STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157543	B. WING		04/29/2014
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIE	R		1ST AVE	
PRIME C	ARE HOME HEAL	TH SERVICES INC		LLVILLE, IN 46410	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	I	(X5)
PREFIX		NCY 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)	DATE
N000000		,			
			N000000		
	This was a hom	e health state complaint			
	investigation.	1			
	investigation.				
	Complaint #: IN	100146418			
	_	l: Lack of sufficient			
		lated deficiencies are			
	cited.				
	Survey date: A	pril 28 - April 29, 2014			
	Facility #: 0031	155			
	Medicaid vendo	or #: 200399260			
	Surveyor: Ingri	d Miller RN, PHNS			
	Onality Review	: Joyce Elder, MSN,			
	BSN, RN	. vojec Blaci, MBI (,			
	May 5,	2014			
	Iviay 5,	2014			
N000446	410 IAC 17-12-1(				
	Home health age				
	administration/ma	anagement			
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		157543	B. WIN			04/29/	/2014
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			1ST AVE		
PRIME C	CARE HOME HEAL	TH SERVICES INC			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Rule 12 410 IAC 1	17-12-1(c)(3)					
Sec. 1(c)(3) The administrator, who may							
also be the supervising physician or							
		equired by subsection (d),					
	shall do the follow	_					
		ied personnel and ensure					
	adequate staff ed	ucation and evaluations.					
			N00	00446	N 0446 The Assistant		04/30/2014
	_	nel file review, policy			Administrator in serviced all	h	
	review, and inter	rview, the administrator			Nursing Staff and Home Healt Aides on the policy, Home Healt		
	failed to ensure t	the agency employed			Aide Training. The job	aitti	
	qualified person	nel for 1 of 2 Home			description for Certified Nursin	ıa	
		(F) reviewed with the			Assistant revised to incorporat	•	
		et all of the agency			Home Health Aide. A copy of	the	
	•	• •			Home Health Aide job descrip	tion	
	patients with nor	me health aide services.			was given to all Home Health		
					Aides and incorporated into th	е	
	Findings				Home Health Aide orientation package. The revised job		
					description will be presented a	ınd	
	1. Employee File	e F, Home health aide			discussed at the next schedule		
	(HHA) with a da	ate of hire 3/21/14 and			PAC meeting. (7/2014) The sk	ills	
	first patient cont	act 4/13/14, failed to			competency evaluation has be		
	evidence the HH	A had completed a skills			completed on employee F. Th	е	
		luation before first			Director of Nursing has been	- 4-	
		nd a job description for a			certified by the state of Indiana train and teach CNA/HHA. The		
	_	-			Director of Nursing will	E	
	home health aide	⋾.			accompany all newly hired HH	IA	
					on first contact visit with patier		
		t 1:50 PM, the director of			and all current active HHA yea		
	nursing indicated	d a competency skills			to observe skills for competen		
	check was neede	ed before the HHA had			All newly hired HHA receive a	l	
	seen any patients	S.			written skill test approved by		
					IAHHC and all incorrect		
	3 On 4/29/14 at	t 3:05 PM, the director of			responses are reviewed and discussed with applicant. All H	ΙΗΔ	
		d the job description of			receive at the minimum 12 hou		
	home health aide	3			of in services yearly. The Off		
		was 101 a muise			Manager will be responsible for		

