PRINTED:	11/19/2019
FORM API	PROVED

	NT OF DEFICIENCIES OF CORRECTION	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	DENTIFICATION NUMBER A. BUILDING 00 15K167 B. WING			(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	ER) HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 ES, INC INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	лΈ	(X5) COMPLETION DATE
3 0000 Bldg. 00	State Licensure su This survey was fi Survey Dates: Sep 2019 Facility #: IN0141 Provider #: 15K16 Census: 90 Skilled: 2 Aide only: 65 Personal Service: Active Census: 44 Skilled: 2 Aide only: 42 These deficiencies	otember 09, 10, 11, 12, and 13, 118 57 23 4 5 reflect State Findings cited in 10 IAC 17. Refer to State Form	G 000	00			
	are precluded from aide training and of for a period of 2 y 2019 to Septembe compliance with O 484.50 Patient Rig Comprehensive as Care planning, coo §484.65; Quality a improvement; and	and Healthcare Services, INC, n providing its own home health competency evaluation program ears beginning September 13, r 12, 2021 for being out of Condition of Participation 42 CFR ghts; 42 CFR 484.55 ssessment of patients; §484.60 ordination, and quality of care; assessment and performance I §484.80 Home Health Aide 5 Organization and					

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

TITLE

(X6) DATE

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

ENTERS FOI	T OF HEALTH AND HU R MEDICARE & MEDI	CAID SERVICES				OM	RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	` ´	ULTIPLE C JILDING	ONSTRUCTION 00	(X3) DATE COMPI	
	of conduction	15K167	B. WING			09/13	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE SUITE				ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400	•		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC	;		NAPOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		R LSC IDENTIFYING INFORMATION services; and §484.110 Clinical		IAG			DATE
	Records.						
	Quality Review Co	ompleted: 10/24/19 by SFF					
G 0350							
Bldg. 00				250			11/07/201
	Based on record re	eview and interview, the agency	G 0	350	As per active RN roster that w provided on 9/10/19 Jennifer N		11/07/203
		ace a current written contract			HHA employee submitting OA		
	-	g on behalf of the agency, to			data, is an employee of Adapt		
	ensure the confide	ntiality of all patient identifiable			Nursing and Healthcare		
	information includ	ed in the clinical record for 1 of			Indianapolis. Personnel file to	be	
	1 agency.				uploaded with current roster list	st	
					that was provided during surve	ey.	
	Findings include:				There has been no HIPAA violation.		
	•	e conference meeting					
		9/19 at 10:30 AM, with the			The deficiency has been corre		
		office manager, the			by a contract has been signed		
		cated that administrator of			with the Jennifer Miller to subr	nit	
		smited the agency's patient			OASIS data. See contract		
	-	and assessment information set] administrator indicated they did			attached.		
		t with the individual.			All OASIS data submissions w	oro	
	not nave a contract	t with the marvidual.			reviewed and had been submi		
	Review of Patient	Orientation Handbook, undated,			by agent who is an active	licu	
		09/09/19, section entitled			employee of Adaptive Nursing		
	-	The patient has the right to			Indianapolis.		
		he clinical records maintained					
		agency" and "The patient has			OASIS data submission contra	act	
	the right to confide	entiality of written, verbal, and			has been created and signed	to	
		tion about the health, social and			cover all future OASIS data		
		ances of the patient or about			submissions.		
	what takes place in	n their home."					
	Record review of t	patient #1 evidenced an			Administrator will monitor year ensure OASIS data submissio	-	
						· •	

	R MEDICARE & MEDIC			ONGTRUCTION	-	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 09/13/2019	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC		VESTPOINT DRIVE, SUITE 400 JAPOLIS, IN 46256)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
110	assessment with O and transmitted by An interview with manager was cond The office manage information was su	ASIS information was collected a non-employee of the agency. the administrator and office ucted on 09/09/19 at 4:45 PM. r indicated that OASIS ibmitted without having a or the individual that transmited		contract is up to date and cur for all OASIS data submission prevent any HIPPA violation.	rent	DATE
G 0372						
Bldg. 00	 failed to submit O/ information set) with completion for 1 or information was con- Findings include: Review of the OAS agency failed to even submissions for the The clinical record start of care of 7/15 assessment was sul 8/30/2019. The real OASIS submission completion. During the entrance 10:30 AM, the adminidividual, from the 	view and interview, the agency ASIS (outcome and assessment ithin 30 days of assessment f 1 skilled record where OASIS ollected and transmitted. (# 1). SIS submission report, the idence any skilled OASIS e year 2019. of patient #1 was reviewed, 5/19. The OASIS certification bmitted for transmission on cord failed to evidence that a occurred within 30 days of e conference on 9/09/2019 at hinistrator indicated an e Jeffersonville, Indiana sister submited the OASIS data and	G 0372	The Administrator did provide OASIS In-service to reeducat Clinical Managers on the spe of the time requirement of OA completion has been complet on 10/29/19. Administrator will track all OA clients weekly to ensure revie and submission of OASIS for within 30 days of visit. Administrator will complete a audit of all skilled clients by 11/4/19 to ensure compliance all clients that could have bee effected. Administrator will ensure that orientation of newly hired clin staff will include review of age OASIS requirements. Administrator will be responsi for monitoring these correctiv actions to ensure that this deficiency is corrected and wir recur.	e all cifics SIS ed SIS w m full e with en cal ency ble e	11/04/2019

MO5T11 Facility ID: 014118

If continuation sheet

Page 3 of 112

		CAID SERVICES	_				B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K167				(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 09/13/2019	
	VIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC		9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256			
(X4) ID PREFIX TAG G 0406	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
fa re of A N tru af cc ca ac pa fa cc pa ar A cc pa ar A cc pa ar A cc pa fa cc pa ar ar A cc pa fa cc ca ba fa cc ca ac pa fa cc ca ac pa fa cc ca ac pa fa cc ca ac pa fa cc ca ac pa fa cc ca ac pa fa cc ca ac pa fa cc ca ac pa fa cc ca ac pa fa cc ca ac pa fa cc ca ac pa fa cc ca ac ca fa cc ca ac ca fa cc ca ac ca fa cc ca ac ca fa cc ca ac ca fa cc ca ac ca fa cc ca ac ca fa cc ca ac ca fa cc ca fa cc ca fa cc ca fa cc ca fa ca cc pa fa cc ca fa ca cc fa ca ca fa ca ca fa ca ca fa ca ca fa ca ca fa ca ca fa ca ca fa ca ca fa ca ca fa ca fa ca ca fa ca fa ca fa ca ca fa ca ca ca ca ca ca ca ca ca ca ca ca ca	iled to ensure par presentatives we the Patient Bill greement, and A otice of Privacy eatment and failed ter 6/07/2019 we ontact for all grie re after 6/07/2011 ministrator cont tients in the pati- iled to ensure the onfidential clinica- tients were prov- dd telephone nun- gency on Aging issure the home h id appropriate tra- hen the needs of HA's capabilities a unknown source tient property by schalf of the HHA ocument the reso e patient/ legal ro- pacted 5 (Patier cords an 4 (Patier ievance entries r these systemic p- calth agency's ina- ere adhered to w	eview and interview, the agency tient and/ or patient re provided an accurate notice of Rights, Authorization, eknowledgement Forms, and Rights before the initiation of ed to ensure all patients admitted ere provided the correct agency vances for patients with start of 9; failed to ensure the current act information was provided to ent orientation handbook; e patient's right to have a al record; failed to ensure that ided current names, addresses, abers for the Indiana Area by service area; failed to ealth agency arranged a safe unsfer to another care entity(s) the patient exceeded the s; failed to investigate injuries of e and misappropriation of anyone furnishing services on (home health agency); failed to lution of complaints made by epresentative. These practices its #1, 2, 3, 6, 8) out of 9 sample ent #25, 26, 27, 28) out of 25 eviewed. The cumulative effect problems resulted in the home ability to ensure apatient rights hich could result in the agency ity health care and safety for all	GO	406	Administrator has updated Par Orientation Handbook and cor was updated to reflect current accurate information in 10/201 Handbook was updated with accurate notice of patient bill or rights, authorization agreemen and acknowledgement forms, Notice of privacy rights and cur Administrator's name and corri information. All current names addresses and phone number have been updated with this update as well. This will be provided prior to initiation of services. All current clients wi receive updated handbook as 11/8/19. Administrator will ensure with monthly checklist that Patient Orientation Handbook is up to date with all requirements. Administrator will ensure reeducation to all internal staff regarding safe and appropriate transfer when the client's need exceed the capabilities of the HHA with HHA Not Meeting Patient Needs In-service to be completed on 11/4/19. Administrator will ensure reeducation to all internal staff regarding misappropriation of complaints, and investigation of Mistreatment, Neglect or Abus	nsent and 9. of it rrent tact 5, s II of	11/08/201	

