	_	mit a complete renewal			application fee and change of		
		ide the license fee, to renew its			information.		
	license prior to the	expiration date (See G 860.)			Administrator has extensively		
					reviewed all the important		
		ect of these systemic problems			regulations related to		
		nome health agency's inability			Administration for Home Healt	:h	
		ion of quality of care in a safe			Agency on ISDH site including		
		Condition of Participation 42			42CFR484 etc Administrator		
		pliance with Federal, State, and			be up to date with all state and		
	_	lations related to the health			federal policies for Home Hea	lth	
	and safety of patien	ts.			Agency and to ensure to		
					implement them as and when		
		(2) (2) (4) (5)			needed.		
	410 IAC 17-10-1(a)				A Governing body meeting wa		
	410 IAC 17-10-1(c)				called on 12/04/2020 to go over	er all	
	410 IAC 17-10-1(d)				the deficiencies		
	410 IAC 17-10-1(d)				including administrative		
	410 IAC 17-10-1(d)	)(2)(A)(B)(C)			deficiencies. A plan in place to		
					follow through by governing bo	-	
					Administrator to update govern	ning	
					body every 3 to 6 months of		
					upcoming changes of officials		
					license renewals etc. and to fo		
					through as and when needed.		
					waiting for renewed license for	rm	
					ISDH, however all the	[	
					deficiencies rectified on or bef		
					12/4/2020. Completion date	OT TO	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING 00 COMPLET  B. WING 11/18/2			LETED		
	PROVIDER OR SUPPLIEI GE HOME HEALTH			429 E.	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 IAPOLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	TE	(X5) COMPLETION DATE
G 0852 Bldg. 00	Standard: The Hi- following informat agency at the time request for certific at the time of any management:	state survey agency HA also must disclose the ion to the state survey e of the HHA's initial cation, for each survey, and change in ownership or	G 0	852	="" p="">Change of Information along with change in officers (		12/04/2020
	structure of the age were made, 6-1-202 agency.  The findings included buring the survey of 11-9-2020, at 10:30 employee A, indicated owner and officer (agency 6-1-2020, at agency's administrator indices agency of 6-1-2020 person BB was not health agency.  When asked on 11-agency had notified Health) related to the changes in ownership characterized as a contract of the change in information.	entrance conference on O A.M., the administrator, sted having become a new 30% CEO) of the home health and held the position of the ator effective 8-12-2020. The ated another person, person			share purchase and sale as o' June 2020) have been submit to ISDH as of 11/17/20. All the requested or required docume have been summited to ISDH Attn to Director of Home Healt Division under ISDH) including COI.  Administrator has extensively reviewed all the important regulations related to Administration for Home Healt Agency on ISDH site including 42CFR484 etc. Administrator be up to date with all state and federal policies for Home Healt Agency and to ensure to implement them as and when needed. A Governing body meeting was called on 12/04/2 to go over all the deficiencies including administed deficiencies. A plan in place follow through by governing body administrator to update govern body every 3 to 6 months of upcoming changes of officials license renewals etc. and to for	ted e e ents ( th g ealth g r to d ltth 2020 trativ to pody. ning	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157090	B. W	NG		11/18/	2020
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				VERMONT ST, SUITE 110		
LEDITAC	SE HOME HEALTH	SEDVICES LLC			· ·		
HERITAG	BE HOME HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46202		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
					through as and when needed.	This	
	On 11-9-2020, at 4:	29 P.M., review of the IDH			deficiency rectified on or befor	е	
	database failed to ev	vidence the state had been		12/4/2020. Completion date			
	notified of the chang	ges in the home health agency					
	ownership structure	, which occurred on 6-1-2020.					
	410 IAC 17-10-1(d)	•					
G 0854	484.100(a)(1)						
	All persons with ov	wnership interest					
Bldg. 00	The names and ac	ddresses of all persons with					
	an ownership or co	ontrolling interest in the					
	HHA as defined in	§420.20I, §420.202, and					
	§420.206 of this cl	hapter.					