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 2 of 23

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	157543	A. BUILDING	00	04/29/2014
		107.040	B. WING	A D D D D G G G G G G G G G G G G G G G	07/23/20 1 <del>4</del>
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE  1ST AVE	
PRIME C	ARE HOME HEALT	TH SERVICES INC		LLVILLE, IN 46410	
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDENCE NAVIOE CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		a home health aide.		auditing 100% of all newly hir Home Health Aides employe files to assure compliance is	l l
		olicy titled "Home		maintained. The Director of	
		ning" with a revised date		Nursing along with the Quality	
	_	stated, "Prime Care		Committee will be responsible monitoring 10% of all Home	e tor
		rvices, Inc. will only hire		Health Aide files to ensure thi	s
		me health aides who		does not happen again during	
	_	a training program or a		their quarterly record review.  The Administrator will be	
	1 3	uation program that		responsible for monitoring the	ese
meets the organization's criteria		zation's criteria.		corrective actions to ensure the	
				this deficiency is corrected ar	nd
N000484	410 IAC 17-12-2(g	1)		will not recur.	
11000404	Q A and performal				
	Rule 12 Sec. 2(g)	All personnel providing			
	services shall mair				
		o assure that their efforts plement one another and			
		ives of the patient's care.			
	The means of com	nmunication and the			
		cumented in the clinical			
	Based on clinical	of case conferences.	N000484	N 0484 The Director of Nursi	ng 04/30/2014
		olicy review, the agency	11000404	in serviced all staff on the pol	<u> </u>
	_	all personnel providing		of Clinical Supervisor and	
	services and ager			Safeguarding/Retrieval of	
	_	tive communications to		Clinical/Service Record. All ca managers instructed that all	48 <del>C</del>
	assure their effor			admissions must be turned in	no
		ne another and supported		later than 5 days after admiss	
	•	the patient's care in 1 of		Chain of command notice gives to all staff. Employee E and F	
		ed (#3) with the potential		serviced and counseled at gre	l l
		patients of the agency.		length and probationary statu	s
	, , , , ,	<u> </u>		lengthen an additional 90 day	
	Findings			All clinical records are locked records room. The Director	
	E			Nursing will audit 100% of all	
	1. Clinical record	l #3, start of care		admissions monthly for the ne	ext 4

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 3 of 23

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157543	B. WIN	IG		04/29/	/ZU14
NAME OF F	PROVIDER OR SUPPLIER	-		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					IST AVE		
PRIME C	ARE HOME HEAL	TH SERVICES INC		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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
	•	d a plan of care for the			months or until 100% complia is reached. Then 10% random		
	certification period of 4/13/14 - 6/11/14.				monthly ongoing to ensure		
	This record was not present in the office				evidence of compliance is		
until 4/29/14 at 4:40 PM. Employee E,					maintained. The Quality	<b>f</b>	
Registered Nurse, had seen the patient on					Committee will be responsible monitoring 10% of all active	TOF	
4/13/14 for the start of care /					cases at their quarterly meetir	ng	
comprehensive assessment. This had not					and a written report will be sei		
been communicated to the director of					the Governing Body for their		
	nursing and no re				review.		
	*	agency office until					
	4/29/14 at 4:40 I	M.					
	0 4/20/4						
		4 at 9:20 AM, Employee					
	• •	rse (RN), indicated					
		t #3 for the agency and					
	1	was also caring for					
	patient #3.						
	1 0 4/20/	14 . 10 05 135					
		14 at 10:05 AM,					
		director of nursing,					
		nployee F, home health					
	` / ·	brought personnel file					
		ad not brought a list of					
	_	r hire. Employee B					
	_	#3 was not on service at					
	this time.						
	0 4/20/4	4 4 10 15 135 3					
		4 at 10:15 AM, the					
		licated Employee F,					
		g patient #3 on her own					
	_	needed bathing and					
	wasn't on service	e yet.					
	1.0.4/20/4	4 - (10 00 PM f - 3					
	d. On 4/29/1	4 at 12:30 PM, the					

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 4 of 23

	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	
		157543	B. WING	ì		04/29/	/2014
NAME OF I	PROVIDER OR SUPPLIER		Ī	STREET A	DDRESS, CITY, STATE, ZIP CODE		
				2632 81			
PRIME C	ARE HOME HEAL	TH SERVICES INC		MERRIL	LVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	caregiver of patie						
	satisfaction with	the services from					
	Employee F, HH	IA, and Employee E, RN,					
	received through	Prime Care.					
	e. On 4/29/1	4 at 1:10 PM, Employee					
	B, the director of	f nursing, indicated that					
	patient #3 had st	arted care with the					
	agency and that	she had not been aware					
	of this. She did	indicate a referral with					
	verbal orders fro	m the physician had					
		he referral book and been					
	_	ree E, who had not					
	1 "	vith her about the					
	patient's care sin	ce the start of care, and					
	_	was not aware that the					
		ed care. Employee E and					
	_	all the documents for					
		ad not followed the					
		nd or agency policies for					
		nents and coordinating					
		here was no record in the					
	office at this time						
	office at this tim	e 101 patient #3.					
	f On 4/20/1.	4 at 4:40 PM, the director					
		ated the record for patient					
	#3 had been prod	•					
	#3 flad been proc	Lesseu.					
	a On 4/20/	14 of 4:40 DM tha					
	_	14 at 4:40 PM, the					
		ng was observed to have					
	clinical record #3	o in her hand.					
	2 Th	aliery titled "Climical					
		olicy titled "Clinical					
	supervisor" with	a revised date of August					

