PRINTED:	08/13/2021
FORM APP	ROVED

OMB NO. 0938-039

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/08/2021 15K023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6855 SHORE TERRACE SUITE 240 HELP AT HOME SKILLED CARE INDIANAPOLIS. IN 46254 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE TAG G 0000 Bldg. 00 G 0000 This visit was for a Federal Recertification and State Re-Licensure Survey of a Medicaid Home Health provider in conjunction with 4 complaints. Complaint #: IN 00315933 Unsubstantiated. Complaint #: IN 00307150 Substantiated -Deficiencies were cited. Complaint #: IN 00306992 Unsubstantiated. Complaint #: IN 00285475 Unsubstantiated. Survey Date: 06/29/21, 06/30/21, 07/01/21, 07/02/21, 07/06/21, 07/07/21, and 07/08/21 Facility #: 004966 Provider #: 15K1023 Medicaid #: 200465840 These deficiencies reflects Sate Findings cited in accordance with 410 IAC 17. Quality Review Completed 07/20/2021 by Area 3 G 0528 484.55(c)(1) Health, psychosocial, functional, cognition Bldg. 00 The patient's current health, psychosocial, functional, and cognitive status; G 0528 1. The comprehensive 08/10/2021 Based on observation, record review and assessment was revised on

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.

	R MEDICARE & MEDI		_				MB NO. 0938-0	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>00</b>			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00		PLETED	
		15K023	B. WINC	ú		07/08	3/2021	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
HEI P A	T HOME SKILLED	CARF			HORE TERRACE SUITE 240 APOLIS, IN 46254			
(X4) ID	1	STATEMENT OF DEFICIENCIE		ID	- ,		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETI	
TAG		REGULATORY OR LSC IDENTIFYING INFORMATION			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
TAG				TAG		lized	DATE	
	-	cy failed to evidence the			7/26/2021 to include individua			
	-	sessments provided were			client assessment criteria whi	cn		
	-	rately reflected the patient's patient's current health,			includes complete health,			
					psychosocial, functional and			
		cognitive status in 5 of 13 evod (Batiant #2, 5, 6, 7, 8)			cognition status. All RN Case			
	active records revi	ewed. (Patient #2, 5, 6, 7, 8)			Managers will be educated or			
	Endines Instals				8/3/2021 via virtual team mee	ting		
	Findings Include:				regarding comprehensive			
	1 D				assessment, health,			
		ndated agency policy titled			psychosocial, functional and			
		its/Comprehensive			cognition status, client goals,			
		cy #9.5.1 indicated, "Policy			strengths, and care preferenc	es.		
	-	Each patient admitted by the Agency will have			Administrator improved audit			
		assessments performed and			process of all comprehensive			
		cedure 1. Each patient admitted			assessments to include review	•		
		prehensive assessment. The			Territory Clinical Manager and			
		flect the patient's current health			Area Clinical Manager with tin	-		
		information to demonstrate the			1:1 feedback provided to the I	RN		
		toward achievement of desired			Case Manager after review.			
	outcomes"				Administrator/designee to pro			
	2	1 . 1 1			1:1 coaching and teaching to	RN		
		ndated agency policy titled			Case Manager if continued			
		pdate of the Comprehensive			deficiencies are noted. RN Ca	ase		
		y #9.6.1 indicated, "Policy Each			Managers to complete			
	-	ppropriate reassessments			comprehensive assessment c	on all		
	-	cumentedProcedure 1. The			clients identified in SOD by			
	_	sessmentmust be updated			8/10/2021. Client's physician			
		uently as the patient's			notified of any changes neede			
		Recertification: the last 5			plan of care and an order will	be		
		ays3. Staff will additionally			obtained.			
		ent on an ongoing basis to			2. Administrator/designee will			
	-	roblems and needs as well as to			ensure compliance by tracking	g		
		vided. Such reassessments will			comprehensive assessment			
	be documented'				completion with each			
					recertification and admission			
		visit at patient #2's home on			Medical Record Review form.			
		M, when Employee I, RN case			Training on comprehensive			
		bout pain the patient stated,			assessment completion will be	е		
		lly sore. My back pain has			incorporated into agency			
	improved with me	ds." Patient #2 then showed soft			orientation.			

	R MEDICARE & MEDI						MB NO. 0938-03
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/08/2021	
	PROVIDER OR SUPPLIE			6855 \$	ADDRESS, CITY, STATE, ZIP COD SHORE TERRACE SUITE 240 NAPOLIS, IN 46254	)	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI	N BE	COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	RIATE	DATE
	collar cushion for	neck and demonstrated how she			Administrator/designee will	track	
	moves she lounge	in a better positioned back if			RN Case Manager compre		
	-	regiver of patient #2 stated,			assessment completion, wi		
	-	e a 10 if not for those pain			threshold of 80% compliand		
	-	urther indicated patient had			weeks. Administrator/desig		
	chest pain and had	l to take nitroglycerin twice for			audit 80% of comprehensiv		
	chest pain and pat	ient's blood pressure has been			assessments for 4 weeks.	Once	
	U U	tated, "The chest pain wasn't			threshold of 80% is met, wi	I	
		t and have to take 3 pills before			decrease to 50% audits by		
		hen the RN case manager			Administrator/designee. RN	Case	
	-	last bowel movement, the RN			Managers to continue com	-	
	-	ed the doctor has recently			comprehensive assessmen	ts with	
	added prunes to he	er diet due to constipation.			each recertification/admissi ensure compliance.	on to	
	Review of the rece	ertification comprehensive			3. If thresholds are not met	the	
	assessment dated	05/03/21 indicated "No changes			agency will continue 80% a		
	since last assessme	ent" under psychosocial,			all comprehensive assessm	nents	
	cardiac status, and	fall risk assessment. The			and provide 1:1 coaching to	RN	
	-	sessment failed to evidence the			Case Managers until thresh	old is	
	-	ealth status of cardiac issues			met.		
		tiple medication changes as			4. The deficiency will be		
		21 discontinue Hydralazine 25mg			completed by 8/10/2021.		
		AM, discontinue Hydralazine					
		noon & evening, start					
	· ·	rothiazide) 25mg by mouth at					
		Discontinue HCTZ 25mg tablet					
		scontinue Hydralazine 50 mg by					
		daily, start Hydralazine 25mg by <i>I</i> , stat Hydralazine 50mg by					
		at noon & evening, Start HCTZ ly, on 04/06/21 Hydralazine					
	· ·	ree times daily on 04/06/21, on					
		nue Amlodipine 2.5 mg daily at					
		/21 Discontinued Hydralazine					
		AM Start Hydralazine three					
		omprehensive assessment failed					
		tient's current health status.					
	-	visit with patient #6 on 07/01/21 t stated, "I would like to ride my					

STATEMEN	R MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CON	STRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN		00	COMPLETED	
	or conduction	15K023	B. WING		00		/08/2021
		131(023				07	100/2021
NAME OF I	PROVIDER OR SUPPLIE	R			DRESS, CITY, STATE, ZIP COD	40	
	HOME SKILLED	CARE			DRE TERRACE SUITE 24 POLIS, IN 46254	40	
					OEI3, IN 40234		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFI	IX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE OPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	TAC	ĩ	DEFICIENCY)		DATE
	-	lso want to get my meds					
	-	ey keep sending me so much. I					
	also have to cut do	wn on my fruit. I gained weight					
	and the doctor said	there is a lot of sugar in fruit."					
		d she had issues getting her					
	breathing masks for	r her nighttime machine. When					
	queried about falls	patient indicated she had a fall.					
	Review of the rece	rtification comprehensive					
		05/03/21 indicated, "No					
	changes since last	·					
	-	o status, musculoskeletal					
		hensive assessment failed to					
	-	nt's current health status with					
	-	atus received a new walker and					
		#6 has Cerebral palsy and					
		ses neuro status not					
		mprehensive assessment failed					
		ient's current health status.					
		· · · · 07/02/21 · · 2.20 PM					
		visit on 07/02/21 at 3:30 PM					
		gns on patient's living room					
		ent #7 steps to take when					
	-	voices, and to wear gloves to					
	-	injury. Employee D, RN					
		case manager was not					
		y questions regarding					
		pression. When queried by the					
	-	regarding falls the patient					
		ent #7 had fallen in the					
	**	on water and showed the RN					
	the bruising on left	t leg.					
	The clinical record	of patient #7 was reviewed on					
		aled a start of care date of					
	05/13/20. The reco	rd contained a recertification					
	comprehensive ass	essment dated 05/06/21					
	indicated "no chan						
		clinical findings in					
		o status, musculoskeletal					
	psychosocial, near	o status, museuloskeletai					