	R MEDICARE & MEDI					-	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	_	9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256)	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	NTE	(X5) COMPLETION DATE
G 0410					In-service, completed by 11/4 Administrator modified grieva review process to ensure grievances are logged and resolved weekly on 10/24/19. Form included. Administrator be notified of all incidents/grievances, delegat investigation and ensure follo and documentation are comp weekly. See attachments	nce will e w-up	
Bldg. 00	failed to ensure par representatives we of the Patient Bill Agreement, and A Notice of Privacy I treatment in 4 of 8 (#1, 2, 4, 6) and 1 and also failed to e 6/07/2019 were pri- contact for all grie reviewed with SOO and 6) with potent agency. The findings include 1. During the entr at 10:30 AM, emp- administrator and of the director of nurs	rance conference on 9/09/2019 loyee C was identified as the employee QQ was identified as	G 0	410	Administrator has updated Patient Orientation Handboo and consent was updated to reflect current and accurate information in 10/2019. Handbook was updated wit accurate notice of patient bi of rights, authorization agreement and acknowledgement forms, Notice of privacy rights and current Administrator's nam and contact information. Al current names, addresses a phone numbers have been updated with this update as well. This will be provided prior to initiation of services All current clients will receiv updated handbook as of 11/8/19. Administrator will ensure with monthly checklist that Patient Orientation Handbook is up to	h II e I nd	11/08/201

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		e survey leted 8 /2019
	NAME OF PROVIDER OR SUPPLIER		9840	ET ADDRESS, CITY, STATE, ZIP COL WESTPOINT DRIVE, SUIT ANAPOLIS, IN 46256		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETIC
TAG	packet, on 9/09/20 contact at the ager was the previous a	OR LSC IDENTIFYING INFORMATION (19, indicated the individual to acy with concerns or grievance administrator, Employee E.	TAG	date with all requirement See attachments	ts.	DATE
	6/07/2019, indicat	to the state agency, dated ed employee C was the current employee QQ was the clinical				
	Nursing and Healt Consent," stated, ' acknowledges that provider, and (b) i medical services."	document titled, "Adaptive hcare Services Admission 'Client fully understands and t Adaptive: (a) is a non-medical s not licensed to perform This document was dated, at , in the individual clinical				
	4. A review of cli [SOC] 7/15/2019, patient representat Patient Rights, Au Acknowledgemen documents before given inaccurate a concerns and griev representative sign	and 8, as received. nical record #1, start of care evidenced that the patient / tive received an inaccurate thorization / Agreement / t, and Notice of Privacy Rights the initiation of treatment and dministrator contact for vances. The patient / patient ned these documents on nployee F, Registered Nurse				
	evidenced that the received an inaccu Authorization / Ag and Notice of Priv the initiation of tre	nical record #2, SOC of 5/20/19, patient / patient representative trate Patient Rights, greement / Acknowledgement, acy Rights documents before eatment. The patient / patient ned these documents on nployee E, a RN.				
	6. A review of cli	nical record #4, SOC of 9/04/19,				

ENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			00	B NO. 0938-03
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION 00	(X3) DATE COMPL	ETED
		15K167	B. WING		09/13/2019	
NAME OF I	PROVIDER OR SUPPLIEF	}	STREET .	ADDRESS, CITY, STATE, ZIP COD	-	
				ESTPOINT DRIVE, SUITE 400)	
ADAPTI	/E NURSING AND	HEALTHCARE SERVICES, INC	C INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	-	patient / patient representative				
	received an inaccur	-				
	-	reement / Acknowledgement,				
		cy Rights documents before atment and given inaccurate				
	administrator conta	-				
		tient / patient representative				
		thents on $9/04/2019$ with				
	Employee L, a RN.					
		ical record # 6, SOC of 7/02/19,				
		patient / patient representative				
	received an inaccur	-				
	Authorization / Agreement / Acknowledgement, and Notice of Privacy Rights documents before					
		atment and given inaccurate				
	administrator conta	-				
		tient / patient representative				
		nents on 7/02/2019 with				
	Employee G, a RN					
		ical record #8, 01/30/2019,				
		patient / patient representative				
	received an inaccur	ate Patient Rights, reement / Acknowledgement,				
	e e	cy Rights documents before				
		atment. The patient / patient				
		ed these documents on				
	0130/2019 with Em					
	9. On 9/12/2019 at	3:30 PM, the administrator				
		nts in the electronic medical				
	record system were	not updated when the				
		rsonal Service Agency and the				
	Home health agenc	y were merged.				
0414						
3ldg. 00						
	1		G 0414	Administrator has updated Pa	atient	11/08/20

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	COMP	(X3) DATE SURVEY COMPLETED 09/13/2019	
NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC		9840	T ADDRESS, CITY, STATE, ZIP COE WESTPOINT DRIVE, SUITE NAPOLIS, IN 46256				
ADAPTI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C Based on record re failed to ensure pa admitted after 6/07 home health agence business address, a order to receive co clinical records rev 6/07/2019 and affe 6/07/2019. (Patien Findings include: 1. The agency's, u titled, "Patient Ori reviewed on 09/09 "Problem Solving concern or grievan a telephone call to Administrator, [na 2. During survey a at 10:30 AM, emp administrator on re out on maternity le Interview with the manager was cond The administrator individual was refe	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Eview and interview, the agency tients / patient representatives 7/2019, received the accurate by administrator's name, and business phone number in implaints for 3 of 3 active viewed with start of care after exceed all patients admitted after ints 1, 4, and 6) Indated, patient information entation Handbook," was /19. The section entitled Procedure" stated "Any ice may be made in writing or by the Indy North Parent Office me of employee E]." entrance conference on 09/09/19 loyee C indicated she was the ecord and that employee E was eave. administrator and office ucted on 09/09/19 at 4:45 PM. relayed that the incorrect erenced in the admission			TION LD BE ROPRIATE d consent rrent and 0/2019. with t bill of ement rms, nd current d contact ames, mbers this ed an ure page nation to e ovided es. All e updated with tient up to	(X5) COMPLETH DATE	
	 admission packet tf 3. A review of clii [SOC] 7/15/2019, patient / patient reported administration and business phonic complaints. 4. A review of cliii 	they would update the to reflect the change. nical record #1, start of care failed to evidence that the presentative received the tor's name, business address, e number in order to receive					

	T OF HEALTH AND HU R MEDICARE & MEDIO				0	ORM APPROVE MB NO. 0938-03	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		СОМ	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	ę	STREET ADDRESS, CITY, STATE, ZIP COI 9840 WESTPOINT DRIVE, SUITE NDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID PROVIDER'S PLAN OF CORREC EFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP FAG DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
	name, business add number in order to 5. A review of clin failed to evidence to representative rece name, business add	-					
Bldg. 00	name, business address, and business phone number in order to receive complaints.		G 043	 As per active RN roster to provided on 9/10/19 Jent HHA employee submittin data, is an employee of A Nursing and Healthcare Indianapolis. Personnel uploaded with current root that was provided during There has been no HIPA violation. The deficiency has been by a contract has been swith the Jennifer Miller to OASIS data. See contrat attached. All OASIS data submissi reviewed and had been so by agent who is an active employee of Adaptive Net Indianapolis. 	nifer Miller, g OASIS Adaptive file to be ster list survey. A corrected igned o submit ct ons were submitted	11/07/20	
	electronic informat	entiality of written, verbal, and tion about the health, social and inces of the patient or about a their home."		OASIS data submission has been created and sig cover all future OASIS da submissions.	gned to		