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 5 of 23

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  157543		(X2) MULTIPLE C  A. BUILDING  B. WING	00	СОМ	e survey pleted 19/2014
	PROVIDER OR SUPPLIER		STREET 2632 8	ADDRESS, CITY, STATE, ZIF B1ST AVE BILLVILLE, IN 46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	· ·	e clinical supervisor is nsuring that patient care id managed				
	Service Record" August 2011 state service records we locked, waterpropercord room: A. at night. B. The room will be locked in the clinical service to the clinical service to the office close clinical / service will remain in the records will be records will be records regulation polifiederal regulation.	Retrieval of Clinical / with revised date of ed, "All patient clinical / vill be maintained in of file cabinets in a All files will be locked clinical / service record ked at night 2. All records will be returned rvice record room prior ing The original record for active patients e office at all times etained according to cy, local, state, and ins records of adult etained for a minimum				
N000494	be informed of the effective means of home health agen	The patient or the resentative has the right to patient's rights through for communication. The cy must protect and ise of these rights and				

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 6 of 23

	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157543	B. WIN	G		04/29/	/2014
NAME OF F	DROVIDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	L		2632 8 <sup>-</sup>	1ST AVE		
PRIME C	ARE HOME HEAL	TH SERVICES INC		MERRI	LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		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
	(1) Provide the p of the patient's rig (A) in advance of patient; or (B) during the init the initiation of tre (2) Maintain document, and p interview, the ag patients were infrights prior to the of 4 patient recorpatients receiving this agency with any new patients  1. Clinical recorpatients  Findings  1. Clinical recorpatients  4/13/14, failed to be decorpatient Patient  410 IAC 17-12-3  admitted to the horecorpatient Rights docomprehensive a completed on 4/13  2. On 4/29/14 at nursing indicated	atient with a written notice ht: furnishing care to the lial evaluation visit before atment. It is atmentation showing that it the requirements of this larcord, agency colicy review and ency failed to ensure formed of the patient ebeginning of care for 1 rds reviewed (#3) of g skilled services from the potential to affect of this agency.  In the patient or ive was informed of the ent Rights required by the was informed of the ent Rights required by the patient was some health agency. The lather patient received a potential to a 4/14/14. The essessment was	N00	00494	N 0494 The Administrator in serviced all staff on the policy Home Health Patient Bill of Rights. All case managers instructed to ensure that the patient consent form, which contains acknowledgement of receiving the Patient Bill of Rights, and the date of admissare the same. All case managwere instructed to educate an give patient/caregiver/family the Patient Orientation Booklet who contains the patient rights. All current active patients reissue copy of the Patient Bill of Right along with the revised version Advance Directives. The case managers were educated on the Advance Directives revised Jul 2013 and copies given to distribute to all current active patients. The Director of Nurswill audit 100% of all admission monthly and then 100% quart for evidence that the patient head the handbook was left in the home. The Quality Committed will be responsible for monitor these corrective actions to ensure that this deficiency is corrected.	sion gers d ne nich ed a ats of the ally sing ans erly as and e ting sure	04/30/2014
	not signed prior	to the start of care.			that this deficiency is correcte and will not recur during their	d	