			G 0	854	G-0854		12/04/2020
	Based on interview	and record review, the agency			Change of Information along		
	failed to disclose to	the state agency, the names			with change in officers ( shar	<b>e</b>	
	and addresses of all	persons involved when the			purchase and sale as of June	•	
	agency had a change	e in ownership structure for 1			2020) have been submitted to	)	
	of 1 home health ag	ency.			ISDH as of 11/19/20. All the		
					requested or required		
	The findings include	ed:			documents have		
					been summited to ISDH ( Att	n	
	During the survey e	ntrance conference on			to Director of Home Health		
	11-9-2020, at 10:30	A.M., the administrator,			Division under ISDH) includir	ng	
		ted having become a new 30%			COI. Administrator has		
		CEO) of the home health			extensively reviewed all the		
	agency 6-1-2020, ar	nd held the position of the			important regulations related	l	
	agency's administration	tor effective 8-12-2020. The			to Administration for Home		
	administrator indica	ted another person, person			Health Agency on ISDH site		
	BB, became a new 3	30% owner and			including 42CFR484 etc		
		gent of this home health			Administrator to be up to dat	е	
		. The administrator indicated			with all state and federal		
	-	an employee of the home			policies for Home Health		
	health agency.				Agency and to ensure to		
					implement them as and wher	1	
		10-2020, at 11:50 A.M., if the			needed. A Governing body		
		d Indiana Department of			meeting was called on		
	-	ired documentation related to			12/04/2020 to go over all the		
	the home health age	ency's changes in ownership			deficiencies including admin	ist	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		157090	B. W	ING		11/18/	2020
	PROVIDER OR SUPPLIER GE HOME HEALTH			429 E. \	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 APOLIS, IN 46202		
(X4) ID	SUMMARY S	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	i	LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	information, or as a administrator answer On 11-9-2020, at 4: database failed to evinformed of the characteristics.	29 P.M., review of the IDH vidence the state had been nges in the home health which occurred on 6-1-2020.			rative deficiencies. A plan in place to follow through by governing body. Administrato update governing body every 3 to 6 months of upcoming changes of official license renewals etc. and to follow through with ISDH and CMS as and when needed. The deficiency rectified on or before 12/4/2020. Completion date of 12/4/2020.	tor Is, d his	
G 0856 Bldg. 00	The name and add an officer, a direct employee of the H §420.202, and §42  Based on interview failed to disclose a dand managing agent the time the changes 1 home health agence.  The findings include On 11-9-2020, at 10 entrance conference A, indicated having officer (CEO) of the and held the position administrator effect administrator indicates BB, became a new 3 agency on 6-1-2020	ed:  0:30 A.M., during the survey e, the administrator, employee become a new 30% owner and e home health agency 6-1-2020, n of the agency's ive 8-12-2020. The tted another person, person	G 0	856	G-0856 Change of Information along with change in officers, director, agent, (share purchase and sale as of June 2020) have been submitted to ISDH as of 11/19/20. All the requested or required documents have been summited to ISDH ( Atto Director of Home Health Division under ISDH) includin COI. Administrator has extensively reviewed all the important regulations related to Administration for Home Health Agency on ISDH site including 42CFR484 etc Administrator to be up to dat with all state and federal	e o n ng	12/04/2020

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157090	A. BU B. W		00	COMPLETED 11/18/2020
		157090	B. W.	ING	_	11/16/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	<del></del>	ID	T	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
	agency had notified Health) related to the health agency, whet	10-2020, at 11:50 A.M., if the IDH (Indiana Department of the changes made at the home ther characterized as a change			policies for Home Health Agency and to ensure to implement them as and wher needed. A Governing body meeting was called on 12/04/2020 to go over all the	
		s a change in ownership, the ered, "No." When asked if the			deficiencies including admin	ist
		the IDH of the administrator's			rative deficiencies. A plan in place to follow through by	
	role as managing ov	vner, and officer of the home			governing body. Administra	tor
		dministrator answered, "No." gency had notified IDH			to update governing body	
		anaging agent, officer, and			every 3 to 6 months of upcoming changes of official	le l
	_	f the governing body) of the			license renewals etc. and to	,
	•	, the administrator answered,			follow through with ISDH and	ı
	"No."				CMS as and when needed. TI	nis
	0 11 0 2020 4 4	20 D.M			deficiency rectified on or	
	·	29 P.M., review of the IDH vidence the state had been			before 12/4/2020. Completion date of 12/4/2020.	n
		ges in the home health agency			uate of 12/4/2020.	
	l '	ers/officers/directors which				
		20, except for notification of				
		administrator, approved on				
	8-12-2020.					
	secretary of state we health agency notifichange in principal	2:30 A.M., review of the ebsite evidenced the home ed the secretary of state of address, change in officer, and d officer, on 11-10-2020.				