	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15K167	B. WING		09/13/2019
NAME OF F	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD WESTPOINT DRIVE, SUITE 400	
ADAPTI	/E NURSING AND	HEALTHCARE SERVICES, INC		NAPOLIS, IN 46256	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Record review of p	patient #1 revealed that an			
	assessment with O	ASIS [Outcome and		Administrator will monitor year	ly to
	ASsessment Inform	nation Set] data information,		ensure OASIS data submission	-
	collected from the	patient, was reviewed and		contract is up to date and curre	ent
	transmitted by a no	on-employee of the agency.		for all OASIS data submissions	
				prevent any HIPPA violation.	
	During an interview	w with the administrator and		, ,	
	-	nducted on 09/09/19 at 4:45 PM,			
	-	indicated that OASIS		See attachments	
		bmitted by an individual,			
	without a contract				
	410 IAC 17-12-3(b	b)(2)(E)			
G 0446					
Bldg. 00					
			G 0446	Administrator has updated Pat	tient 11/08/201
	Based on record re	view and interview, the agency		Orientation Handbook and con	isent
	failed to ensure that	t patients were provided		was updated to reflect current	and
	current names, add	resses, and telephone numbers		accurate information in 10/201	9.
	for the Indiana Are	a Agency on Aging by service		Handbook was updated with	
	area for 1 of 1 ager	ncy.		accurate notice of patient bill o	of
				rights, authorization agreemen	ıt
	The findings include	le:		and acknowledgement forms,	
				Notice of privacy rights and cu	rrent
	Review of Patient	Orientation Handbook, undated,		Administrator's name and cont	act
	included Indiana's	Area Agencies on Aging by		information. All current names	s,
	service area (dated	07/03/17).		addresses and phone numbers	s
				have been updated with this	
		gencies on Aging from in.gov,		update as well. We added an	
	-	late on $02/05/19$. The update		acknowledgement signature pa	-
		act addresses/ phone numbers		with Administrators information	1 to
	for Public Service	Area's /, 8, and 9.		ensure when updates are	.
				received. This will be provided	
	An interview was o			prior to initiation of services. A	
		office manager on 09/09/19 at		current clients will receive upda	ated
	_	time, both the administrator and		handbook as of 11/8/19.	
		curred that the current		Administrator will ensure with	
	admission handboo	ok contained outdated Area on		monthly checklist that Patient	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION (X	(3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15K167	B. WING		09/13/2019
			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	PROVIDER OR SUPPLIE	R		VESTPOINT DRIVE, SUITE 400	
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC	INDIAN	NAPOLIS, IN 46256	
(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 APPROPRIATE DEFICIENCY)	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Aging information			Orientation Handbook is up to	
				date with all requirements.	
				See attachments	
				See allachments	
G 0454					
Bldg. 00					
			G 0454	Patient #1	11/04/2019
		view and interview, the agency		Chart reviewed and documentat	ion
		e home health agency arranged		has been updated to show	
		iate transfer to another care		communication with primary	
		needs of the patient exceeded		caregiver that she was okay to	
	-	ities for 2 of 2 adult skilled		wait after skilled nurse did not	
	records reviewed (#1 and 0).		show up for orientation. Mom	oit
	The findings inclu-	ded		reported that she was oaky to w for new skilled nurse as she had	
	The midnigs metu	ueu.			
	The clinical record	for patient # 1, with start of		someone providing the services	
		019, included a plan of care for		and wanted to give them an appropriate notice that they were	
		riod of 7/15/19 to 9/12/19, with		no longer needed.	
	~	urse services, 8 hours a day, 5		All charts have been reviewed to	
	days a week, effec			ensure services are being provid	
				as orderd.	
	Review of the elec	tronic medical record for patient		Administrator will ensure	
		ce skilled nurse visits were		reeducation to all internal staff	
	provided as ordere	d. The first skilled nurse visit		regarding safe and appropriate	
	note, dated 8/13/20	019, by employee I, a registered		transfer when the client's needs	
	nurse, was the first	documentation of skilled nurse		exceed the capabilities of the HI	HA
	services. The clini	ical record failed to evidence		with HHA Not Meeting Patient	
	documentation to e	explain why skilled nurse		Needs In-service to be complete	d
	services were not o	completed as ordered on the		on 11/4/19.	
	plan of care.			Administrator will review all clier	nt
				admission charts to ensure 1009	%
	-	on 9/10/19 at 3:30 PM, the office		compliance.	
		the patient was accepted and		Patient #6	
	-	is established and the nurse for		Documentation from interoffice	
		gin the following day,		emails showing communication	
		led to arrive for her first day of		with primary caregiver and her	
	orientation, therefo	ore, the agency did not have a	1	wishes to wait on services until	

MO5T11 Facility ID: 014118

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			survey leted /2019
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	;	9840 W	ADDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE 400 APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	communication be primary care giver information was p A review of record assessment was co employee G, a reg The record include and Plan of Care ff 7/02/2019 to 8/30/ nursing services 8 throughout the cer failed to evidence provided as ordere of care. During an intervie administrator indic provided. The record	d a Home Health Certification or the certification period of 2019 with orders for skilled hours per day 5 days a week dification period. The record any skilled service was d in the physician ordered plan w on 9/10/2019 at 3:20 PM, the ated there were no visits ord failed to evidence explain why there were no			she received a hoyer lift in the home is in chart. All charts have been reviewed ensure services are being pro as orderd. Administrator will ensure reeducation to all internal staff regarding safe and appropriate transfer when the client's need exceed the capabilities of the with HHA Not Meeting Patient Needs In-service to be comple on 11/4/19. See attachments Administrator will review all cli admission charts to ensure 10 compliance. See attachments	l to vided f e ds HHA s eted ent	
G 0482							
Bldg. 00	investigate injuries misappropriation of furnishing services health agency) for (#25 and 26) Findings include: 1. Review of polic	view, the agency failed to of an unknown source and f patient property by anyone on behalf of the HHA (home 2 of 25 grievances reviewed.	G 0	482	Administrator will ensure reeducation to all internal sta regarding misappropriation of client property, resolution of complaints, and investigation of injuries with Investigation Mistreatment, Neglect or Aba In-service, completed by 11/4/19. Administrator modified grievance review process to ensure grievances are logge	n of use	11/04/201

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K167	A. BUILDING B. WING	<u>00</u>	COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 JAPOLIS, IN 46256		
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETIO	
TAG 3 0484	 verbal expression of service that is exprise not solved at the written complaint is grievance; as are complexence; as are complexence; as are complexence; as are complexence; as are complexence, client harmon-compliance with a sevent service of the complaint and the complaint and the investigate the complaint and the investigate the complexent shall docut complaint and the investigate the complexent shall docut complaint and the investigate the complexent service. 3. Complaint/Griedocumented "Patier reported that she be her husband, took entry was signed be failed to evidence investigated. 4. Activity Tracki date 04/02/19, india a swollen wrist/with the service of the the transmitted of the the transmitted. 	ent Orientation Handbook, tated "The Administrator/ iment both the existence of the resolution of the complaint, inplaint and report the outcome in to the patient or their evance dated 01/02/18, nt #25 called the office and elieved the caregiver for and a woman's suit from her." This y administrator. The agency that the incident was ing Log, Complaint/ Grievance cated indicated Patient #26 had th an unknown origin. The idence that the injury was	TAG	10/24/19. Form included. Administrator will be notified all incidents/grievances, delegate investigation and ensure follow-up and documentation are completed weekly. Administrator will monitor 100% compliance wee with report from Matrix and place in QAPI binder. Administrator will review all chat to ensure 100% compliance with all documentation and resolution See attachments	l kly ce arts th	
Bldg. 00	Based on record re	view, the agency failed to	G 0484	Administrator will ensure reeducation to all internal staff	11/04/20	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	00 (X	3) DATE SURVEY COMPLETED 09/13/2019
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256	
ADAPTI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF document the resolut the patient / legal re- grievances reviewed Findings include: Review of agency p Policy", dated 03/11 addressed by the m- designee and respon within seven (7) cal "Grievances are con complainant has be investigation/resolut will be used to dete regarding improver services, or individu Grievances are con client is satisfied w behalf." Review of Patient A page 17 stated "The document both the the resolution of the complaint and repo investigation to the representative."	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL ALSC IDENTIFYING INFORMATION ition of complaints made by presentative for 4 of 25 d. (#3, 25, 27. 28) colicy entitled "Grievance 8/18, stated "Grievances will be anager/administrator or his/her ase made to the complainant endar days of receipt." And asidered completed when the en provided with the tion of the grievance. This rmine actions to be taken hents in organizational process, hal employee performance. sidered resolved when the th the actions taken on their			e II up ed or ts n. g
	 / Grievance for the 9/9/19 was complet complaints logged in documentation of a 1. Complaint/ Grie the following intake and reported that sh and her husband, to 	time period of 1/1/18 through ed on 09/09/19. The following ailed to evidence			