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 7 of 23

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

PRINTED: 05/22/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157543	B. WIN			04/29/	2014
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
PRIME C	CARE HOME HEAL	TH SERVICES INC			1ST AVE LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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
		ooklet titled "Patient			quarterly record review meetir	ıg.	
		Iome Health Care" with					
no date included a section titled " Your							
rights & responsibilities as a Health Care							
	patient," the doc	ument stated, "As a					
	home care provid	der, we have an					
	obligation to pro	tect your rights and					
	explain these rig	hts to you in a way you					
	can understand b	pefore treatment begins					
	and on an ongoir	ng basis, as needed.					
	Your family or le	egal representative may					
exercise these rights for you in the event							
	that you are not	competent or able to					
	exercise them for	r yourself You have					
	the right to A. th	e client has the right to					
	be informed of h	is or her rights and					
	responsibilities.	Prime Care Home					
	Health services v	will protect and promote					
	the exercise of th	nese rights and					
	responsibilities a	nd maintain					
	documentation to	o demonstrate					
	compliance. B.	The agency will provide					
	the client with w	ritten notice of the					
	Client's rights in	advance of furnishing					
	care or during th	e initial evaluation visit					
	before the initiat	ion of care or treatment."					
	1 The agency no	olicy titled "Home Health					
		ghts" with a revised date					
	1						
	_	stated, "Each patient will					
		ormed participant in his /					
	_	To ensure this process					
		n advance about care to					
	be furnished and	changes in the care to					

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 8 of 23

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157543	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  04/29/2014
	ROVIDER OR SUPPLIER		STREET 2632 8	ADDRESS, CITY, STATE, ZIP CODE 1ST AVE ILLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
N000518	be furnished."  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 directidescription of applhome health agendirectives information is furn provided. Based on clinical interview, and agthe agency failed provided the curricular directives, including applicable State in reviewed (#1 - 4 affect all the 52 agency.  Findings include	alth agency must inform ten information to the se, concerning its policies ives, including a licable state law. The cy may furnish advanced tion to a patient at the time isit, as long as the ished before care is  I record review, gency document review, to ensure patients were tent Advanced ling a description of law, in 4 of 4 records  ) with the potential to active patients of the	N000518	N 0518 The Administrator inserviced all staff on Adva Directives. The July 2013 iversion of Advance Directivo obtained and given to all st distribute to their patients. Manager given revised vers Advance directives to be plinside of the Patient Orienta Booklet. A copy of the curr Advance Directives has be placed in all Patient Orienta Booklet. The Assistant Administrator will audit 100 all Patient Orientation Book quarterly for evidence the	nce revised ves aff to Office sion of aced ation rent en ation % of
	patients failed to May 2004 and re of Indiana advan	include the effective evised July 1, 2013, state ced directives in the that was distributed to		Advance Directives and oth pertinent information are cuand updated. The Quality Committee will be responsimonitoring these corrective	urrent ble for

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 9 of 23

	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JETIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		157543	B. WING	G		04/29/	/2014
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					IST AVE		
PRIME C	ARE HOME HEAL	TH SERVICES INC		MERRII	LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ORRECTION (X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	the patients at the	e start of care (SOC).			actions to ensure that this deficiency is corrected and will	ı	
					not recur.	'	
	2. On April 29, 2014 at 3:45 PM, the						
director of nursing indicated the							
	advanced directives were not the						
effective and current Indiana advanced							
directives (effective May 2004 and							
revised July 1, 2013) in patient # 1 - 4's							
home admission books and that all the							
	patients of the ag	gency needed to receive					
	the updated adva	nced directives.					
	3. Clinical recor	rd #1, SOC 4/11/14,					
	failed to contain	an updated July 1, 2013,					
	version of the 20	04 Indiana Advanced					
	Directives docum	nent. The patient signed					
		nt was received on the					
	SOC date.						
	soc date.						
	4 Clinical recor	rd #2, SOC 3/13/14,					
		an updated July 1, 2013,					
		04 Indiana Advanced					
		ment. The patient signed					
		nt was received on the					
	SOC date.						
		1 112 000 4/12/14					
		rd #3, SOC 4/13/14,					
		an updated July 1, 2013,					
		04 Indiana Advanced					
	Directives docum	nent. The patient signed					
	that the documer	nt was received on					
	4/14/14.						
	6. Clinical recor	rd #4, SOC 3/10/14,					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION  00	(X3) DATE COMPL	ETED
		157543	B. WING		04/29/	2014
	PROVIDER OR SUPPLIER		2632 8	ADDRESS, CITY, STATE, ZIP CO 1ST AVE ILLVILLE, IN 46410	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	failed to contain version of the 20 Directives document that the document SOC date.  410 IAC 17-13-1(a Patient Care Rule 13 Sec. 1(a) a written medical and periodically redentist, chiropract podiatrist, as follows:  Based on clinical review and intervensure skilled secondered on the pland 4 ) clinical repotential to effective secondered of the potential to effective secondered of the potential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered on the pland 4 ) clinical repotential to effective secondered	an updated July 1, 2013, 04 Indiana Advanced nent. The patient signed at was received on the  Medical care shall follow plan of care established eviewed by the physician, or, optometrist or		CROSS-REFERENCED TO THE AF	f Nursing he policies ess and in Plan of l in d written on e H for ccupational . All staff d Visit make	
	3/13/14, included certification peri with orders for the urinary status were no orders for the urinary status.	d #2, Start of care (SOC) d a plan of care with a od of 3/13/14 - 5/11/14 he skilled nurse to assess s of the patient. There or the frequency and		All staff will attempt to scheduled ordered visit When unable to make visits the staff member the office and missed v will be completed and for physician's office. All s	make s weekly. scheduled will notify isit report axed to taff are to	
	visits listed in fir	accupational therapy ading a and b. Care failed tten plan of care (POC)		report to office when ur make scheduled visit so applicable arrangement made to cover visit with	o if ts can be	