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15K023	(X2) MULTIPLE CC A. BUILDING B. WING	A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 07/08/2021	
	PROVIDER OR SUPPLIE THOME SKILLED		6855 SI	ADDRESS, CITY, STATE, ZIP C HORE TERRACE SUITE APOLIS, IN 46254			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETIC	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE	
	status. The compr	ehensive assessment failed to					
	evidence the patie	nt's current health status					
	-	nosis of Bipolar, Schizophrenia,					
		atient #7 indicated has fallen in					
		uses a walker for ambulation.					
		e assessment failed to evidence					
	the patient's current						
	-	were reviewed with the					
		ical manager and alternate					
		rnate clinical manager on					
		PM to 2:10 PM in which they had					
		ation or documentation to					
	provide.						
		ical record of Patient #5, revealed					
		agnoses of Moderate					
		ilities, unsteady gait, HTN					
		nemia, Hypothyroidism,					
		Major Depressive Disorder,					
		ophageal reflux disease),					
		toid Arthritis, and Obesity.					
	· ·	ehensive assessment completed					
		certification period of					
		7/2021; Mental Status was marked					
		le), Psychosocial was not					
	~	lity to cope with altered health					
		d by:" "How does the					
		cial condition affect functional					
	ability and/or safe	ty" was not addressed.					
	A review of comp	prehensive assessment dated					
	06/23/2021 for the	e certification period					
		/2021, diagnoses Epilepsy,					
		Major Depressive Disorder,					
		tis, and GERD were not listed on					
	-	sessment. The Mental Status					
		(not applicable) and					
	Psychosocial was	not completed.					
	During an intervie	ew on 7/1/2021 at 1:50 PM, the					

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 07/08/2021
	PROVIDER OR SUPPLIEF		6855 S	ADDRESS, CITY, STATE, ZIP COD HORE TERRACE SUITE 240 JAPOLIS, IN 46254	
(X4) ID	1	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETIC
	discussed but yet the comprehensive asso well as some psych When asked if a par would the agency e assessment, the adm "Absolutely." 8. A review of clim revealed the patient Pain Syndrome, Dia Obstructive Pulmon Weakness, Degener CHF (Congested H A review of a comp 05/26/2021 for cert 05/30/2021-07/28/2 code for vision was Foot exam, it was c Musculoskeletal, it problem but docum lower extremities re of "How does the p	essment is marked "N/A" as osocial areas were left blank. tient has a mental illness, xpect documentation on the ninistrator responded, ical record of Patient #8, t has Diagnoses of Chronic abetes, COPD (Chronic hary Disease), Generalized rative Disc disease Edema, and eart Failure). orehensive assessment dated ification period 2021, under Sensory status, the a not completed, under Diabetic			
	410 IAC 17-14-1(a	)(1)(A)(B)			
6 0530 Bldg. 00	The patient's street preferences, inclu be used to demor progress toward a	and care preferences ngths, goals, and care ding information that may astrate the patient's achievement of the goals atient and the measurable			
			G 0530	1. The comprehensive	08/10/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/08/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
HELP A	T HOME SKILLED	CARE	INDIAI	NAPOLIS, IN 46254		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLET	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Based on record re	eview and interview, the agency		assessment was revised on		
	failed to ensure co	mprehensive assessments		7/26/2021 to include individual	ized	
	contained patient g	goals, strengths, and care		client assessment criteria whic	h	
	preferences for 12	of 13 active records reviewed.		includes complete health,		
	(Patient #2, 3, 4, 5	, 6, 7, 8, 9, 10, 11, 12, 13)		psychosocial, functional and		
		-		cognition status, goals, patient		
	Findings include:			strengths, and care preference		
	C C			All RN Case Managers will be		
	1. Review of Ager	cy's Policy titled "Initial		educated on 8/3/2021 via virtua	al	
	Ũ	prehensive Assessments"		team meeting regarding		
		ated, "Each patient admitted by		comprehensive assessment,		
	-	ave appropriate initial		health, psychosocial, functiona	4	
		med and documented		and cognition status, client goa		
	-	e Initial Comprehensive		strengths, and care preference		
		cludes:Strengths, goals and		Administrator improved audit	0.	
		ncluding information that may		process of all comprehensive		
	-	trate the patient's progress		assessments to include review	, by	
		nt of the goals identified by the		Territory Clinical Manager and	<i>by</i>	
		rable outcomes identified by the		Area Clinical Manager with tim	elv	
	Agency"	able outcomes identified by the		1:1 feedback provided to the R	-	
	rigency			Case Manager after review.	.1 N	
	2 Review of Age	ncy's Policy titled, "IX		Administrator/designee to prov	ide	
	-	Treatment, and Services (PC),		1:1 coaching and teaching to F		
		ssments/Comprehensive		Case Manager if continued		
		", indicated "Each patient		deficiencies are noted. RN Cas	20	
		gency will have appropriate		Managers to complete		
		performed and documented.		comprehensive assessment or		
		initial comprehensive		clients identified in SOD by		
		cludes, Strengths, goals and		8/10/2021. Client's physician to	n he	
		ncluding information that may		notified of any changes needed		
		trate the patient's progress		plan of care and an order will b		
		nt of the goals identified by the		•	e	
		rable outcomes identified by the		obtained.		
	Agency."	able outcomes identified by the		2. Administrator/designee will		
	Agency.			ensure compliance by tracking		
	2 The alignet 1	and of nations #2 was and -1		comprehensive assessment		
		ord of patient #2 was reviewed		completion with each	_	
		idicated a start of care date of		recertification and admission o	n	
		ord contained a plan of care for		Medical Record Review form.		
		period of 05/05/21 to 07/03/21		Training on comprehensive		
	that indicated diag	noses, Muscle Weakness, Pain		assessment completion will be		

NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUIL		DNSTRUCTION 00	. ,	E SURVEY PLETED
	15K023	B. WING	ù		07/08	3/2021
PROVIDER OR SUPPLIE			6855 S	ADDRESS, CITY, STATE, ZIP C HORE TERRACE SUITE IAPOLIS, IN 46254		
F HOME SKILLED         SUMMARY         (EACH DEFICIENT         REGULATORY O         disorder with psyct         Arthritis, Idiopathi         Restless Leg Synd         Heart Failure, Hyp         Hyperlipidemia.         A review of the rec         assessment dated 0         weaknesses, patient         centered goals.         4. The clinical rec         on 06/30/21 and in         09/17/18. The reco         the recertification p         that indicated diag         IBS (Irritable Bow         Acid Reflux, Chro         Migraines.         A review of the rec         assessment dated 0         patient care prefere         outcomes, and pati         During a home vis         3:00 PM patient sta         stationary bike. I a         [medications] strai         me so much. I also	STATEMENT OF DEFICIENCIE STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION hological factors, Scoliosis, c Progressive Neuropathy, rome, Essential Hypertension, othyroidism, and certification comprehensive 5/03/21, failed to evidence t care preferences, and patient ord of patient #6 was reviewed dicated a start of care date of rd contained a plan of care for beriod of 05/04/21 to 07/02/21 noses, Cerebral Palsy, Epilepsy, el Syndrome), Spastic Bladder, nic Constipation, Arthritis, and certification comprehensive 5/03/21, failed to evidence ences, weaknesses, measurable	PI			RECTION HOULD BE HYPPROPRIATE CY e will track nprehensive n, with oliance for 4 lesignee to ensive eks. Once et, will s by e. RN Case completing sments with mission to met, the D% audits of essments ing to RN preshold is	(X5) COMPLETIO DATE
on 07/30/21 and in 05/13/20. The reco the recertification p that indicated diag Bipolar/Schizophro	ord of patient #7 was reviewed dicated a start of care date of rd contained a plan of care for period of 05/08/21 to 07/06/21 noses, Chronic Pain, enia, Hypothyroidism, GERD al Reflux Disease), History of					