Event ID: MO5T11 Facility ID: 014118

If continuation sheet Page 14 of 112

PRINTED: 11/19/2019 FORM APPROVED

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K167	A. BUILDING B. WING	00	09/13/2019	
	PROVIDER OR SUPPLIE			COD ITE 400		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC	INDIA	NAPOLIS, IN 46256		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE COMPLETIN	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	2 Complaint/ Gri	evance dated 03/14/19, related to				
	~	ented "I received a call from				
	-	s balling her eyes out. Basically,				
		ning and her do not get along.				
		[name of aide]. She works at				
		a MA (medical assistant) and				
		tient care for a long time so I				
	• •	hat she is doing. Patient				
		cause she bought the wrong				
		ntain) Dew and because [aide				
		ke a box of incontinent supplies				
		a different house (agency told				
		I asked patient if she is being				
		I kept clean and she said yes,				
		ggest concerns. I will replace				
		patient request, but it will take				
		w, hire, and train someone."				
		s void author, there was no				
	-	ency failed to evidence a				
	resolution.					
	3. Complaint/ Gri	evance dated 08/13/19, patient				
	#27, documented	'Caregiver [sent] text - I can no				
		tient #27. I refuse to put myself				
	in that environmen	nt. Him and Ms. [patient] want				
		. I have to hear them argue and				
		screaming episodes plus more.				
	He needs more he	lp than I can give him. If that				
	means I have to re	sign then I am sorry. \$12 isn't				
		ne agency failed to evidence a				
	resolution.					
	4 Complaint/Gri	evance dated 09/05/19, patient				
	^	Patient #28 is threatening to				
		ause aide isn't able to do 7:15				
	-					
		e is scheduled for 7:30-5:30 PM.				
		everything else is great, but she				
	-	e her ASAP if she can't do the s. Neither the aide nor the				
	schedule she need	s. Neither the aide nor the				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167		JILDING	ONSTRUCTION 00	СОМ	e survey pleted 3/2019
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	2	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 4 JAPOLIS, IN 46256	100	
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O patient are coming	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION to an agreement with the times.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DN BE PRIATE	(X5) COMPLETION DATE
	time and I am not	h staffing all of her hours at this sure what else to do to keep the he agency failed to evidence a					
G 0510	410 IAC 17-12-3(6	2)(2)					
Bldg. 00	interview, the ager service was provid [SOC], ensured the accurately reflected psychosocial, func correct home safet nutritional risk ass patient's strengths, including informat toward goals and r a patient's current is changes in medica patient's strengths, incorporation of th Assessment Inform ensured an updated was completed wit certification period updated comprehe These practices im out of 8 sample red focused sampled red cumulative effect of resulted in the hom	on, record review and by failed to evidence a skilled ed to establish the start of care e comprehensive assessment d the patient's current health, tional status, including a y evaluation, and a correct essment, ensured included the goals, and care preferences, ion to demonstrate progress measurable outcomes, updated medication additions and tions; ensured included the ensured to include the e current Outcome and hation Set [OASIS] items; d comprehensive assessment hin the last 5 days of l; and ensured to complete an insive assessment at discharge. pacted 5 (Patient #1, 2, 4, 6, 7) cords and 1 (Patient #9) out of 1 ecords reviewed. The of these systemic problems he health agency's inability to are assessed accurately and	G 0	510	Administrator will ensure reeducation to all internal regarding complete and accurate comprehensive assessments with Comprehensive Assessm In-service, completed by 11/4/19. In-service includes reeducation to acc reflected the patient's curre health,psychosocial, function status, including acorrect h safety evaluation, and a correctnutritional risk assess ensured included thepatient strengths, goals, and care preferences, including inform to demonstrate progresstow goals and measurable out updateda patient's current medication additions andch in medications; ensured ino thepatient's strengths, ensu- include theincorporation of current Outcome andAssess Information Set [OASIS] items;ensured an updated	ent curately ont ome ssment, t's mation ward comes, manges cluded ured to the	11/04/201

	R MEDICARE & MEDIC					MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPL A. BUILDING B. WING	e construction G <u>00</u>	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	984	EET ADDRESS, CITY, STATE, ZIP COD 0 WESTPOINT DRIVE, SUITE IANAPOLIS, IN 46256	400	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	TON D BE OPRIATE	(X5) COMPLETION DATE
	environment.			ofcertification period; and to complete anupdated comprehensive assessme atdischarge.Administrator monitor for 100% complia reviewing each chart with visits completed week prior review will be completed weekly. See attachment	ent will nce by home	
G 0528 Bldg. 00						
	interview, the ager comprehensive ass the patient's curren including a correct (patient #2); failed of care in regards t assessment (patien endocrine system, cardiopulmonary, a with bowel assess functional limitation permitted, allegory discharge planning evidence an accura a client's environm medications, activity	on, record review, and cy failed to ensure the essment accurately reflected t health and functional status home safety evaluation to be consistent with the plan o the nutritional risk t #7); failed to assess of the integumentary status, a complete elimination status nent, psychosocial assessment, ons, musculoskeletal, activities assessment, patient goals, and (patient #1) and failed to te and complete assessment of ent, personal care needs, ty level, and the wheelchair during 1 of 3 home visits and records reviewed.	G 0528	Administrator will ensure reeducation to all interna- regarding complete and accurate comprehensive assessments with Comprehensive Assess In-service, completed by 11/4/19. In-service includes reedu- to accurately reflected th patient's current health,psychosocial, fun- status, including acorrect safety evaluation, and a correctnutritional risk assessment, ensured ind thepatient's strengths, g and care preferences, ind information to demonstr progresstoward goals ar measurable outcomes, updateda patient's curre medication additions	al staff ment ucation le ctional ct home cluded oals, cluding ate nd	11/04/201
	1. The "Comprehe	nsive Client Assessment"		andchanges in medication	ons;	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167			(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	[°] Address, city, state, zip c WESTPOINT DRIVE, SUI NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETIC DATE
	 policy was provide 1:00 p.m. This cur A thorough, well of accurate assessment immediate needs we a timely manner, be days after start of of the appropriate car meet client initial in needs. To collect of history, (physical, and their needs as setting. To make of decisions based on each client's needs to careSPECIAL Comprehensive As of all medications Assessment and do regarding whether suitable for provid 2. Review of polic dated 03/20/18, on evaluation in sectific following forms and the admission proof the patient's home maintained in the of Safety Evaluation. 3. A home observe 09/11/19 at 6:50 and home visit it was of alternate exit in car of a renovated attice 	d by Employee C on 9/11/19 at rent policy indicated "POLICY rganized comprehensive and nt, consistent with the client's vill be completed for all clients in ut no later then five (5) calendar earePURPOSE To determine e, treatment and services to needs and his/her changing data about the client's health functional and psychological) appropriate to the home care are, treatment or service information developed about and the individual's response INSTRUCTIONS2. The ssessment will include a review the client is using6. coumentation are made the home environment is ing home care" ey entitled "Admission Criteria", ly refers to the home safety on #8. which stated "The e signed, by the patient, during ess with a copy remaining in chart and the original will be office clinical record; Home "		ensured included the strengths, ensured to theincorporation of th Outcome andAssess Information Set [OAS items;ensured an upo comprehensive asses completed within the days ofcertification pre- ensured to complete anupdated comprehe assessment atdischarge.Administr ensure reeducation for safety concerns with T Safety Evaluation In-se 11/4/19. Administrato monitor for 100% com by reviewing each cha- home visits complete prior. This review wil completed weekly. See attachment ="" span="">	patient's o include ne current ment IS] dated ssmentwas last 5 eriod; and nsive rator will r home 'he Home ervice on or will npliance art with ed week	
	Review of the "Ho	me Environment Safety				