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 11 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		157543	B. WIN			04/29/2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8			IST AVE	
PRIME C	CARE HOME HEAL	TH SERVICES INC			LLVILLE, IN 46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	
TAG	<del> </del>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	as evidenced by the following:				staff member. The Director of	
					Nursing will audit 100% of all nurses notes, therapy evals, a	nd
	a. Occupation	onal therapy visits			POC monthly for 3 months the	
	occurred on 3/20	0/14, 3/26/14, 3/28/14,			25% quarterly for evidence that	<b> </b>
	and 3/31/14, 4/2	/14, 4/9/14, and 4/10/14.			assessments are completed,	
					frequencies are on therapies	
	h An occur	pational therapy			evaluations, POC is followed,	and
	_	15/14 failed to evidence			all missed visit reports are	
	the frequency an				completed with physician notification. The Quality	
		rapy visits and a signed			Committee will be responsible	for
	*	rapy visits and a signed			monitoring 10% of all active	
	physician order.				cases at their quarterly meetin	· .
					and a written report will be ser	nt to
	· ·	g visit noted on 3/28/14			the Governing Body for their	ina
	evidenced the ur	inary status was not			review. The Director of Nurs along with the Quality Commit	·
	assessed by the r	registered nurse,			will be responsible for monitor	<b> </b>
	Employee H.				those corrective actions to ens	- I
					that these deficiencies are	
	d. On 4/29/	14 at 3:15 PM, the			corrected and will not recur.	
	director of nursing	ng indicated there were				
	no signed orders	including frequency and				
	_	ccupation therapy visits				
		did not assess the				
		patient #2 at the 3/28/14				
	visit.	patient //2 at the 3/20/11				
	VISIT.					
	2 Clinical recov	rd #4, SOC 3/10/14,				
	included a plan of					
	•	od of 3/10/14 - 5/8/14.				
	Care failed to follow the written POC as					
	evidenced by the	e tollowing:				
	a. The POC	evidenced skilled nurse				
	visits were to be	2 times a week for 2				
	weeks and then	1 times a week for 7				

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 12 of 23

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

PRINTED: 05/22/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  157543	A. BUILDING 00			COMPLETED 04/29/2014	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ST AVE		
PRIME C	ARE HOME HEALT	TH SERVICES INC			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ed nurse visit occurred					
	the week of Marc	ch 30 - April 5th.					
	of nursing indica	4 at 4 PM, the director ted a skilled nurse visit week of March 30 -					
	3. The agency po	olicy titled "Care					
		" with a revised date of					
	1 01	ed, "A written plan of					
	_	ated within 5 days of					
		updated at least every 60					
		t's condition warrants					
	-	of care included Specific					
	•	performed by the					
	•	ing amount, frequency,					
	-	ne plan of care will be					
		hysician's orders."					
	- по том ор от том р	,					
	4. The agency po	olicy titled "Physician					
		lan of care" with a					
		ugust 2011 stated, "The					
		an will certify the need					
	for the home hea	lth care services by					
	signing the plan	of care / treatment within					
	30 days of the sta	art of care orders will					
	be reviewed and	revised by the patient's					
	physician base	ed on changes in the care					
	or service being J	provided."					