	410 IAC 17-10-1(d)	)				
	410 IAC 17-10-1(d)					
G 0860	484.100(b)					
_ 5555	Licensing					
Bldg. 00	(b) Standard: Lice	ensing.				
-		ches, and all persons				
	_	s to patients must be				
	licensed, certified,	or registered, as				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		A. BU	(X2) MULTIPLE CONSTRUCTION       (X3) DATE:         A. BUILDING       00       COMPL         B. WING       11/18/			ETED
	PROVIDER OR SUPPLIE GE HOME HEALTH			429 E. \	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 APOLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	(X5) COMPLETION DATE
	applicable, in accilicensing authority requirements.  Based on record re observation, the aghealth agency only having failed to sul application, to inclicense prior to the health agency.  The findings include Review of pre-survible (Indiana Depaagency state license)  During the entrance 10:30 A.M., when had been renewed administrator indicapplication but have mandatory \$250 aprindicated having se \$250 dollars to IDI Health] and that it wrong address. The the agency had application by the agency had a possible by the agency had a pos	ordance with the state y as meeting those  view, interview, and ency failed to operate a home with a valid state license by omit a complete renewal ude the license fee, to renew its expiration date, for 1 of 1 home  ded:  rey documentation from the artment of Health) evidenced the expiration at 10-31-2020.  The conference on 11-9-2020, at queried if the state licensure prior to expiration, the ated having sent in a renewal ing forgotten to include the application fee. The administrator ent the application check for H [Indiana Department of was returned to the agency for the nursing supervisor indicated proximately 107 patients.  The agency had been operating the state of the state of the supervisor indicated proximately 107 patients.	G 0		G-0860  The renewal application for stilicense is currently pending with ISDH as of October 2020. Application Fee was received 11/5/20 or 11/6/20 by ISDH, however not cashed till 11/20/2020. All the requester required documents have been submitted to ISDH (Attn. Director of Home Health Divisunder ISDH) including a chan information. Administrator to update the governing body exto 6 months of upcoming charof license renewals etc. and the follow through as and when needed. At this point, we are waiting for renewed license for ISDH, however everything has been completed or provided the Administrator of Heritage HH rectify this deficiency on or be 12/04/20. This deficiency will rectified 100% once we receivenewal license. The governity body and administrator will be monitoring any upcoming lice renewal every 3-6 months and be stated in the meeting note Any new renewal application be sent at least 60-90 days be the due date and application be reviewed by 1 more board member before mailing out to ensure that there is 100% compliance for any future	with  d or  d or  n to sion nge of wery 3 nges to still orm as by to efore be ve our ing e ense d will es. will efore will	12/04/2020

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 11/18/2020	
	ROVIDER OR SUPPLIER		429 E.	ADDRESS, CITY, STATE, ZIP COD . VERMONT ST, SUITE 110 NAPOLIS, IN 46202	
(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
	having obtained a reagency's state licens			application renewal. Administ and board members will be responsible for monitoring.  ="" p=""> ="" p="">	trator