	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	1B NO. 0938-03 SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	r í	JILDING	00	COMP	
		15K167	B. W		<u></u>		/2019
NAME OF	PROVIDER OR SUPPLIE	P		STREET A	DDRESS, CITY, STATE, ZIP COD		
					ESTPOINT DRIVE, SUITE 40	00	
ADAPTI		HEALTHCARE SERVICES, INC			APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E RIATE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		dated 05/20/19, #6 asked if					
		e accessible in case of fire, in					
	which the response	e/ answer was "yes."					
	On 09/11/19 at 12:	30 p.m., a copy of a home					
	environment asses	sment policy was requested.					
	On 09/11/19 at 1 p	.m., the administrator indicated					
	that there was no p	oolicy for home safety/					
		sment or policy of any kind					
		vironment and that it is					
	included in the Ad	mission Criteria policy.					
	4. Record review	for patient #7, a form titled					
		Assessment" dated 02/15/19,					
	indicated a risk sco	ore of 10, low risk (score range					
	0-25). This score	was comprised of "takes 3 or					
	more prescribed or	OTC (over the counter)					
	medications per da	y, frequently has problems with					
	diarrhea or constip	ation."					
	Plan of care review	v for certification period					
	02/17/19-04/17/19	, the nutritional requirements					
	stated "Medium nu	atritional risk." 60-day summary					
	(page 2 of 4) stated	d "She isn't physically able to					
	provide her own p	ersonal care, cook her own					
		atient #7 has no willing or able					
	-	of agency name"					
		n 10:46 a.m. to 1:35 p.m., Client					
		conducted. Upon entry into					
		or was detected. Employee M,					
		n the kitchen, indicated the odor					
	-	y tapes were observed hanging					
		next to the exit door, another					
		nd a third tape above the					
		ts and flies were observed on					
	· ·	s same time Employee M					
		pes were not present					
		flies were "pretty bad"					
		rigerator door was observed substances on the outside door,					
	with brown dried s	substances on the outside door,					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00		
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)) BE	(X5) COMPLETI DATE
	dried food present had standing wate floating in the wat a pan on the table The bagless trash but not limited to, pasta box, and foo was presently turn gray to black dust front screen of thi In the living room observed eating a was observed in a and brown, soiled length of her shou Foley catheter wit small amount of d at the end of the c this room was obs areas with a sauce near the end of on lift and walker wa room. As Employee M v her bed bath, the c and indicated she Client 4 urinated i between her legs v female roommate was turned to her client's shoulders and wet with loos observed in the re rectal care and per indicated she had Employee L left a	ed in 1 side of the sink with and the other side of the sink r with brown substances er. Soiled rags were observed in located in front of the window. can was full of trash, including, disposable gloves, cardboard d wrappers. A floor fan, which ed off, was observed with dark covering the majority of the s fan. with lights on, Client 4 was bowl of cereal in her bed. She hospital gown with several wet sheets underneath her the lders to her upper legs. A h the attached bag containing a ark, yellow urine in the bag hung lient's bed. The carpeting in erved with scattered stained r size worn hole in the carpeting e of the bed's wheels. A Hoyer s observed giving the client client apologized to staff present needed to urinated, and then, n the bed. This puddle of urine was absorbed by the client's with a towel. When the client right side, the mattress from the to her upper legs was odorous e, brown soft bowel movement ctal area. At the time for the trienal care, Employee L (RN) to leave for a short period. t 12:35 p.m. and returned at 12:46 lient's bath she complained of				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	r í	JILDING	NSTRUCTION 00	со	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC		9840 W	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256			
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT	JLD BE	(X5) COMPLETI	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APP DEFICIENCY)	RUPRIATE	DATE	
	being too hot ,and	the fan present in the kitchen wing towards the client in her						
	interview Employ	:40 a.m. to 12:09 p.m., during an ee L indicated her initial visit						
	client's past medic review all medicat	leting the admission forms, al history, any falls, nutrition, ions and document the						
	would be obtained of Care would be	brbal order for the start of care from the physician, and a Plan nitiated and would be reviewed						
	indicated Client 4	or the Director of Nursing. She s assessment included her vital e client's hand grasps, any						
	did a visual check	tles and feet. She indicated she of the skin from head to toes was unable to do a posterior						
	check as no one w client to her side.	as present to help turn the She did indicate she asked the						
	indicated Client 4	ndition of her skin. She was found in the same condition d sheets and condition of her						
	9/10/19. She also	at the home visit conducted indicated the house was "very						
	the fan or the F/C	ains pulled, and she did not see bag and tubing at the end of the e medications she indicated a						
	concern with the labut she had not dis	axatives the client was taking, secure this with the client at the						
	was a concern due house. When que	by e L indicated the environment to the possible bugs in the ried Employee L indicated 1						
	roommates have in help with the clien	able to turn her, and the ndicated they did not want to t's care. Employee L also						
		continued to refuse to use the was present in the home, and her t was broken and						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K167	B. WING		09/13/	/2019
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC		/ESTPOINT DRIVE, SUITE IAPOLIS, IN 46256	400	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	.D BE OPRIATE	COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	Client 4's clinical	record was reviewed on on				
	9/10/19 at 3:45 p.r	n. The client's diagnoses				
	included, but were	not limited to, rheumatoid				
	arthritis, Type 2 D	iabetes Mellitus, hypertension,				
	and obesity. The	Start of Care was 9/4/19. The				
	Plan of Care with	the certification period of 9/4/19				
	through 11/2/19 in	dicated the HHA (Home Health				
	Aide) was to provi	ide 4 to 5 hours a day for 5 days				
	per week and not t	per week and not to exceed 25 hours per week				
	throughout the 60	day certification period. The				
	"Professional Services Orders" the HHA was to					
	assist with all AD	Ls (Activities of Daily Living)				
		ed/ tub/ shower), hair care,				
	-	, incontinence care, meal prep				
		lication reminders, light				
		transfers. Patient is widowed				
	-	ling to provide care. She lived in				
	-	with 2 room mates (no relatives),				
		and unwilling to care for the				
		day time hours. Patient was				
		self due to immobility related to				
	Ũ	evere pain mainly in her left hip				
	-	wrist. Patient was considered				
		not ambulate. Patient had				
		e of both bladder and bowel				
		st with any personal care.				
		to prepare meals for self or				
		ekeeping. The motorized				
	wheelchair (w/c) v	vas currently not working.				
	The "MEDICAL H	HISTORY/ PHYSICAL/				
		SSESSMENT," dated 9/4/19,				
		a new client's assessment. The				
		elchair and her own				
		Activity Level" was "Transfer				
		assistance was indicated for				
		and dressing. The client was				
		r dressing with meals/snacks to epared and served to				
	1 of completely pre	parou and solved to		1		1