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 13 of 23

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157543		A. BUILDING B. WING	00	COMPLETED 04/29/2014	
	ROVIDER OR SUPPLIER		STREET 2632 8	ADDRESS, CITY, STATE, ZIP CODE 1ST AVE LLVILLE, IN 46410	-1
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
N000524	plan of care shall:  (A) Be developed home health agen (B) Include all ser skilled service is b (B) Cover all perti (C) Include the folion (i) Mental statu (ii) Types of ser required.  (iii) Frequency a (iv) Prognosis.  (v) Rehabilitatio (vi) Functional lir (vii) Activities per (viii) Nutritional re (ix) Medications (x) Any safety ragainst injury.  (xi) Instructions referral.  (xii) Therapy modern (xiii) Any other ap Based on clinical interview, the agricular plan of care inclusing ature and free occupational their records reviewed	in consultation with the cy staff. vices to be provided if a eing provided. nent diagnoses. llowing: s. vices and equipment and duration of visits. In potential. mitations. mitted. quirements. and treatments. measures to protect for timely discharge or dalities specifying length of propriate items. I record review and ency failed to ensure the	N000524	N 0524 The Director of Nur inserviced all nursing staff a therapist on the policy, Phys Participation in Plan of Care copy of the policy was sent to Physicians. The Occupation Therapist inserviced extension including the frequency of evaluations. A part time office staff has been hired and dut	nd sician . A to all nal vely on

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 14 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLI	ETED
		157543	B. WIN			04/29/	2014
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			IST AVE		
PRIME C	ARE HOME HEAL	TH SERVICES INC			LLVILLE, IN 46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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	· ·		DATE
	Findings  1. Clinical record 3/13/14, included certification perithat failed to evid duration of the ovisits listed in final a. Occupation occurred on 3/20 and 3/31/14, 4/2/20 b. An occupation of the frequency and occupational the physician order.  c. On 4/29/20 director of nursing no signed orders duration of the occupational record 3/10/14 and diagonal failure, included certification peri	rd #2, Start of care (SOC) d a plan of care with a od of 3/13/14 - 5/11/14 dence the frequency and ccupational therapy inding a and b. onal therapy visits 0/14, 3/26/14, 3/28/14, /14, 4/9/14, and 4/10/14. oational therapy 15/14 failed to evidence			(EACH CORRECTIVE ACTION SHOULD BE	up im  aff b il ty, dit thly s s e f of rly iil for	
	nursing indicated	at 4 PM, the director of d the plan of care had not by the physician.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  157543		A. BUILDING B. WING  A. STREET ADDRESS CITY STATE A				
	ROVIDER OR SUPPLIER		2632 8	ADDRESS, CITY, STATE, ZIP CODE 1ST AVE LLVILLE, IN 46410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
N000596	shall be responsib to patient contact, furnish home healt behalf meet the re as follows:  (1) The home healt have success competency evaluaddresses each of subsection (h) of the Based on persons review, and interto ensure the home completed a comprogram for 1 of reviewed (F) with all patients with 1. Findings  1. Employee File (HHA) with a dafirst patient contact evidence the HH competency evaluation patient contact.	The home health agency le for ensuring that, prior the individuals who th aide services on its quirements of this section alth aide shall: sfully completed a ation program that if the subjects listed in his rule; and nel file review, policy view, the agency failed ne health aide had petency evaluation 2 home health aides the the potential to affect	N000596	N 0596 The Director of Nur in serviced all nursing staff opolicy, Home Health Aide Tr on 4/30/2014. A competenc checklist was performed wit employee F on 5/2/2014. T Director of Nursing will performed to the competency skill checklist was newly hired HHA at the time employment and yearly for a currently employed HHA. A time of hire all HHA are give skilled test approved by IAH All incorrect answers are reviewed and discussed wit HHA. The Director of Nursing been certified by the state of Indiana to train and teach CNA/HHA. The Director of Nursing will accompany and observe newly hired HHA in care contact and yearly with current active HHA. All HHA	on the aining cy skill h he orm a vith all e of all t the en a IHC. h ag has f	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED
		157543	B. WING		04/29/2014
	PROVIDER OR SUPPLIER		2632 8	ADDRESS, CITY, STATE, ZIP CODE 1ST AVE ILLVILLE, IN 46410	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION DATE
N000608	nursing indicated check was needed seen any patients.  3. The agency per Health Aide Train of August 2011 st. Home Health Serindividuals as how have completed a competency evaluated meets the organization of the competency evaluated for every patient at (1) The medical appropriate identification of the chiropractor, podiation of the chiropractor, podiation of the contributed to by a contributed to the con	la competency skills d before the HHA had before the health are care revices, Inc. will only hire me health aides who a training program or a formation program that before the past and current force with accepted for ards shall be maintained and shall be maintained as follows: plan of care and formation, physician, dentist, for optometrist, treatment, and activity that activity the lated clinical notes follows: I be written the day service for the medical patient's care. Summary.		receive at least 12 hours of inservices yearly. The Dire of Nursing along with the Q Committee will audit 100% HHA personnel employee fi quarterly for evidence that competency skill checklist a completed. The Director of Nursing will be responsible monitoring those corrective actions to ensure that this deficiency is corrected and not recur.	ector uality of les are f for will
	<ul><li>(14) days.</li><li>(5) Copies of surperson responsible component of the</li><li>(6) A discharge state of the component of the componen</li></ul>	mmary reports sent to the e for the medical patient's care.	N000608	N 0608 The Administrator i	n 04/30/2014