AND PLAN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K023		A. I	BUILDING WING	NSTRUCTION 00	CON	te survey Mpleted 08/2021
NAME OF	PROVIDER OR SUPPLIEF	R			DDRESS, CITY, STATE, ZII		
HELP A	T HOME SKILLED O	CARE		INDIANA	APOLIS, IN 46254		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF C		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	HE APPROPRIATE	COMPLETIO
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY	1	DATE
		ajor Depressive Disorder), less, Arthritis, and Depression.					
	A review of the rec	ertification comprehensive					
		5/06/21, failed to evidence					
	patient care prefere outcomes, and patie	nces, weaknesses, measurable ent centered goals.					
		rd of patient #9 was reviewed					
		licated a start of care date of					
		d contained a plan of care for					
	-	eriod of 05/14/21 to 07/12/21					
	-	oses, Cognitive Impairment,					
	(Gastric Esophagea	eizure disorder, and GERD l Reflux Disease).					
		ertification comprehensive					
		5/10/21, failed to evidence					
		nces, weaknesses, measurable					
	outcomes, and patie	ent centered goals.					
		rd of patient #10 was reviewed					
		licated a start of care date of					
		rd contained a plan of care for					
		eriod of 04/06/21 to 06/04/21					
	-	oses, Altered mental status					
	unspecified, Autisti and Acne.	c disorder, Seizure disorder,					
		ertification comprehensive					
		4/01/21, failed to evidence					
	outcomes, and patie	nces, weaknesses, measurable ent centered goals.					
		rd of patient #11 was reviewed					
		licated a start of care date of					
		l contained a plan of care for					
		eriod of 05/10/21 to 07/08/21					
		oses, Generalized Weakness, Ieart Failure), TIA (Transient					

AND PLAN OF CORRECTION IDENTIFICATION NUM		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>			· · ·	(X3) DATE SURVEY COMPLETED	
		15K023	B. WING			07/08/2021		
	PROVIDER OR SUPPLIE		6	855 SH	DDRESS, CITY, STATE, ZIP CO IORE TERRACE SUITE APOLIS, IN 46254			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			D			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLETIC	
TAG		PR LSC IDENTIFYING INFORMATION	Т	'AG	DEFICIENCY)		DATE	
	Cardiac Dysrhythr	Chronic Pain, Constipation, nia, Pacemaker, GERD (Gastric & Disease), and Overactive						
	Bladder.							
	A review of the re-	certification comprehensive						
		05/07/21, failed to evidence						
	measurable outcor	ences, strengths, weaknesses, nes.						
		ord of patient #3, SOC (start of						
	,	013, was reviewed 06/30/202,.						
		ned a plan of care for a fod of 05/12/2021-07/10/2021.						
	-	ncluded: TIAs' (Transient						
		and cerebral infarction without						
		listory of Falls, HTN, Diabetes sophageal reflux disease,						
		y incontinence, Major						
	-	ler, Chronic Kidney Disease,						
	Stage 3, Anemia, disturbances, and	Gout, Unspecified Speech Constipation.						
		certification assessment dated to evidence patient strengths,						
	goals, and care pre							
		cord of patient #4, SOC						
		eviewed 06/30/2021. The record f care for a recertification period						
	· ·	02/2021. Patient diagnosis						
		Weakness, Gastro-esophageal						
		nout esophagitis, Essential						
		e 2 Diabetes Mellitus, onic Obstructive Pulmonary						
		oid Arthritis, Other Idiopathic						
	peripheral autonor	nic Neuropathy, Urinary						
	Incontinence, Full Shortness of breat	incontinence of feces, and h.						
	A review of recert	ification assessment dated						

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15K023	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			CON	OMB NO. 0938-03 TE SURVEY MPLETED 08/2021
	PROVIDER OR SUPPLIEF			6855 SH	DDRESS, CITY, STATE, ZIP		
				L	APOLIS, IN 46254		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX	CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETIC DATE
TAG	1	to evidence patient strengths,		TAG			DATE
	goals, and care pref						
	11. The clinical rec	ord of patient #5, SOC					
		viewed 06/30/2021. The record					
	contained a plan of	care for a recertification period					
		7/2021. Patient diagnosis					
		e Intellectual Disabilities,					
	-	N (Hypertension), Anemia,					
		ancer, Hypothyroidism, GERD					
		reflux disease), Anxiety					
	Disorder, Major De	pressive Disorder.					
		ertification comprehensive					
		6/23/2021, failed to evidence					
	patient strengths, go	bals, and care preferences.					
	12. The clinical red	cord of patient #8, SOC					
		viewed 06/30/2021. The record					
		care for a recertification period					
	of 05/30/2021-07/2	8/2021. Patient diagnosis					
	included: Chronic	Pain, Type 2 DM (Diabetes					
		Chronic Obstructive Pulmonary					
	Disease), and Muse	ele Weakness.					
		ertification comprehensive					
		5/26/2021, failed to evidence					
	patient strengths, go	oals, and care preferences.					
		cord of patient #12, SOC					
		viewed 07/06/2021. The record					
	-	care for a recertification period					
		4/2021. Patient diagnosis					
		Back Pain, Chronic Obstructive					
	Pulmonary Disease Dysphasia, and Dia	, End Stage Renal Disease, betes.					
	A review of the rec	ertification comprehensive					
		5/04/2021, failed to evidence					
	patient strengths, g						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15K023 B. WING 07/08/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6855 SHORE TERRACE SUITE 240 HELP AT HOME SKILLED CARE INDIANAPOLIS, IN 46254 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 14. The clinical record of patient #13, SOC 03/10/2020, was reviewed 07/06/2021. The record contained a plan of care for a recertification period of 05/04/2021-07/02/2021. Patient diagnosis included: CVA (Cardiac Vascular Accident) with Right Side Weakness/Paralysis, Diabetes Mellitus, Depression, and Hypertension. A review of the recertification assessment dated 04/30/2021, failed to evidence patient strengths, goals, and care preferences. 15. These findings were reviewed with the administrator/clinical manager and alternate administrator/alternate clinical manager on 07/06/21 at 4:45 PM to 4:30 PM in which they had no further information or documentation to provide. 16. During an interview on 07/07/21 at 4:15 PM, when queried about goals being patient specific/ individualized, an example of patient #6's plan of care indicating, "Patient will maintain medication compliance throughout the cert period" and the patient expressing their goals was to ride their stationary bike, the administrator/clinical manager stated, "Absolutely". G 0572 484.60(a)(1) Plan of care Bldg. 00 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 signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a 746P11 Event ID: Facility ID: 004966 Page 12 of 35 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

08/13/2021

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	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	ULTIPLE C	onstruction 00	COMP	E SURVEY PLETED
		15K023	B. WING			07/08	3/2021
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
HELP A	T HOME SKILLED	CARE			HORE TERRACE SUITE 240 NAPOLIS, IN 46254		
X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	<ul> <li>patient under a p completed until a physician or allow to approve additi original plan.</li> <li>Based on observat interview the agen needs were met by aide services for 2 records reviewed of health aide service care were individu patients (Patient #).</li> <li>Findings Include:</li> <li>Review of an ur of Care-CMS #48: #9.9.1 indicated, " must receive an in including revision individualized plan and services neces patient-specific ne comprehensive ass identification of th measurable outcor occur as a result of coordinating the p furnished in accord of practice"</li> <li>During a home observed poster sig wall that gave pati upset, when hears protect hands from</li> </ul>	lan of care that cannot be fter an evaluation visit, the ved practitioner is consulted ons or modifications to the ion, record review, and cy failed to ensure patient failing to provide home health (Patient #7, 9) out of 12 active of patients receiving home s and failed to ensure all plan of alized for 10 out of 13 active 3, 4, 5, 7, 8, 9, 10, 11, 12, 13). dated agency policy titled "Plan 5 and Physician Orders" Policy Procedure2. Each patient dividualized written plan of care, s or additions. The n of care must specify the care sary to meet the eds as identified in the sessment, including e responsible discipline(s)and nes that Agency anticipates will f implementing and lan of care Services must be dance with accepted standards visit on 07/02/21 at 3:30 PM, gns on patient's living room ent #7 steps to take when voices, and to wear gloves to a injury. The RN case manager regarding falls, in which the	G 0.		1. The comprehensive assessment was revised on 7/26/2021 to include individua client assessment criteria whi includes complete health, psychosocial, functional and cognition status. All RN Case Managers will be educated or 8/3/2021 via virtual team mee regarding comprehensive assessment, client goals, strengths, and care preference Administrator improved audit process of all comprehensive assessments to include review Administrator/designee with ti 1:1 feedback provided to the Case Manager after review. A audit reviews to be completed Medical Record Review form created on 7/29/2021 and tra- per RN Case Manager. Administrator/designee to pro 1:1 coaching and teaching to Case Manager if continued deficiencies are noted. RN Ca Managers to complete comprehensive assessment of clients identified in SOD by 8/10/2021. Client's physician notified of any changes need plan of care and an order will obtained. All RN Case Manager will be educated via virtual tear meeting on 8/3/2021 regardin	ch ting es. w by mely RN ull t on cked RN ase on all to be ed to be lers am	08/10/202