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	ì í	JILDING	NSTRUCTION 00		(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE VE NURSING AND) HEALTHCARE SERVICES, INC		9840 W	.DDRESS, CITY, STATE, ZIP ESTPOINT DRIVE, SI APOLIS, IN 46256			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	I SHOULD BE	(X5) COMPLETI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	EAPPROPRIATE	DATE	
	by staff, and perso be done "by others" "Dependent - required assistance with all required to the Hon instructed to repose	ekeeping was to be performed onal laundry and linens was to s." Her "MOBILITY" was irres assistance from bed to sa; requires wheelchair for ot maneuver without assistance. Int of bowel and bladder. The essment was totaled as ondent" The "NARRATIVE ON" indicated the client was not ambulate and had "severe" oth bladder and bowel. There of information regarding the r wheelchair was not working, to use the Hoyer lift. The DNMENT SAFETY dated and electronically signed a 9/9/19 at 2:33 p.m., indicated safe for the provision of care a for food prep, etc.)15. Overall equately sanitary for the ' The answer to both of these "SKILLED NURSE VISIT delectronically signed by 10/19 at at 3:03 p.m., indicated ND REASON" was the need for activities, residual weakness, e to ambulate, unable to safely sted, and dependent upon with no clarifications included. Licated as incontinent with no no medication changes. The OTES" included, but were not me Health Aide (HHA) was istion the patient when possible, ntinually incontinent, and						
	medications were nurse visit also did information relate	the difficulty in turning the						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTI A. BUILD B. WING		ISTRUCTION 00	COMP	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	HEALTHCARE SERVICES, INC	98	reet ai 340 WE IDIANA	100)		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	II PRE		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETI DATE	
	Hoyer lift, the med client as taken and used as observed of observation. 6. A review of cli 7/15/2019, was rev included a Plan of period 7/15/2019 to skilled nurse 8 hou The comprehensive failed to evidence system, integumer complete eliminat assessment, psych limitations, muscu allegory assessment planning. These at blank. The docum nursing service wat assessment, to esta 7/15/2019; the are was left blank. The record failed to services were prov record failed to ev comprehensive asses completed prior to dated 8/13/19, a pu staff member asses A review of record assessment was con employee G, a reg evidenced the patit to evidence a head assessment, that in	sessment with OASIS items was the first skilled nurse visit eriod of 29 days passed since a						

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	î /	JILDING	ONSTRUCTION <u>00</u>		survey leted /2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	;	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 4 NAPOLIS, IN 46256	400		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	permitted, allegory involvement of the planning, and the of The document fail service was provid establish the start of The record include and Plan of Care fr 7/02/2019 to 8/30/ nursing services 8 throughout the cer During an intervie administrator indic	w on 9/10/2019 at 3:20 PM, the cated there were no other e patient found in the clinical						
G 0530								
Bldg. 00	interview, the agen care preference for based on the comp (patient #2) out of reviewed and 1 (pa records reviewed. Findings include: 1. Home observat	ion, record review, and ney failed to ensure the patient's r Boost and a sink bath were rehensive assessment for 1 1 pediatric skilled record atient #7) out of 2 closed ion was completed on 09/11/19 ient #2. During the home visit,	G 0	530	Administrator will ensure reeducation to all clinical managers regarding patie preference/requests with Comprehensive Assessm In-service, completed by 11/4/19. Administrator will monitor for 100% complian reviewing each chart with h visits completed week prior review will be completed weekly. See attachment	ent ce by iome	11/04/201	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	II TIPI E CO	NSTRUCTION	(X3) DA	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	î î	JETH LE CO JILDING	<u>00</u>	· · ·	MPLETED	
		15K167	B. WI		<u></u>		13/2019	
		 、		STREET A	ADDRESS, CITY, STATE, ZIP (COD		
	PROVIDER OR SUPPLIEF				ESTPOINT DRIVE, SU	ITE 400		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC	2	INDIAN	APOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLET	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	the patient was give	en a carton of Boost to drink.			="" span="">			
	Record review of a	plan of care for the certification						
		- 07/18/19 was completed.						
	· ·	tion (page 2 of 4) stated						
		four times a day" and						
		ments section (page 3 of 4)						
	stated "Pediasure fo							
	Record review of a	plan of care for the certification						
		- 09/16/19 was completed.						
	Gastrointestinal sec	tion (page 2 of 4) stated						
	"Pediasure 237 ml	four times a day." and						
	Nutritional Require	ments section (page 3 of 4)						
	stated "Pediasure fo	our times a day."						
	Review of the Intra	ke/ Referral form indcated the						
	patient was to have	Pediasure.						
	Review of the nutri	tional section of the						
	comprehensive asse	essment dated 5/20/19, the						
	nutritional assessme	ent indicated Pediasure. The						
	assessment failed to	address the patient's care						
	preferences for boo	st over the ordered pediasure.						
	Interview with emp	loyee K, RN, stated "we use						
		Pediasure when we run out of						
	Boost."							
	Interview with patie	ent caregiver (father) was						
	-	e on 09/11/19 at 2:53 p.m He						
	indicated that the p	atient prefers Boost, so she						
	gets Boost during th	ne day.						
	2. Patient #7 clinic	al record was reviewed and						
		me health aide visit notes that						
	the sink baths were							
	Review of a comm	unication note from the RN,						
		d 03/28/19 states "Client						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	ì í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/13/2019		
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC		9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION h"		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETIO DATE	
	4/17/19, failed to e for bathing.	rtification reassessment dated vidence the patient's preference care for patient #7, for						
	certification period professional servic stated "HHA (hom	l of 04/18/19-06/16/19, es order section (page 2 of 4) e health aide) to assist with all f daily living) such as bathing						
G 0536								
Bldg. 00	interview, the ager current medication medications for 1 of (Patient #4) and 1 reviewed. (Patient Findings include: 1. On 9/9/19 from entrance conference Employee C. Duri Employee C indica documented on a p the home, and elec medical record wh for drug interaction process should be medication change	10:30 a.m. to 11:05 a.m., the e was completed with ng this entrance conference tted new medications were aper copy, which was left in tronically in the electronic ere the information was checked hs. She also indicated this completed any time there was a	G 0	536	 For client #4 chart was revi and all medications updated w supplemental order sent to M validation signature. All files were reviewed and un-validated orders re-sent to for validation signature. All Clinical Managers received in-service and re-education to update medication/plan of car with any and all changes and supplemental order to the MD All charts will be reviewed by Administrator with following envisit to ensure updates of medication profile and supplemental orders sent to M for validation signature. For client #7 Client has been discharged, unable to verify medication change and get or 	vith D for MD d e send c ach MD en	11/08/201	
	home visit was con	0:46 a.m. to 1:35 p.m., Client 4's aducted. During the client's bed m and Nystatin powder were			at this time. All charts are being reviewed ensure all medication change	to		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIP A. BUILDIN B. WING	ILE CONSTRUCTION NG <u>00</u>	СОМ	(X3) DATE SURVEY COMPLETED 09/13/2019		
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	984	REET ADDRESS, CITY, STATE, ZIP C 40 WESTPOINT DRIVE, SUI DIANAPOLIS, IN 46256	WESTPOINT DRIVE, SUITE 400			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREF TAC	CROSS-REFERENCED TO THE A	RECTION HOULD BE IPPROPRIATE	(X5) COMPLETIO DATE		
	used in the redden fold and breasts. A milliliters) of Pept stomach) for her c client's medication Atorvastatin 10 m tab nightly; 1 bottl take 1 every day a Amlodipine 0.5 m evident to include cream or Nystatin inquired, the clien tablet of the Amlo dose for the Atorv The client's medic carbamide peroxic build up), Amlodig day (hypertension every day (hypertension every day (hypertension every day (hypertension every day (hypertension every day (hypertension every day (hypertension every 4 hour oxybutynin 10 mg mg once a day (bla mg take 1 to 2 tim 500 mg 2 times a d Drugs.com but ind for hyperlipidemia The "SKILLED N electronically sign at 3:03 p.m., failed changes. The medi indicate all the me correct doseages. 2. The clinical rec 12/19/18, was revi	ed areas under the abdominal Also, the client took a dose (30 ol Bismol (nausea and upset omplaint of nausea. When the as were checked, 3 bottles of g with directions to take a 1/2 le of Amlodipine Besylate 10 mg nd a second bottle of g every day. No information was the Bepto Bismol, Nystatin powder. When Employee L t indicated she only took a 1/2 dipine and did not clarify the astatin. ation list, dated 9/4/19, indicated de 6.5% otic solution (for ear wax pine 10 milligrams (mg) once a), hydrochloric 12.5 mg 1 tablet ension), ducolax 50 mg-8.6mg 2 dtime (constipation), lorazepam lay (anxiety), Atorvastatin 10 mg lipidemia), tramadol 50 mg 1 rs as needed for pain, /24 hour, extended release, 10 adder spasms), gabapentin 300 es a day (pain), and metformin day (oral diabetic medication per licated on this medication sheet		have supplemental ord MD with MD validation All current employees I in-serviced on updating profile with each visit a supplemental order for changes. All charts will be review Administrator with follo visit to ensure updates medication profile and supplemental orders se for validation signature Administrator will ensu reeducation to all intern regarding review of all with Comprehensive A In-service, completed to 11/4/19. Administrator monitor for 100% comp reviewing each chart w visits completed week review will be complete See attachment ="" 4="" 11="" accura and="" complete="" be charts="" current="" all review="" will="">	signature. have been g medication nd sending all wed by wing each of ent to MD re hal staff medications ssessment by will bliance by vith home prior. This ed weekly. te="" ="" to=""			