G 0942 Bldg. 00	functioning) must and responsibility management and all home health se review of the ager operational plans, and performance is Based on record revigoverning body fail policies reviewed with federal and state record revigoverning body fail policies reviewed with federal and state record revigoverning body fail policies reviewed with federal and state record revigoverning body fail policies reviewed with federal and state record for the findings included Review of a policy, undated, evidenced Discharge Planning care patient at the time for home care Pudischarge or transfer continuity of care, the planning for discharge planning for discharge planning for discharge patient's needs for care the planning for discharge planning for discharge patient's needs for care the planning for discharge p	(or designated persons so assume full legal authority for the agency's overall operation, the provision of ervices, fiscal operations, and its quality assessment improvement program.  Tiew and interview, the ed to ensure 3 policies of 20 ere updated to comply with quirements.	G 0942	G-0942 Administrator and governing body have reviewed all the policies and procedures. Administrator ensively reviewed three policies that governing body failed to comply. Administrator has extensively reviewed all current policy and procedure and all the important regulations related to Administration for Home Health Agency on ISDH site including 42CFR484 etc Administrator to be up to dawith all state and federal policies for Home Health Agency and to ensure to	xte ies l es,

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		157090	B. W	ING		11/18/2	2020
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIER	2			VERMONT ST, SUITE 110		
LIEDITAC	SELIOME LIEM TH	CEDVICES II C			· ·		
HERITAG	SE HOME HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 46202		
(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
	and patients are tolo	l in a timely manner of the			implement them as and wher	<u>,                                     </u>	
	need to plan for disc	charge " The governing			needed. A Governing body		
	body failed to ensur	re the agency's policy required		meeting was called on			
	_	nd written notice of discharge,			12/04/2020 to go over all the		
	-	IAC 17-12-2 (i), unless the			deficiencies including all		
		elfare of employees would be			policies and procedures. A		
	-	gnificant risk; the patient			plan in place to follow throug	<sub>ih</sub>	
		e patients' services are no			by governing	,	
		e; or the patient no longer			body. Administrator to upda	te	
	_	iteriasuch as having an			governing body every 3 to 6		
	attending physician	_			months to review all policy a	nd	
	81 7				procedures and upcoming		
	Review of a policy.	"Physicians Orders," undated,			changes of license renewals		
		y stated, "When the nurse or			etc. and to follow through as		
	-	verbal order from the			and when needed. All		
	-	nall write the order as given			the deficiencies related to		
		der back to the physician			G-0942 are rectified on or		
		erson receiving the order heard			before 12/4/2020. Completion	n	
		rpreted the order correctly.			date of 12/4/2020.	· ·	
	-	all verify the order was taken			uato et 12 1/2020.		
		umenting this on the form and					
		The order must include the date,					
		gned will the full name and title					
	_	ring the order and be sent to					
		gnature " The governing					
		re the agency's policy required					
		r be documented on the verbal					
		standard of practice for verbal					
	orders in the clinica	-					
	Review of a policy.	"Plan of Care," undated,					
		y failed to require the plan of					
	-	ients' risk for emergency					
	_	nd hospital re-admission;					
	_	cognitive status, and					
	_	to any advance directives; as					
		regulations. The governing					
		gency's policy listed all the					
		the plan of care. The					
	_	ed to ensure the home health					
	governing body fail	ed to ensure the nome nearth					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157090	B. W	NG		11/18/	2020
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER						
UEDITA <i>C</i>	SE HOME HEALTH	SEDVICES LLC		429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202			
HERITAG	BE HOME HEALTH	SERVICES LLC		INDIAN	APOLIS, IN 40202		
(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	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. =	DATE
	agency updated all r	required policies to be in					
	compliance with fee	leral and state requirements.					
	On 11-18-2020, at 3	3:15 P.M., the administrator					
	verified the above fi	indings.					