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 17 of 23

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION  00	(X3) DATE S COMPLI		
THE LUM	or conduction	157543		LDING		04/29/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER	R			IST AVE		
PRIME C	ARE HOME HEAL	TH SERVICES INC			LLVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	serviced all staff on the policie	e of	DATE
		view, the agency failed to			Admission Criteria and Proces		
		ecords were maintained			and Safeguarding/Retrieval of		
		ith agency policy for 3 of			Clinical/Service Record. The		
		ed of patients receiving			Administrator instructed office		
		vices with the potential			staff that all admission charts to be completed within 48 hrs		
		2 agency patients (2 -			receiving them in the office. A		
	4).				medical records will be stored	in	
	P' 1'				the record room at the end of		
	Findings				day and the record room will be locked. Office staff will only h		
					access to the keys to the reco		
		d #2, start of care (SOC)			room. All staff has been		
	•	ed no completed clinical			instructed to turn their notes in		
		maintained in the agency			weekly. A new office person h	as	
	until after the rec	cord was requested.			been hired to assist with filing records and delivering and		
	a On 4/28/1	14 at 3:02 PM, an			retrieving physician orders. T	he	
		rapy evaluation dated			Assistant Administrator and Office Manager will monitor da	ailv	
	•	apational therapy notes			that all medical records are	,,	
		/26/14, 3/28/14, and			stored in the locked record roo	om	
		served to be on a very			at the end of each business d	•	
		ers surrounding the			The Assistant Administrator w be responsible for monitoring	III	
		ng's desk. Under these			those corrective actions to en	sure	
		eximately 300 - 400 other			that the deficiency is corrected	d l	
	* *	led in the office. There			and will not recur.		
		be many other notes					
	behind her desk						
	beiling her desk	aiso iiot iiicu.					
	h On 4/28/	14 at 3:05 PM, the					
		ng indicated that clinical					
		ot in the record room and					
		where it was. She					
	indicated being b						
	maicated being t	John Gil Hillig.					
	c. On 4/28/1	14 at 3:05 PM, clinical					

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 18 of 23

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

PRINTED: 05/22/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157543	B. WIN			04/29/	ZU14
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
סטיאר מ	ADE HOME HEAT				ST AVE		
	CARE HOME HEAL		T	<u> </u>	_LVILLE, IN 46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG		ot observed to be in the		TAG	DEFICIENCY)		DATE
		oom. The director of					
	_	hrough the documents or					
		ound her desk and was					
	unable to find the	e documents at this time.					
		14 at 3:15 PM, the office					
		served to put together a					
	folder for clinica						
		for the patient's name on					
the side of the folder. She continued							
searching for the clinical record		clinical record					
	documents.						
	e. On 4/28/1	14 at 3:30 PM, the					
	clinical record w	as put together. This					
	record contained	the admission					
	agreement and se	ervice agreement with					
	the patient rights	signed on 3/13/14; a					
	comprehensive n	ursing assessment					
	completed on 3/1	13/14; a medicare					
	secondary payer	sheet signed on 3/13/14;					
	physician verbal	orders for physical					
	therapy to see the	e patient dated 3/14/14;					
	verbal orders to	start care on 3/13/14; a					
	home health cert	ification and plan of care					
	for the certificati	on period of 3/13/14 -					
		ation profile with no					
		ed and a date of 3/13/14;					
		erapy notes from $4/2/14$ ,					
	_	/14; and nursing notes					
	· · · · · · · · · · · · · · · · · · ·	21/14, 3/25/14, 4/4/14,					
	and 4/11/14.						
	wiid i/ 11/17.						