	R MEDICARE & MEDI				OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>00</u>	COMPLETED
		15K167	B. WING		09/13/2019
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
ΔΠΔΡΤΙΙ		HEALTHCARE SERVICES, INC		WESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256	
	r	STATEMENT OF DEFICIENCIE			
(X4) ID PREFIX			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO
		NCY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
	-	tinent diagnoses include			
		hypertension, anxiety disorder,			
	-	nin syndrome, type II diabetes			
	mellitus, and mixe	d incontinence.			
	Skilled nurse visit	note, dated 03/12/19, medication			
	section, page 2 of	4, indicated that "medication			
	changed since last	visit" and "Pt (patient) to call			
	pharmacy for accu	check and new med."			
	Review of the me	lication profile dated 4/17/19			
		(bone health), Humira			
		tis), acetaminophen (pain),			
		emia), prednisone (arthritis),			
		ety), metoprolol (hypertension).			
	· ·	ofile failed to evidence any			
	medication change	-			
		5 5 5 1 1 2 1 2 1 7 7 1 0 .			
	410 IAC 17-14-1(a)(1)(B)			
6 0546					
Bldg. 00					
			G 0546	Patient #9	11/05/201
		ew, the agency failed to ensure		failed to ensure an updated	
	· · ·	ehensive assessment was		comprehensive assessment wa	
	-	the last 5 days of certification		completed within the last 5 day	/S
	· ·	ocused discharged records		of certification period.	
	reviewed. (Patient	t #9)		Chart has been reviewed. Clied has SOC 3/29/18 for cert perio	
	Findings include:			3/29/18 -5/27/18. Recertificatio	
	C C			OASIS was completed 5/23/18	
		vas reviewed on 9/13/19. The		cert period 5/28/18 -7/26/18.	
	record included a	plan of care for the certification		Recertification OASIS was	
	period 7/27/18 to 9	0/24/18 with orders for skilled		completed 7/23/8 for cert perio	d
		week for oral medication preset		7/27/18 -9/24/18. Client was	
	and pre-fill of insu	lin syringes.		discharged from services due t	to
				switching to a new provider on	
				9/14/18. Client was discharged	

	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION (2 00	X3) DATE SURVEY COMPLETED
		15K167	B. WING		09/13/2019
AME OF	PROVIDER OR SUPPLIEI	λ.		ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400	
DAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC		IAPOLIS, IN 46256	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E COMPLETIO DATE
	comprehensive ass	essment, which included the		days before recertification visit	
	collection of OASI	S data items.		due. Client was discharged price	or
	During an interview on 9/10/2019 at 3:20 PM, the			to the 5 day window for recertification.	
	administrator indic	ated there were no other			
	assessments for the record.	patient found in the clinical		All charts have been reviewed a will continue to be monitored for	
	record.			timely recertifications.	1
				All visits are entered into calend	dar
				in EMR program for tracking	
				purposes. Each week report is ran to see what visits are due.	
				Cert period end dates previous	v
				were monitored monthly to mak	-
				sure recertifications were	
				completed on time. Going forw	ard
				they will be reviewed weekly to ensure recertifications are not la	ato
				In the event of a missed	ale.
				recertification visit, MD will be	
				notified and order sent to MD for validation.	pr
				Clinical Managers have been	
				re-educated that all recertification	ons
				must be done on time with the	
				56-60 day window.	
				Administrator will be responsible for monitoring these corrective	e
				actions to ensure that this	
				deficiency is corrected and will	not
				recur. Administrator will	
				monitor for 100% compliance	
				by reviewing each chart with home visits completed week	
				prior. This review will be	
				completed weekly.	

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Event ID: MO5T11 Facility ID: 014118

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	` ´	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/13/2019		
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC		9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 40 IAPOLIS, IN 46256	E, SUITE 400		
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N BE RIATE	(X5) COMPLETION DATE	
					See attachment ="" accurate="" and="" complete="" to="" current="" be="" will="" review="" all="" charts="" 11="" 5="">			
G 0550 Bldg. 00	failed to complete assessment at discl records reviewed. Findings include: 1. Review of clini physician order da client from agency switching to anoth physician authentic Review of clinical did not include a d assessment. An interview was of PM with the admin They reviewed the there was no disch assessment. 2. Cli start of care of 7/00 certification period physician orders fo a day, five days a v discharge date of 8	record completed on 09/12/19 ischarge comprehensive conducted on 09/12/19 at 5:45 histrator and office manager. clinical record and agreed that arge comprehensive nical record # 6 evidenced a 2/2019 and a plan of care for the 17/02/19 to 8/30/2019 with or skilled nurse services 8 hours week. The record evidenced a 2/21/2019. The record failed to ge assessment with the	G 0	550	The Administrator will provid OASIS and Comprehensive Assessment In-service to reeducate all Clinical Manage the discharges completed of 10/29/19 and 11/4/19. Administrator will track all O clients weekly to ensure rev and submission of OASIS for within 30 days of visit. Administrator will complete a audit of all skilled clients by 11/4/19 to ensure compliance all clients that could have be effected. Administrator will ensure that orientation of newly hired cli staff will include review of age OASIS requirements. Administrator will be respon for monitoring these correcti actions to ensure that this deficiency is corrected and o recur.	gers on n ASIS iew orm a full ce with cen at nical gency sible ive	11/04/201	

				OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840	ADDRESS, CITY, STATE, ZIP COD WESTPOINT DRIVE, SUITE 4 NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRC DEFICIENCY)	DBE COMPL	
G 0570 Bldg. 00	 confirmed there was assessment available 3. Clinical record 01/30/2019 and a period 7/29/19 to 9 for aide services 7 week. The record 8/16/2019. The re assessment at disclet 4. Clinical record included a period 7/27/18 to 9 nurse visit once a vand pre-fill of insu The record evidence patient was transfe 9/14/2018. The re discharge assessment of assessment at terms. 410 IAC 17-13-2(2) Based on observation interview, the ager medical and nursir of residence, visits care, ensured a phyto providing care, ensured fall period and pre-fill period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care, ensured fall period for the services in accordate care. 	 # 8 evidenced a start of care of olan of care for the certification 0/26/2019 with physician orders 8 hours a day, 5-6- days a evidenced a discharge date of cord failed to evidence an narge. 9 was reviewed on 9/13/19. The olan of care for the certification 0/24/18 with orders for skilled week for oral medication preset lin syringes. ce documentation that the rred to another agency on cord failed to evidence a ent with the incorporation of 	G 0570	The Administrator will prov Comprehensive Assessme In-service to reeducate all Managers on the specifics medications, supplemental physician authentication requirements has been con by 11/4/19. The Administrator will prov	ent Clinical pain orders, mpleted	5/201