	410 IAC 17-12-1(b)	)					
G 0946	484.105(b)(1)(i)						
	Administrator appo	pinted by governing body					
Bldg. 00	(i) Be appointed by	y and report to the					
	governing body;						
			G 0	946	G-0946		12/04/2020
		riew and interview, the			Administrator and governing b	ody	
		to recognize and report to the			have reviewed all the policies	and	
		need for the home health			procedures. Administrator exte	ensiv	
	agency to update 3 of	of 20 policies reviewed.			ely reviewed three policies of 2		
					policies that governing body fa	iled	
	The findings include	ed:			to comply. Administrator		
					acknowledged the 15 days of		
		"Patient Discharge Process,"			verbal and written policy to bo		
		the policy stated, "Policy			and ensure that policy is being		
		is initiated for every home			implemented in 100% complia		
	-	me of the patient's admission			as of 12/1/2020. Administrate	or	
		rpose To facilitate patient's			has extensively reviewed all		
	•	r to another entity. To ensure			current policy and procedure	95,	
		reatment, and services when			and all the important		
		collaboration with the			regulations related		
		imily and other disciplines in			to Administration for Home		
		ge from the agency			Health Agency on ISDH site		
		ontinuing care to meet plogical needs are identified			including 42CFR484 etc	•	
		l in a timely manner of the			Administrator to be up to dat	E	
	-	charge " The administrator			with all state and federal policies for Home Health		
	-	and report to the governing					
	•	olicy should have required 15			Agency and to ensure to implement them as and wher		
		vritten notice of discharge, as			needed. A Governing body	•	
	-	C 17-12-2 (i), unless the health			meeting was called on		
		of employees would be at			12/04/2020 to go over all the		
	-	ificant risk; the patient refuses			deficiencies including all		
	miniculate and sign	meant risk, the patient refuses			denote notes including all		

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		157090	B. W			11/18/	
				_	_		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					VERMONT ST, SUITE 110		
HERITA	GE HOME HEALTH	SERVICES LLC		INDIAN.	APOLIS, IN 46202		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		ts' services are no longer			policies and procedures. A		
	_	e patient no longer meets			plan in place to follow through	nh	
	·	such as having an attending			by governing	···	
	physician.	such as having an according			body. Administrator to upda	to	
	physician.				governing body every 3 to 6		
	Review of a policy	, "Physicians Orders," undated,			months to review all policy a	nd	
		y stated, "When the nurse or			procedures and upcoming	iiu	
		verbal order from the			changes of license renewals		
	•	hall write the order as given			etc. and to follow through as		
		rder back to the physician			and when needed. All		
		erson receiving the order heard			the deficiencies related to		
		erpreted the order correctly.			G-0942 are rectified on or		
	-	all verify the order was taken				_	
		umenting this on the form and			before 12/4/2020. Completion date of 12/4/2020.	"	
	_	The order must include the date,			date of 12/4/2020.		
		igned will the full name and title					
	_	-					
		ving the order and be sent to					
		gnature " The administrator					
	_	and report to the governing					
	-	sure the agency's policy					
	_	f the order be documented on					
		recognized standard of practice					
	for verbal orders in	the clinical record.					
		, "Plan of Care," undated,					
	_	y failed to require the plan of					
	_	tients' risk for emergency					
	_	nd hospital re-admission;					
	_	cognitive status, and					
		to any advance directives; as					
		regulations. The administrator					
	_	and report to the governing					
		ent for the agency's policy to					
	•	elements for the content of the					
	plan of care.						
		3:15 P.M., the administrator					
	verified the above f	findings.					
	410 IAC 17-12-1(b)	)(1)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 11/18/2020	
	PROVIDER OR SUPPLIER GE HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202			
(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 APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
	REGULATORY OR  484.105(b)(1)(ii) Responsible for al (ii) Be responsible operations of the last operations of the last operations of the agrain of the last operation of the agrain operation of the last operation of the agrain operation of the last operation of the	I day-to-day operations for all day-to-day HA; riew and interview, the to ensure day to day ency could continue with a by having failed to timely ry fee with the state licensure wal, for 1 of 1 home health ed:  escription of the administrator, by employee A on 8-1-2020, cluded, but were not limited to acy complies with all state, my policies for operating a	G 09	TAG	CROSS-REFERENCED TO THE APPROPRI	ATE	
	for the fee to the ID Health] and that the agency for wrong as supervisor indicated	H (Indiana Department of envelope was returned to the ddress. The nursing I the agency had patients between the parent					

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r í		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157090	A. BU B. W.		00	11/18/	