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

Event ID: **746P11** Facility ID: **004966** 

If continuation sheet Page 13 of 35

AND PLAN OF CORRECTION  DENTIFICATION NUMBER 15K023  NAME OF PROVIDER OR SUPPLIER  HELP AT HOME SKILLED CARE  (X4) ID PREFIX (CACH DEFICIENCY MUST BE PRECEDED BY FU TAG  REGULATORY OR LSC IDENTIFYING INFORMAT bathroom, slipped on water, and showed the RN the bruising on left leg. Patient #7 stated, "When am I going to get my showers and aide again, haven't had one since last month?" The RN case manager stated, "We are working on it."  The clinical record of patient #7 was reviewed of 07/30/21 and revealed a start of care date of 05/13/20. The record contained a plan of care for the recertification period of 05/08/21 to 07/06/2 with diagnoses of Chronic Pain, Bipolar/ Schizophrenia, Hypothyroidism, GERD (Gastrie Esophageal Reflux Disease), History of Seizure MDD (Major Depressive Disorder), Generalized Weakness, Arthritis, and Depression.  Review of home health aide visit notes evidence the following: Missed visits awaiting staffing 06/04/21, 06/08/21 to 07/06/21 indicated "Ord for Discipline and Treatments (specify Amount) Frequency/Duration): HHA 1 hr/d, 1-3 days/week x 9 weeks to assist with ADL's and IADL's Measurable Goals and Outcomes: Patient's ADL's and IADL's will be met this cert period with the assistance of the home health aide. The patient's safety will be intended throughout the home care service as evidenced by no injury r/t falls or seizures within the cert period time " The agency failed to evidence at individualized patient care needs and goals and failed to ensure they provided home health aide services as ordered per the plan of care.			CAID SERVICES				OMB NO. 0938-03
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individualized patient care needs and goals and failed to ensure they provided home health aide services as ordered per the plan of care.					completion with each		
failed to ensure they provided home health aide services as ordered per the plan of care.		-			recertification and ac		
services as ordered per the plan of care.					Medical Record Rev		
					Training on compreh		
2 The efficient mean of a first #0 mean inter-			Per die plan of euro.		assessment complet		
1 1 ne clinical record of nation ing was reviewed		3 The clinical reco	ord of natient #9 was reviewed		incorporated into age		
3. The clinical record of patient #9 was reviewed on 07/06/21 and indicated a start of care date of					orientation.	Gilly	
08/30/17. The record contained a plan of care for					Administrator/design		

NT OF DEFICIENCIES OF CORRECTION	x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		СОМ	(X3) DATE SURVEY COMPLETED 07/08/2021	
PROVIDER OR SUPPLIE		6855 \$	i address, city, state, zip c SHORE TERRACE SUITE NAPOLIS, IN 46254			
FHOME SKILLED         SUMMARY (EACH DEFICIE REGULATORY O         the recertification ( that indicated diag Autistic disorder, S         A review of the pla period of 03/15/21 for Discipline and Frequency/ Durati- days/week x 9 wee IADL'sMeasura Patient's ADL's an period with the ass aide. The patient's throughout the hor by no injury r/t fal period of time" evidence individual individualized patient Review of home h the following: Mis 05/05/21, 05/19/21 agency document of Visit Form" indica shifts." The agence aide services as or provide a frequence needs.         4. The clinical record on 07/07/21 and in 02/05/21. The record the recertification	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Deriod of 03/15/21 to 05/13/21 moses, Cognitive Impairment, Beizure disorder, and GERD. an of care for the recertification to 05/13/21 indicated "Orders Treatments (specify Amount/ on): HHA 1-3 h/d, 3-5 ks to assist with ADL's and ble Goals and Outcomes: d IADL's will be met this cert istance of the home health safety will be enhanced ne care service as evidenced ks or seizures within a 60 day The plan of care failed to lized patient care needs and		SHORE TERRACE SUITE NAPOLIS, IN 46254 PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION SP CROSS-REFERENCED TO THE A DEFICIENCY) RN Case Manager com assessment completion threshold of 80% comp weeks. Administrator/d audit 80% of comprehe assessments for 4 wee threshold of 80% is me decrease to 50% audit Administrator/designee Managers to continue of comprehensive assess each recertification/adr ensure compliance. Administrator/designee 80% of meeting minute 1:1 coaching will be pro- office personnel if mee not held per standard. 3. If thresholds are not agency will continue 80 all comprehensive asses and provide 1:1 coachin Case Managers until th met. If meeting minutes completed per standard Administrator/designee 1:1 coaching to office p until standard level is a 4. The deficiency will b completed by 8/10/202	RECTION ROULD BE PPROPRIATE nprehensive n, with pliance for 4 lesignee to ensive ext. Once ets. Once ets. Once ets. Once ets. NN Case completing sments with mission to e to review es per week. oviding to tings are met, the D% audits of essments ing to RN preshold is s are not d, e to provide personnel achieved. e	(X5) COMPLETIC DATE	
and Acne. Review of a plan of period of 04/06/21	ic disorder, Seizure disorder, f care for the recertification to 06/04/21 indicated "Orders Treatments (specify Amount/					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	A. E	MULTIPLE CO BUILDING VING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/08/2021	
NAME OF	PROVIDER OR SUPPLIEF	t			DDRESS, CITY, STATE, ZIP COI IORE TERRACE SUITE 2		
HELP A	T HOME SKILLED C	CARE		INDIAN	APOLIS, IN 46254		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		n): HHA 1-2 hour/visit, 5-7					
	-	ts to assist with ADL's and					
	-	ply bilateral AFO's (Ankle foot					
		t Measurable Goals and ADL's and IADL's will be met					
		the assistance of the home					
	-	ient's safety will be enhanced					
	•	-					
	throughout the home care service as evidenced by no injury r/t falls this cert period of time. The						
		free of injury r/t seizures this					
cer		e plan of care failed to evidence					
	individualized patie						
	-	lualized patient centered goals.					
	on 07/07/21 and ind 10/07/15. The recor- the recertification p that indicated diagn CHF, TIA, Chronic	rd of patient #11 was reviewed licated a start of care date of rd contained a plan of care for eriod of 05/10/21 to 07/08/21 oses, Generalized Weakness, Pain, Constipation, Cardiac maker, GERD, and Overactive					
	Review of a plan of period of 05/10/21 for Discipline and T Frequency/ Duratio (visits)/day, 5-7 day with ADL's and IA Goals and Outcome will be met this cerr the home health aid enhanced throughou evidenced by no inj " The plan of car individualized patie individualized patie 6. The clinical reco care) 07/05/2013, w						

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	ì í	UILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/08/2021	
	PROVIDER OR SUPPLIER			6855 SH	DDRESS, CITY, STATE, ZIP C		
HELP A	F HOME SKILLED C	ARE		INDIAN	APOLIS, IN 46254		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETIO
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	1-07/10/2021. Patient					
	-	TIAs' (Transient Ischemic					
	· · · · · · · · · · · · · · · · · · ·	al infarction without residual					
	-	Falls, HTN (Hypertension),					
	DM (Diabetes Mell						
		reflux disease), Urinary					
		r Depressive Disorder, Chronic					
		ge 3, Anemia, Gout,					
	Unspecified Speech	disturbances, and					
	Constipation.						
	A review of the Hor	me Health Certification/					
	Recertification Plan	of Care dated 05/04/202,					
	revealed orders for	Hha home (health aide					
	services) 1-2 hours/	day, 3-5 days per week for 9					
	weeks to assist with	ADL's(activities of daily					
	living) and IADL's	(instrumental activities of daily					
		rable goals and outcomes					
		ADL's and IADL's will be met					
	-	the assistance of the home					
		's safety will be enhanced					
	e e	are service as evidenced by no					
	-	vithin certification period of					
	time." The agency f						
	-	of care that identifies					
	patient-specific mea	asurable outcomes and goals.					
	9. The clinical reco	ord of patient #4, SOC					
	04/05/2021, was rev	viewed 06/30/2021. The record					
	contained a plan of	care for a recertification period					
	of 06/04/2021-08/02	2/2021. Patient diagnoses					
	included: Muscle V	Veakness, Gastro-esophageal					
		out esophagitis, Essential					
	hypertension, Type	2 Diabetes Mellitus,					
	Fibromyalgia, Chro	nic Obstructive Pulmonary					
		id Arthritis, Other Idiopathic					
	peripheral autonom	ic Neuropathy, Urinary					
	Incontinence, Full i	ncontinence of feces, and					
	Shortness of breath.						
	1						