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 19 of 23

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157543	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE COMPI 04/29	LETED
PRIME C	PROVIDER OR SUPPLIER		2632 81	ADDRESS, CITY, STATE, ZIP ( IST AVE LLVILLE, IN 46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	certification peri This record was until 4/29/14 at 4 Registered Nurse 4/13/14 for the si comprehensive a been communica nursing and no re completed in the 4/29/14 at 4:40 F a. On 4/29/1 E, registered nur for patient #3 for Employee F, hor was also caring for b. On 4/29/2 administrator ind HHA, was seeing since the patient wasn't on service c. On 4/29/1 B, the director of patient #3 had sta agency and that so of this. She did verbal orders fro been present in the	d a plan of care for the od of 4/13/14 - 6/11/14.  not present in the office 1:40 PM. Employee E, e, had seen the patient on tart of care / ssessment. This had not sted to the director of ecord had been agency office until PM.  4 at 9:20 AM, Employee se (RN), indicated caring the agency and that me health aide (HHA), for patient #3.  14 at 10:15 AM, the licated Employee F, g patient #3 on her own needed bathing and				

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 20 of 23

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157543	LDING	onstruction 00	(X3) DATE COMPL 04/29	ETED
	PROVIDER OR SUPPLIER		2632 81	ADDRESS, CITY, STATE, ZIP CODE IST AVE LLVILLE, IN 46410	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	ATE	(X5) COMPLETION DATE
	Employee B was patient had starte Employee F had this record and h chain of comman turning in docum record in the offit #3.  d. On 4/29/1 director of nursin for patient #3 had e. On 4/29/2 director of nursin clinical record #3.  3. Clinical record #3.  3. Clinical record #3.  3. Clinical record #3.  4. On 4/28/3 of nursing indicated this record.  b. On 4/28/3 of nursing preservith a binder and it. The clinical rof care for the ceta 3/10/14 - 5/8/14;	d #4, start of care ed no completed clinical maintained in the agency				

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

PRINTED: 05/22/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	COM	TE SURVEY PLETED
		157543	B. WING		<b>—</b> 04/2	29/2014
	PROVIDER OR SUPPLIER		2632 81	ADDRESS, CITY, STATE, ZIP C ST AVE LLVILLE, IN 46410	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	nurses notes date 4/17/14, and 4/24 dated 3/10/14; ph notes dated 3/18/ 3/27/14, 4/1/14, 4 4/15/14; and a sta comprehensive a  4. The agency po Criteria and Proc of August 2011 s will be initiated a for home health a  5. The agency po "Safeguarding / I Service Record" August 2011 stat service records w locked, waterpro record room: A. at night. B. The room will be lock clinical / service to the clinical ser to the office clos clinical / service will remain in the records will be re organization poli federal regulation	olicy titled "Admission ress" with a revised date stated, "A clinical record for each patient admitted services."  olicy titled Retrieval of Clinical / with revised date of red, "All patient clinical / will be maintained in of file cabinets in a All files will be locked clinical / service record red at night 2. All records will be returned record for active patients are office at all times retained according to cy, local, state, and as records of adult retained for a minimum				

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 22 of 23

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

PRINTED: 05/22/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 157543	A. BUILDING B. WING	00	COMPLETED 04/29/2014
PRIME C		TH SERVICES INC	2632 8 <sup>2</sup>	ADDRESS, CITY, STATE, ZIP CODE IST AVE LLVILLE, IN 46410	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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

State Form Event ID: FSVB11 Facility ID: 003155 If continuation sheet Page 23 of 23