		107000	D. 11		A PARAGO CITILI CTATE TIA COR	11/10/	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110		
HERITAG	SE HOME HEALTH	SERVICES LLC	_		APOLIS, IN 46202		
(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
G 0974 Bldg. 00	As of 11-9-2020, the without a state licent previously issued lied. During observation 9:18 A.M., the agent observed posted and of 10-31-2020.  At the time of the extra agency is state licents agency is state licents agency had been opticate license.  410 IAC 17-10-1(a) 410 IAC 17-10-1(c) 410 IAC 17-12-6  484.105(d)(2) Direct support and The parent HHA padministrative control Based on record revolucation of the home exercise its supervisimonitor, and take control the control of the	e agency had been operating ase for 9 days, because the cense expired on 10-31-2020.  of the lobby on 11-17-2020, at acy's state license was devidenced an expiration date an expiration date are devidenced an expiration date an expiration date are devidenced an expiration date.  On 11-18-2020, the devidence devidence days without a devidence days without a device devidence date and days without a devidence date of the parent devidence date and interview, the parent devidence date date are devidenced at the branch office, of 2 lab orders at the start of and 1 out of 1 referral (Patient dage therapy, not to be devidenced at the date of	G 0	974	G 0974-Directive Support and Administrative Control="" p="" Clinical Director will monitor a referrals. QA RN will audit chat time of POC completion to ensure deficiency is not re-occurrent. Clinical Director audit 25% or more of all new admissions until 100% compliance is achieved. Clinic Director, Administrator and Int Coordinator. They will monito these corrective actions to ensure deficiencies are corrected.	> all art will cal take r sure	12/04/2020

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/18/2020		
	PROVIDER OR SUPPLIEF			429 E. \	ADDRESS, CITY, STATE, ZIP COD VERMONT ST, SUITE 110 APOLIS, IN 46202		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	1. Review of the clevidenced a start of contained a plan of of 10-11-20 to 12-0 physical therapy (Property of the refer revealed physical therapy (OT,) speech health aide (HHA,)  During an interview DON (Director of Property of the clevidenced a start of contained a plan of of 9-17-20 to 11-12 and labs. The computated 9-17-20 and 9-17-20 failed to experformed lab draw Review of referral chome care order for the contained and the intake plabs were not drawn speech language party of the clevidenced as the computation of th	inical record of patient # 1, Care date of 10-11-20, and care for the certification period 19-20, with skilled nursing (SN,) T,) occupational therapy (OT,) ral order, dated 10-05-20, herapy (PT,) occupational the therapy (ST,) and home  of on 11/13/20 at 3:00 PM, the Sursing) verified all disciplines in the plan of care.  inical record of patient # 5, Care date of 9-17-20, and care for the certification period 5-20, with skilled nursing (SN,) rehensive assessment / OASIS care coordination noted dated ridence that Employee C, on admission.  order, dated 9-10-20, revealed TSN and labs.  3:15 P.M., the above missed reviewed with the DON who in location in Martinsville process for the above patient, in and run as ordered, and the thologist had not yet levaluation as ordered.		TAG	and will not reoccur. All proto are in place as of 12/1/2020. Completion date of 12/4/2020.		DATE
G 1010	484.110(a) Contents of clinica	al record					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  11/18/2020			
NAME OF PROVIDER OR SUPPLIER HERITAGE HOME HEALTH SERVICES LLC			-	STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202				
(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	
Bldg. 00	Standard: Contented record must include Based on record revito ensure the clinical documentation with attempt to obtain a fresponse/ denial records revier active records revier Findings include:  During a home visito occupational therape employee E discuss toe nails and the new Patient #1 stated he During the interview employee E was que involvement. Employee E was que involvement. Employee E was admitted record failed to evidabout the agency's a Social Worker service.  During the interview about the interview of the properties of the social worker will be but no additional into the patient #1 has stated pati	ts of clinical record. The le:  iew and interview, the agency 1 record contained in a patient record of their Medical Social Worker and the eived for 1 (Patient #1) of 7 wed in a sample of 10.  with employee E, (OT,) ist, on 11-12- 20 at 10:15 AM, ed with patient #1 their long ed for a podiatrist referral. could not afford to go.  v on 11-12-20 at 10:25 AM, eried about social work oyee E indicated a request was ut was not approved.  