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	r í	IULTIPLE CON UILDING 'ING	NSTRUCTION 00	CO!	te survey Mpleted 108/2021
	PROVIDER OR SUPPLIEF			6855 SH	DDRESS, CITY, STATE, Z ORE TERRACE SU APOLIS, IN 46254		
	1			<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO	CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO T DEFICIENCY	THE APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCE		DATE
		me Health Certification/					
		n of Care dated 06/02/2021, home health aide services 1-2					
		es a week for 9 weeks to assist					
		DL's. The goals revealed were:					
		at this time". The measurable					
	-	revealed: "The patient's					
	-	nced throughout the home care					
		ed by no injuries from falls					
		f time. Patient's ADL's and					
	-	this certification period with					
		e home health aide. The					
		sure an individualized plan of					
		patient-specific measurable					
	outcomes and goals						
		cord of patient #5, SOC viewed 06/30/2021. The record					
		care for a recertification period					
		7/2021. Patient diagnoses					
		e Intellectual Disabilities,					
		N (Hypertension), Anemia,					
		ancer, Hypothyroidism, GERD					
		reflux disease), Anxiety					
	Disorder, Major De						
	A review of the Ho	me Health					
	Certification/Recer	tification Plan of Care Order					
	dated 06/23/2021, r	evealed orders for Hha (home					
		) 1-3 hours per visit, 1-2 days					
	-	to assist with ADL's and					
		arable goals and outcomes:					
	-	y will be enhanced throughout					
		and IADL's will be met". The					
		sure an individualized plan of					
		patient-specific measurable					
	outcomes and goals	i.					
	11. The clinical rec	cord of patient #8, SOC					
		viewed 06/30/2021. The record					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	AULTIPLE CO	ONSTRUCTION	(X3) DA7	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	r í	BUILDING	00	. ,	IPLETED	
	or conduction	15K023		VING	00	_	)8/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP (	COD		
	PROVIDER OR SUPPLIE			6855 S	HORE TERRACE SUIT			
HELP A	T HOME SKILLED	CARE		INDIAN	IAPOLIS, IN 46254			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COF	RRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	f care for a recertification period						
		28/2021. Patient diagnosis						
		Pain, Type 2 DM (Diabetes						
		Chronic Obstructive Pulmonary						
	Disease), and Mus	cle Weakness.						
	A review of the He	ome Health						
		rtification Plan of Care Order						
		revealed orders for home health						
		our visit, 3-5 days/week x 9						
		ce with ADL's and IADL's. The						
		and outcomes revealed:						
		nd IADL's will be metThe						
		l be enhanced throughout"						
		to ensure an individualized plan						
		ies patient-specific measurable						
	outcomes and goal	ls.						
		ecord of patient #12, SOC						
		eviewed 07/06/2021. The record						
	-	f care for a recertification period						
		04/2021. The Patient diagnoses						
		Back Pain, COPD, End Stage						
	Renal Disease, Dy	sphasia, and DM.						
	A review of the He	ome Health Plan of						
		dated 05/04/2021, revealed						
		ealth aide services 7-8						
	hours/visit, 4-5 day	ys/week x 9 weeks for						
	assistance with AI	DL's and IADL's. Measurable						
	Goals and Outcom	es revealed: "Patient's ADL's						
	and IADL's will be	e metThe patient's safety will						
		failed to ensure an						
		n of care that identifies						
	patient-specific me	easurable outcomes and goals.						
	13. The clinical re	ecord of patient #13, SOC						
		eviewed 07/06/2021. The record						
		f care for a recertification period						
	-	02/2021. Patient diagnosis						

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	î /	UILDING	NSTRUCTION 00	(X3) DA COM	OMB NO. 0938-039 TE SURVEY APLETED 08/2021
	PROVIDER OR SUPPLIEF			6855 SH	DDRESS, CITY, STATE, ZIF IORE TERRACE SUI APOLIS, IN 46254		
(X4) ID	1	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION	N SHOULD BE	COMPLETIO
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO TH DEFICIENCY)		DATE
	included: CVA (Ca	ardiac Vascular Accident) with					
	Right Side Weakne	ss/ Paralysis, Diabetes					
	Mellitus, Depressio	n, and Hypertension.					
	A review of the Ho						
		lated 04/30/2021, revealed alth aide services for 9-11					
		s/week x 9 weeks for					
		L's and IADL's. The Patient/					
		tified Measurable Goals and					
	-	: Patient will remain at current					
		ce through the certification					
	-	rable Goals and Outcomes					
	•	ADL's and IADL's will be					
		safety will be". The agency					
	-	individualized plan of care that					
		ecific measurable outcomes					
	and goals.						
	14 51 61	· • • • • •					
	-	were reviewed with the					
		al manager and alternate					
		ate clinical manager on <i>I</i> to 4:30 PM in which they had					
		ion or documentation to					
	provide.	ion of documentation to					
	410 AC 17-13-1 (a)	)					
0574							
6 0574	484.60(a)(2)(i-xvi)						
Bldg. 00		include the following					
Bidg. 00	the following:	l plan of care must include					
	(i) All pertinent dia	aanoses:					
		nental, psychosocial, and					
	cognitive status;	iona, poyonosooa, anu					
	-	ervices, supplies, and					
	equipment require						
		/ and duration of visits to be					
	made;						
	(v) Prognosis;						1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	(X2) MULTIPL A. BUILDING B. WING	e construction g <u>00</u>	(X3) DATE SURVEY COMPLETED 07/08/2021	
	PROVIDER OR SUPPLIE		685	EET ADDRESS, CITY, STATE, ZIP CO 5 SHORE TERRACE SUITE IANAPOLIS, IN 46254		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIZ TAG	CROSS-REFERENCED TO THE A	IOULD BE	(X5) Completio Date
	<ul> <li>(xi) Safety measu injury;</li> <li>(xii) A description emergency depa re-admission, an to address the ur (xiii) Patient and training to facilita (xiv) Patient-spece education; measu identified by the l (xv) Information n directives; and</li> <li>(xvi) Any addition physician or allow to include.</li> <li>Based on observat interview, the agen individualized plan plan of care includ accurate medication measures, all nece the underlying risk education and train outcomes and goal agency and patient (Patient #2, 3, 4, 5)</li> <li>Findings Include:</li> <li>1. Review of an ur of Care-CMS #483 #9.9.1 indicated, "</li> </ul>	nitations; rmitted;	G 0574	1. The comprehensive assessment was revise 7/26/2021 to include in client assessment crite includes complete heal psychosocial, functiona cognition status. All RM Managers will be educa 8/3/2021 via virtual teal regarding comprehensi assessment, client goa strengths, and care pre Administrator improved process of all comprehe assessments to include Territory Clinical Manager 1:1 feedback provided	dividualized ria which th, al and N Case ated on m meeting ive ls, ferences. I audit ensive e review by ger and with timely to the RN	08/10/202

	R MEDICARE & MEDI				-	AB NO. 0938-0
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	î ź	ESURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00		LETED
		15K023	B. WING		07/08	3/2021
NAME OF	PROVIDER OR SUPPLIE	R		TADDRESS, CITY, STATE, ZIP COD		
		CARE		SHORE TERRACE SUITE 240		
	T HOME SKILLED	CARE	INDIA	NAPOLIS, IN 46254		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	RIATE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	-	s or additions. The		audit reviews to be complete		
	-	n of care must specify the care		Medical Record Review form	۱	
	and services neces	-		created on 7/29/2021 and tra	acked	
	· ·	eds as identified in the		per RN Case Manager.		
	-	essment, including		Administrator/designee to pr	ovide	
		e responsible discipline(s)and		1:1 coaching and teaching to	> RN	
	measurable outcor	nes that Agency anticipates will		Case Manager if continued		
	occur as a result of	f implementing and		deficiencies are noted. RN C	Case	
	coordinating the p	an of care. The individualized		Managers to complete		
	plan of care must s	pecify the patient and caregiver		comprehensive assessment	on all	
	education and train	ning. Services must be		clients identified in SOD by		
	furnished in accord	lance with accepted standards		8/10/2021. Client's physiciar	ı to be	
		e individualized plan of care		notified of any changes need		
	-	ollowing The frequency and		plan of care and an order wi		
		nade A description of the		obtained. All RN Case Mana		
		nergency department visits and		will be educated via virtual te	•	
	-	on, and all necessary		meeting on 8/3/2021 regardi	na	
		dress underlying risk factors		comprehensive plan of care	-	
		nterventions and education,		individualized to the client ar		
	-	nes and goals identified by the		his/her care needs.		
		tient 14. Recertification		Administrator/designee will a	audit	
		de:A revised plan of care		comprehensive plan of care		
	-	t information concerning the		conjunction with comprehensi		
		omprehensive assessment, and		assessment.	5110	
		n the patient's progress toward		Administrator/designee to pr	ovide	
		als identified by the Agency		1:1 coaching and teaching if		
	and patient in the			continued deficiencies are no		
				This includes individualized		
	2 During a home	visit at patient #2's home on		with interventions, individual	0	
		A, when Employee I, RN case		orders consisting of call orde		
		bout pain the patient stated,		and signs/symptoms of disea		
		lly sore. My back pain has		processes to observe. On	200	
		ds." Patient #2 then showed soft		7/27/2021 a meeting templat	te was	
	-	neck and demonstrated how she		created to be utilized weekly		
		in a better positioned back if		all members of the team whi		
	-	-				
	-	M of patient #2 stated, "Her		discusses scheduled new hi		
	-	) if not for those pain pills."		plans for competency evaluation		
		dicated patient had chest pain		open client schedules, nurse		
		roglycerin twice for chest pain		schedules, planned admissio		
	and patient's blood	pressure has been high.	1	and discharges, and grievan	ces	1

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED 07/08/2021	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K023	A. BUILDING B. WING	<u>00</u>		
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
HELP A	T HOME SKILLED	CARE		SHORE TERRACE SUITE 240 NAPOLIS, IN 46254		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Patient #2 stated, "	The chest pain wasn't like I use		needing follow-up.		
		to take 3 pills before when I		Administrator/designee to revie	w	
	had it." When the	RN case manager queried		all meeting minutes on a weekl	у	
		el movement client stated, "I		basis and provide feedback as		
	had one this morni	ng." RN case manager		applicable.		
	indicated the docto	or has recently added prunes to		2. Administrator will ensure		
	her diet due to con	stipation.		compliance by tracking		
				comprehensive assessment		
	The clinical record	of patient #2 was reviewed on		completion with each		
	06/30/21 and indic	ated a start of care date of		recertification and admission or	n	
	09/18/18 and conta	ained an agency document titled		Medical Record Review form.		
	"Medication Profil	e" indicated the following:		Training on comprehensive		
	Hydralazine 50 mg	g (milligrams)/ tab (tablet) ½		assessment completion will be		
	tablet by mouth the	ree times per day. If B/P (blood		incorporated into agency		
	pressure) is lower	than 120/60 in the evening hold		orientation.		
	that dose, Furosem	ide 20 mg by mouth daily at		Administrator/designee will trac	:k	
	noon, HCTZ 25 m	g by mouth daily at noon,		RN Case Manager comprehens		
	Isosorbide Monon	trate 90 mg ER 1 tab by mouth		assessment completion, with		
	daily in the mornin	ig, Lisinopril 40 mg by mouth		threshold of 80% compliance for	or 4	
	daily at bedtime, C	lopidogrel 75 mg; 1 tab by		weeks. Administrator/designee		
	mouth daily, Aspin	in 81 mg 1 tab by mouth daily at		audit 80% of comprehensive		
	bedtime, Nitroglyc	erin 0.4 mg SL (sublingual); 1		assessments for 4 weeks. Onc	e	
	tab every 5 minute	s as needed for chest pain up to		threshold of 80% is met, will		
	3 times. If not reso	lved after 3 tabs notify MD		decrease to 50% audits by		
	(Medicine Doctor)	and call 911, Carvedilol 3.125		Administrator/designee. RN Ca	ise	
	mg 1 tab by mouth	daily in the morning,		Managers to continue completi		
		ninophen 5-325 mg; tab by		comprehensive assessments w	•	
	mouth four times d	laily, Diclofenac Topical 1% gel		each recertification/admission t		
	apply 2 gm (grams	) topical four times daily as		ensure compliance.		
	needed for pain, G	abapentin 100 mg by mouth 1		Administrator/designee to revie	w	
		and 2-3 tabs every night, Senna		80% of meeting minutes per we		
		50 mg 1 tab by mouth daily at		1:1 coaching will be providing t		
		70% 10 ml (milliliters) by mouth		office personnel if meetings are		
		ylene Glycol 3350; 17 gm mixed		not held per standard.		
		of H20 (water) by mouth daily at		3. If thresholds are not met, the	e	
		for constipation. The daughter		agency will continue 80% audit		
	is to check B/P.			all comprehensive assessment		
				and provide 1:1 coaching to RN		
	The record contain	ed a plan of care for the		Case Managers until threshold		
		od of 05/05/21 to 07/03/21 that		met. If meeting minutes are not		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K023	A. BUILDING <u>00</u> B. WING		00	COMPLETED 07/08/2021	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP		
HELP A	T HOME SKILLED	CARE			HORE TERRACE SUIT IAPOLIS, IN 46254	FE 240	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE E APPROPRIATE	COMPLETIC DATE
	disorder with psyc Arthritis, Idiopathi Restless Leg Synd Heart Failure, Hyp Hyperlipidemia wi Treatments(Specif Duration): SN 1hr weeks to assess VS systems, set up me medication compli Health Aide) 3-5hr to assist with ADL and IADLS (Instru Living)Measura patient's safety wil home care service (related to) falls w patient's hygiene a met this cert period HHA. The patient compliance throug plan of care failed to check the patient blood pressure, pu to be provided, CF interventions, cons measurable outcom 3. During a home v at 3:00 PM patient stationary bike. I a straightened out th also have to cut do and the doctor said	th " Orders for Discipline and y Amount/ Frequency/ (hour)/visit, 1 day/week x 9 S (Vital Signs)& all body dications and monitor ance every visitHHA (Home r/visit, 3-5 days/week x 9 weeks s (Activities of Daily Living) mental Activities of Daily able Goals and Outcomes: The 1 be enhanced throughout the as evidenced by no injury r/t ithin the cert period of time. The nd personal care needs will be d with the assistance of the will maintain medication hout the cert period" The to evidence that the daughter is t's B/P, call parameters for lse, and weight gain, education IF interventions, pain tipation interventions with			completed per standa Administrator/designe 1:1 coaching to office until standard level is 4. The deficiency will completed by 8/10/20	ee to provide personnel achieved. be	
	breathing masks for	or her night time machine. of patient #6 was reviewed on ated a start of care date of					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		CON	(X3) DATE SURVEY COMPLETED <b>07/08/2021</b>	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 6855 SHORE TERRACE SUITE 240				
HELP A	T HOME SKILLED C	CARE		INDIAN	APOLIS, IN 46254		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	HE APPROPRIATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	)	DATE
		rd contained a plan of care for					
	-	eriod of 05/04/21 to 07/02/21					
	-	oses, Cerebral Palsy, Epilepsy,					
		el Syndrome), Spastic Bladder,					
		ic Constipation, Arthritis, and					
		an of care indicated, "					
		s and Outcomes: To remain at ependence throughout the cert					
		Discipline and Treatments					
	-	Frequency/ Duration): SN					
		r (hour)/visit, 1 day every other					
		assess vital signs and all body					
		med planner and assess					
		ince every visit" The plan of					
		nce interventions and goals for					
		entions and goals for IBS,					
	-	oals for pain, individualized					
	-	als, failed to address CPAP					
		ve Airway Pressure), a					
		used for individuals who stop					
	-	settings and call parameters for					
		the measurement of oxygen.					
	e e	isit on 07/02/21 at 3:30 PM					
		ns on patient's living room					
		nt #7 steps to take when					
	-	roices, and to wear gloves to					
	-	injury. Employee D, RN					
		case manager was not					
		y questions regarding					
		pression. When queried by the					
		egarding falls patient indicated					
	_	fallen in the bathroom slipped					
		ed the RN the bruising on left					
		d to surveyor, " When am I					
		owers and aide again haven't nonth?" The RN case manager					
	stated, "We are wor						
	The clinical record						