for patient #1 evidenced the d on 10-11-20. The clinical lence any documentation ttempt to obtain Medical	G 10		/b> (Patient #1)  By educating and training all clinical staff to follow through, document and communicate with the team members when they observe needs to add addition disciplines services that need be addressed by HHA. Additional discipline orders to be comple on a physician's order and approved by the Clinical Direct then immediately schedule the evaluation. Patient #1 was discussed with the clinical teat that was providing direct care the patient on 11/23/2020. The case Manager and OT decide MSW was not indicated at this time because the caregiver declined needs assessment be MSW. Patient has been discharged from the agency. Clinical Director will audit 10 wonotes weekly to ensure any clinical status change in care and or additional service needs are reported to the Case Manager Clinical Director, Physician an representative when applicable Clinical Director will continue and until 100% compliance is achieved. 100% compliance to achieved on or before 1/15/20	nal to onal ted  ctor e m to ne d s y risit and e f, d Pt e audit	12/16/2020	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157090		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/18/2020		
NAME OF PROVIDER OR SUPPLIER HERITAGE HOME HEALTH SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202				
(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	
				Agency will provide consistent staff mandatory meetings and trainings every 3-6 months. The Administrator and Clinical Director of Home Health Care services will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will recur.  Completion date of 12/16/2020	r I not	
N 0000 Bldg. 00	This visit was for a State Re-licensure survey. A complaint investigation was conducted in conjunction with the State Re-licensure survey.  Complaint #: IN 00273503; Substantiated; no deficiencies were cited.  Survey Dates: 11-9, 11-10, 11-12, 11-13, 11-16, 11-17, and 11-18-2020  Facility #: 005294  CCN: 157090  Medicaid #: 200805010  Census unduplicated for prior 12 months: 426		N 0000	N 518 Patient Rights #1 Agency has now added the State Dept of Health Advance Directives 11/1/2018 to the SC packets effective 11/20/2020. #2 Agency will follow up in the QAPI meetings every quarter ensure this deficiency does no occur in the future. #3 Clinical Director and Administrator will directly mon and be responsible for #1 and #4 Deficiency has already bee corrected by 11/20/2020.	to ot itor #2.	
	Current census: Ski Indianapolis parent:					

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157090	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED  11/18/2020		
NAME OF PROVIDER OR SUPPLIER HERITAGE HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
N 0518 Bldg. 00	Martinsville branch  Total Skilled patien  Patients who receive services or personal  Home Visits with C  Clinical record revie  Clinical record revie  Total Clinical Record  Quality Review Cord  3  410 IAC 17-12-3(e)  Patient Rights  Rule 12 Sec. 3(e)  (e) The home he and distribute writt patient, in advance on advance direction of applicable state agency may furnise information to a pathome visit, as long furnished before compared to inform patient and the state of application of current Indiana laterials which proof current Indiana laterials	ts: 107  ed home health aide only services only: 0  linical Record Review: 4  ew only Active: 3  ew Closed: 3  rds Reviewed: 10  mpleted on 12/03/2020 by Area  e)  alth agency must inform ten information to the ten, concerning its policies to the en, concerning its policies to the en, including a description law. The home health the advanced directives attent at the time of the first to as the information is	N 0518	N 518 Patient Rights Agency has now added the IN State Dept of Health Advance Directives 11/1/2018 to the SC packets effective 11/20/2020. Agency will follow up in the QA	11/20/2020 OC		
	The findings included:			meetings every quarter to ensi this deficiency does not occur			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157090	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/18/2020		
NAME OF PROVIDER OR SUPPLIER HERITAGE HOME HEALTH SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP COD 429 E. VERMONT ST, SUITE 110 INDIANAPOLIS, IN 46202				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Review of an undated patient admission packet, failed to evidence a complete description of applicable Indiana advance directive law. The agency provided the 7-1-2013 version of "Your Right to Decide." The patient rights materials failed to include updated description of current Indiana law, updated 11-1-2018  On 11-18-2020, at 3:00 PM, the nursing supervisor indicated agency clinicians used the patient admission packet as a guide to advise all agency patients of the current description of Indiana state law in relation to advance directives, and stated the packets in each patient home did not provide the updated information in the 11-1-20218 description of current Indiana advance directive law. The administrator verified the above findings. When queried for any additional pertinent information, explanation, or documentation, the administrator stated having nothing further to present.				the future. Clinical Director and Adminis will directly monitor and be responsible for #1 and #2. Deficiency has already been corrected by 11/20/2020. Completion date of 11/20/202		

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