NTERS FO	R MEDICARE & MEDIC	AID SERVICES					OMB NO. 0938-03	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) I	MULTIPLE CO	NSTRUCTION	(X3) DA	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. I	BUILDING	00	CO	MPLETED	
		15K023	В. У	WING		07/	07/08/2021	
NAMEOE	PROVIDER OR SUPPLIEF			STREET A	DDRESS, CITY, STATE, ZIP	COD		
	THOME SKILLED (				IORE TERRACE SUIT APOLIS, IN 46254	E 240		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	- T	ID		(XS		
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		COMPLETI	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE	
		ated a start of care date of						
	05/13/20. The record	rd contained a plan of care for						
		period of 05/08/21 to 07/06/21						
	-	oses, Chronic Pain, Bipolar/						
	-	oothyroidism, GERD (Gastric						
		Disease), History of Seizures,						
	MDD (Major Depr	essive Disorder), Generalized						
	Weakness, Arthritis	s, and Depression with "						
	Orders for Disciplin	ne and Treatments (specify						
	Amount/ Frequency	y/ Duration): SN 1 hr/visit, 1 d						
		eks to assess VS & all body						
	•	lications and monitor						
		nce every visitMeasurable						
		es: Client will remain						
	-	lication regimen for this cert						
		epresentative Measurable						
		es: None at this time." The plan						
		dence individualized patient						
	-	n of care failed to address						
		pression and Bipolar/						
		n interventions and goals,						
	constipation intervel centered goals.	entions and goals, and patient						
	5. The clinical reco	rd of patient #9 was reviewed						
		licated a start of care date of						
	08/30/17. The record	rd contained a plan of care for						
	the recertification p	period of 03/15/21 to 05/13/21						
	that indicated diagr	oses, Cognitive Impairment,						
		eizure disorder, and GERD. "						
	_	line and Treatments (specify						
		y/ Duration): HHA 1-3 h/d, 3-5						
		ks to assist with ADL's and						
		ble Goals and Outcomes:						
		tive Measurable Goals and						
		er declines to set a goal at this						
	_	care failed to evidence patient						
	centered goals.							
	During a phone inte	erview with patient #9's						

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	A. BUILI B. WINC		MULTIPLE CONSTRUCTION BUILDING <u>00</u> WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/08/2021	
	PROVIDER OR SUPPLIEF			STREET AI 6855 SH INDIANA	ZIP COD UITE 240			
(X4) ID		STATEMENT OF DEFICIENCIE	1	ID	· · · · · · · · · · · · · · · · · · ·		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN C (EACH CORRECTIVE ACT CROSS-REFERENCED TO	OF CORRECTION FION SHOULD BE	COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE	
		on 07/06/21 at 1:45 PM when					Diff2	
		ed about complaint regarding						
		n a Theology teacher. We						
	-	zation for 5 days a week 2						
	-	d 3 hours in the afternoon so I						
		es Monday thru Friday. I do						
	-	staff. They even have pulled						
		another patient. They have						
		tion. The scheduler one time						
		ore told my Entity O when she						
	•	ould not staff that day that he						
		Entity O had to go to work						
		and watch patient #9. I have						
		tly to let me know on my						
	-	taffing issue do not call my						
	-	at #9 need 24 hour supervision						
		ar eyes off him. I had to have						
		he garage with him one time and						
		use they could not staff.						
		k hours patient #9 needs						
	-	his behaviors. The prior						
	authorization is for	the hours I work."						
	6. The clinical reco	rd of patient #10 was reviewed						
	on 07/07/21 and inc	licated a start of care date of						
	02/05/21. The record	d contained a plan of care for						
	the recertification p	eriod of 04/06/21 to 06/21/21						
	that indicated diagr	oses, Altered mental status						
	unspecified, Autisti	c disorder, Seizure disorder,						
	and Acne.							
	Review of a plan of	f care for the recertification						
	-	to 06/04/21 indicated "Orders						
		Freatments (specify Amount/						
	-	n): HHA 1-2 hour/visit, 5-7						
		ks to assist with ADL's and						
		ply bilateral AFO's (Ankle foot						
	-	t Measurable Goals and						
		ADL's and IADL's will be met						
		the assistance of the home						
	ans cert periou with	i me assistance of the nonic					1	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COI		CO1	(X3) DATE SURVEY COMPLETED 07/08/2021	
				6855 SH				
	T HOME SKILLED C			INDIANA	APOLIS, IN 46254			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO T DEFICIENCY	THE APPROPRIATE	COMPLETIO	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE	.,	DATE	
	-	ient's safety will be enhanced e care service as evidenced						
	-	s this cert period of time. The						
		free of injury r/t seizures this						
	-	t/ Representative Measurable						
	-	es: CG (Caregiver) doesn't wish						
		becific goal" The plan of						
		nce individualized patient care						
	needs in regards to	-						
	-	l to AFO with measurable goals						
	and patient centered	l goals.						
		ord of patient #11 was reviewed						
		licated a start of care date of						
		d contained a plan of care for						
	-	eriod of 05/10/21 to 07/08/21						
	-	oses, Generalized Weakness,						
		Pain, Constipation, Cardiac						
	Bladder.	naker, GERD, and Overactive						
	Review of a plan of	care for the recertification						
	-	to 07/08/21 indicated "Orders						
	-	Freatments (specify Amount/						
		n): HHA 2-4 hrs/visit, 1-2vs						
		/s/week x 9 weeks to assist	1					
		DL's. HHA Measurable						
		es: Patient's ADL's and IADL's						
		t period with the assistance of						
		e. The patient's safety will be						
		ut the home care service as ury r/t falls within cert period	1					
	" The plan of car							
	_	e home health aide to weigh	1					
		veight gains 2 plus a day to the						
		plan of care failed to include						
		e home health aide to monitor	1					
		movements and report to the						
	-	patient does not have a bowel	1					
		urs. The plan of care failed to	1					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K023		(X2) MULTIPLE CC A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>07/08/2021</b>		
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD HORE TERRACE SUITE 24	10	
HELP AT HOME SKILLED CARE				IAPOLIS, IN 46254	10	
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETIO
TAG	REGULATORY C	PR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	report increased pa pain scale of report have goals for the and heart failure. 8. During an inter when queried about individualized, an care indicating, "P compliance throug patient expressing stationary bike, the stated, "Absolutely 9. The clinical rec care) 07/05/2013, diagnoses included	cord of patient #3, SOC (start of was reviewed 06/30/2021. Patient d: TIAs' (Transient Ischemic				
	deficits, History of DM (Diabetes Me (Gastro-esophagea incontinence, Maj Kidney Disease St	al reflux disease), Urinary or Depressive Disorder, Chronic age 3, Anemia, Gout, ch disturbances, and				
	Certification/Rece 05/04/2021 and as revealed patient is mg 2 times a day, and Amlodipine 14 pressure). The Pat blood sugar daily. evidence diabetic is parameters with bl Hha (home health of daily living), M of Care Hha order.	rtification Plan of Care dated sessment dated 05/04/2021, taking Metoprolol Tartrate 100 Hydralazine 50 mg 4 times a day, 0 mg 1 x a day for HTN (blood tient/Family is to check patient's The Plan of Care failed to foot care and physician call lood sugars and vital signs. The aide) provides ADL's (activities fonday through Friday, the Plan s revealed Hha services 1-2 veek x 9 weeks. The agency				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023		IULTIPLE CO UILDING /ING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/08/2021	
NAME OF	PROVIDER OR SUPPLIEI	R			DDRESS, CITY, STATE, ZIP CO		
HELP A	T HOME SKILLED (	CARE	6855 SHORE TERRACE SUITE 240 INDIANAPOLIS, IN 46254				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
PREFIX	,	VCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE PPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCI		DATE
	with patient centered	i individualized Plan of Care ed goals.					
	10. The clinical re	cord of patient #4, SOC					
		viewed 06/30/2021. Patient					
	-	: Muscle Weakness,					
	Gastro-esophageal reflux disease without						
		ial hypertension, Type 2					
	Diabetes Mellitus, Fibromyalgia, Chronic Obstructive Pulmonary Disease, Rheumatoid						
		opathic peripheral autonomic					
		ry Incontinence, Full					
		es, and Shortness of breath.					
		me Health Certification/					
		n of Care dated 06/02/2021 and					
		6/02/2021, revealed there were					
		Pain assessment, with patient					
		the Plan of Care revealed the o goals". The patient has					
	-	nd is receiving O2 2L Nasal					
		is and a CPAP machine, being					
		blied by Other K. Patient is					
		25 mg 2 times day for HTN					
	(blood pressure). T	The Plan of Care failed to					
		oot care, CPAP settings and					
		meters with oximeter (oxygen)					
	-	pressure ranges. The agency					
	•	individualized Plan of Care					
	with patient centered	ed goals.					
		cord of patient #5, SOC					
		viewed 06/30/2021. Patient					
	-	: Moderate Intellectual					
		ady Gait, HTN (Hypertension),					
	Anemia, History of	ECOIon Cancer, ERD (Gastro-esophageal reflux					
		Disorder, Major Depressive					
	Disorder.	isoraer, major Depressive					
	2						

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	A. E	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 07/08/2021	
	PROVIDER OR SUPPLIEF			STREET A 6855 SH INDIAN				
(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 COR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
	Recertification Plan assessment dated 00 is taking Furosemic Succinate ER 25 m Losartan-hydrochlo 100 mg 1 x day for Plan of Care failed parameters ranges f centered goals. The individualized Plan goals. 12. The clinical rec 06/10/2019, was rev diagnosis included: (Diabetes Mellitus) Pulmonary Disease A review of the Hor Certification/Recert 05/26/2021 and ass- revealed diabetic fo on assessment. The evidence diabetic fo perform glucometer daily in AM before failed to evidence p glucometer reading evidence an individ patient centered goa 13. The clinical rec 07/10/2020, was rev diagnoses included: End Stage Renal Di A review of the Hor Certification/Recert	cification Plan of Care dated essment dated 05/26/2021 ot exam failed to be completed e Plan of Care failed to bot care. The patient is to readings (blood sugar testing) breakfast, the Plan of Care hysician call parameters for s. The Agency failed to ualized plan of care with als. Ford of patient #12, SOC viewed 07/06/2021. Patient Chronic Back Pain, COPD, sease, Dysphasia, and DM.						

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING STREET ADDRESS, CITY, STATE, ZIP COD			CON	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 07/08/2021	
	PROVIDER OR SUPPLIEF			STREET A 6855 SH INDIANA				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF assessment dated 0	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION 5/04/2021, revealed patient is e 5 mg 3 times a week before		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	dialysis for hypoten 5 mg 3 times a wee Care failed to indica ranges for blood pro- revealed patient has toward pain goal, m required". The Plan goals. The assessme checks patient's blo Care failed to evide physician call parar evidence an individ patient centered goa	sion (low blood pressure) and k during dialysis. The Plan of ate physician call parameter essure. The assessment Pain goals of "0-3, progress aet, ongoing, monitoring n of Care failed to identify pain ent revealed family member(s) od sugar weekly. The Plan of nce glucometer readings and neters. The Agency failed to ualized plan of care with						
	diagnosis included: Accident) with Rigl Diabetes Mellitus, I A review of the Hot Certification/Recert 04/30/2021 and ass revealed the patient 9-11 hrs per visit, 2 review, Hha service	viewed 07/06/2021. Patient CVA (Cardiac Vascular nt Side Weakness/Paralysis, Depression, and Hypertension. me Health dification Plan of Care dated essment dated 04/30/2021 is to receive Hha services -4 days per week. Per record es are being provided 4 days a e each day. Patient is receiving						
	Metoprolol 100 mg 5 mg 1 time a day f Plan of Care failed parameters for bloo of Care failed to ide agency failed to to p of Care with patient 15. These findings administrator/clinic	2 times a day and Amlodipine for HTN (blood pressure), the to identify physician call d pressure readings. The Plan entify diabetic foot care. The provide an individualized Plan						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	(X2) MUI A. BUII B. WIN	DING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/08/2021	
	PROVIDER OR SUPPLIE			6855 S	ADDRESS, CITY, STATE, ZIP COD SHORE TERRACE SUITE 240 NAPOLIS, IN 46254		
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE	p	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
G 0682	no further informa provide. 16. During an inte when queried abou individualized, an care indicating, "P compliance throug patient expressing	)(iii)(xii)					
Bldg. 00	practice, includin precautions, to p infections and co	on Prevention. Illow accepted standards of g the use of standard revent the transmission of mmunicable diseases.	G 068	82	1. Administrator completed immediate re-education to the	RN	08/10/202
	precautions to prev infections and com home visits conduct Findings include: 1. Review of an ap Prevention and Co POLICY The Age implemented infect conform to OSHA state and local regi standards of practi precautions will be	cy failed to use standard vent the transmission of umunicable diseases for 3 of 7 cted. (Patients #1, #3, and #5) gency policy titled, V. Infection ntrol (IC), revealed "5.2.1 ency has developed, and tion control practices that regulations, CDC guidelines, alations and currently accepted cc5.6.1 Blood and body fluid of followed for all patients5.7.1 be done by all employees and			Case Managers and home he aides observed on home visits during survey process on prop infection control practices rela- to hand hygiene and donning/doffing of gloves, as y as bag barrier technique with Case Managers only. On 7/27/2021 Administrator bega competency assessment prop for all RN Case Managers rela- to hand hygiene and bag barri technique. On 7/27/2021 a Ho Observation Form was create RN Case Managers to comple during 80% of all home visits	s ber ted well RN n vess ated ier ome d for	

	R MEDICARE & MEDI						MB NO. 0938-03	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u>			(X3) DATE SURVEY COMPLETED		
		15K023	В. \	VING		07/08	8/2021	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
HELP A	T HOME SKILLED	CARE			SHORE TERRACE SUITE 240 NAPOLIS, IN 46254			
(X4) ID	T	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/		COMPLETIC	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	Home Care Infecti	on Control Guidelines for			which ensures proper infectio	n		
	COVID-19".				control techniques by home h			
					aides and skilled nurses is			
	-	visit observation on 06/30/2021			performed. All home health a	des		
		ent's #1 home, with Employee D			and skilled nurses will watch	/ideo		
		rse), and Employee M Hha			on donning/doffing PPE by			
		, Employee M was observed			8/6/2021. All RN Case Manag	jers		
		vithout any hand hygiene,			to watch video on proper bag	04		
		tient #1 with undressing, throom, showering, drying off,			technique created on 7/30/20 8/6/2021.	21 Dy		
		m, assisting with dressing, all			2. Administrator/designee to			
	e	ne pair of gloves. After the			ensure compliance by trackin	a		
	-	ressed, with same gloves,			completion of home observati	servation		
	-	ed the alarm and necklace for			forms on 80% of home visits			
		Employee M was observed			100% completion of video			
	placing their perso	nal bag on the chair without the			education by 8/6/2021.			
	use of a barrier.				3. If threshold of 80% home			
					observation forms is not met,	1:1		
	-	w on 06/30/2021 at 11 am,			coaching will be provided to			
		ueried about the home visit, in			employees. If threshold of 10			
		D admitted the aide did not use			compliance with video educat			
	hand hygiene prop	erly.			not met, employee to be remo	oved		
	2 During a house				from their schedule until			
	0	visit observation on 07/02/2021 tient's #3 home with Employee K			complete.			
		aide). Employee K answered			4. The deficiency will be completed by 8/10/2021.			
		vearing a mask. Employee K					1	
		as not awake. Employee K	1				1	
	-	oom, with no mask, woke						
		assisted patient #3 to					1	
		yee K had not used hand						
	hygiene, no gloves	, and no mask. Employee K	1				1	
		hair and assisted the patient to						
	-	oyee K, not wearing mask or	1				1	
	-	t performed hand hygiene,						
	-	k to take medications, put drink						
		nedication box, emptied						
		heir non-gloved hand and						
		d hygiene, put pills into cup for						
	patient. Employee	K then started washing dishes,	1				1	

PRINTED: 08/13/2021 FORM APPROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K023	· /	JILDING	DINSTRUCTION 00	(X3) DATE COMPI <b>07/08</b>	ETED
	NAME OF PROVIDER OR SUPPLIER HELP AT HOME SKILLED CARE			6855 S	ADDRESS, CITY, STATE, ZIP COD HORE TERRACE SUITE 240 APOLIS, IN 46254		
(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 B) CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	3	(X5) COMPLETION DATE
	<ul> <li>applied.</li> <li>4. During a home v at 09:45 AM at Pati (registered nurse) w hygiene at the sink, on patient #5's bed,</li> </ul>	rformed and gloves not isit observation on 07/02/2021 ent's #5, Employee F RN as observed performing hand placed a paper towel barrier and put clip board and otly on patient's bed without					

P11 Facility ID: 004966