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 COMPLETED 00 B. WING 09/13/2019 15K167 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256 ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE plan included patient-specific interventions with Meeting Patient Needs In-service measurable outcomes for aspiration precautions, to reeducate all internal staff of fall precautions, pain precautions, failed to ensure specifics of documenting missed the skilled nurse put new orders in writing to be shifts and all communications sent to the physician for signature, failed to accurately. ensure the physician was notified when it was decided the patient declined to have skilled New clients will not be admitted nursing services as ordered per the plan of care, unless the agency is able to meet changes in feeding supplements, and unrelieved their staffing needs. Once pain, and failed to ensure the physician was admitted services will begin notfied when it was decided the patient declined immediately. All internal to have skilled nursing services as ordered per the employees will be re-educated on plan of care. These practices impacted 4 (#1, 2, 6, this with meeting on 11/15/19. 7) out of 8 sampled records reviewed. The cumulative effect of these systemic problems Administrator will monitor all resulted in the home health agency's inability to referrals and admissions weekly to ensure care and services provided which could ensure services begin result in the agency not providing quality health immediately. care in a safe environment. In regards to G570 Administrator will be responsible for monitoring these corrective Based on record review and interview, the agency actions to ensure that this deficiency is corrected and will not failed to ensure patients medical and nursing needs were met in their place of residence for 2 recur with weekly reporting out of 2 skilled adult records reviewed. (Patient checks. Administrator will monitor #1, 6) for 100% compliance by reviewing each chart with home visits Findngs include: completed week prior. This review will be completed weekly. 1. Clinical record # 1, with Start of care 7/15/2019, Administrator will review all charts included a plan of care for the certification period for completion by 11/5/19. 7/15/2019 to 9/12/2019 with orders for skilled nurse see attachments 8 hours a day, 5 days a week. Review of the electronic medical record for patient #1 failed to evidence skilled nurse visits were provided as ordered. The first skilled nurse visit note, dated 8/13/2019, by employee I, a registered nurse, was the first documentation of skilled nurse services. The record failed to evidence skilled Event ID: MO5T11 Facility ID: 014118 Page 33 of 112 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

11/19/2019

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	INSTRUCTION	(X3) DA	TE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K167	A. BUILDING B. WING	00	_	^{4PLETED} 13/2019
JAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C 'ESTPOINT DRIVE, SUI'		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC	INDIAN	APOLIS, IN 46256		
X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	 8/13/2019. The clidocumentation to deservices were not of plan of care. During interviews manager indicated the plan of care was the case was to beg 7/16/2019, and fail orientation, therefore nurse for the case. that there were no patient 1 until 8/13 the communication primary care giver 	e provided from 7/15/2019 to inical record failed to evidence explain why skilled nurse completed as ordered on the on 9/23/19 at 4:30 PM, the office the patient was accepted and as established and the nurse for gin the following day, led to arrive for her first day of ore, the agency did not have a The administrator confirmed skilled services provided to a/2019. Employee A indicated to between the agency and the was in her agency emails. No				
	 A review of rec 7/02/2019, evidend and Plan of Care for 7/02/2019 to 8/30/ nursing services 8 throughput the cert record failed to evid were provided as of notes to explain wh During an intervier office manager, intervier office manager, intervier giver decided, after did not want other 	rovided by survey exit. ord #6 with a start of care eed a Home Health Certification or the certification period of 2019, with orders for skilled hours per day 5 days a week tification period. The clinical idence skilled nursing services ordered and communication hy services were not provided. w on 9/10/2019 at 3:20 PM, the dicated patient #6 did not services due to the primary care r meeting multiple nurses, they individuals in the home.				
	410 IAC 17-13-1(a	•)				
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dg. 00						

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Event ID: MO5T11 Facility ID: 014118

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	ULTIPLE CO JILDING	DNSTRUCTION 00	(X3) DATE COMPI	
		15K167	B. W.	NG		09/13/2019	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
		HEALTHCARE SERVICES, INC			VESTPOINT DRIVE, SUITE 400 JAPOLIS, IN 46256		
	I				1	,	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG			DATE
	Deced on record re	wine and interview the accord	G 0	572	1. Patient #2		11/29/20
		eview and interview, the agency			Chart reviewed and processes	s put	
		re and services were not			in place to prevent any future		
		he physician approving the			services being provided without	Jt	
	· · ·	nt #2), failed to ensure			physician order. Clinical	~	
		nent was provided per the plan			Managers will notify scheduling	-	
) and OSHA kit was in place per			staff when VSOC is received s		
	agency policy and plan of care failed to ensure home health aide visits and skilled nursing visits				that services can be scheduled		
		-			All employees re-educated wit		
		ordered per the plan of care I failed to ensure medications			in-service to ensure that MD o		
		be feeding were administered			obtained prior to any service b		
		e (Patient #1), and for 4 of 7			provided. Supplemental order been sent to MD for Boost or	nas	
	records reviewed.	(Fattern #1), and for 4 of 7					
	iecolus levieweu.				Pediasure. All employees hav		
	Findings include:				been educated on maintaining		
	rindings include.				accurate supplies and documentation, ensuring that e	aaab	
	1 A review of no	licy entitled "Admission			home has these supplies listed		
	· · ·	/20/18, section 5 stated "No			All nurses to have extra gloves		
		for services without an order			sanitizer and OSHA kits, and (
	from a physician."				masks to replace those missin		
	nom a physician.				supplies provided by Adaptive	-	
	2 A review of no	licy entitled "Clinical			immediately. RN will send		
	· · ·	lissed Shifts", dated February			supplemental order for all upda	hated	
		² stated "A separate note shall			changes to the plan of care to	alcu	
		each visit/shift and signed and			ensure that the plan of care		
	~	priate professional."			matches what is in the home a	and	
	and appro	r r			being provided to the client.		
	3. A home observ	ation was completed on			All charts are being reviewed t	0	
		m, for patient #2. During the			ensure that services did not be		
		lled nurse offered the patient a			prior to MD order.	3	
		drink. During this time,					
		nterviewed in regards to the			All charts are being reviewed t	ov	
		led versus the Pediasure that			the Administrator after each vi	-	
		loyee K stated "we use Boost			to ensure order received from		
	-	sure when we run out of			prior to services being provide		
	-	is visit, surveyor asked					
	-	o see the OSHA kit. Employee K			The Administrator will provide		
	stated "I have no i				Comprehensive Assessment		
					In-service to reeducate all Clin	ical	
							1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 09/13/2019		
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256			
	1			NAF OLIS, IN 40250			
X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETIO DATE	
TAG	A plan of care revi 05/20/19 - 07/18/1 Gastrointestinal se "Pediasure 237 ml Nutritional Require stated "Pediasure ff DME [durable mea of 4) stated "OSH4 the patient home." evidence instruction to use the Pediasure is out of Boost. Th registered nurse of orders on 10/22/19 Review of the climi Skilled Nurse Visit 05/21/19. Review 05/22/19 stated "A 05/20/19. Spoke v office on 05/22/19 start of care) for SI 5/20/19 to 7/18/19 verbal start of care completed on 05/2 skilled nursing ser- from the physician Further record revi certification period completed. Gastro stated "Pediasure ff DME [durable mea of 4) stated "OSH4 the patient home."	ew for certification period of 9 was completed. ction (page 2 of 4) stated four times a day" and ements section (page 3 of 4) four times a day." The section dical supplies]/ Supplies (page 3 A kit" as one of the supplies in The plan of care failed to on to use Boost supplement and re supplement when the patient the plan of care indicated the otained verbal start of care of the physician order on dmission completed on with [NAME] RN at physician's at 9:57 am for VSOC (verbal N (skilled nurse) services." The plan of care evidenced that a date was documented as 2/19. The agency provided vices prior to obtaining orders		Managers on the specifics pat preferences, supplemental oro physician authorization requirements has been comple by 11/4/19. Administrator will be responsit for monitoring these corrective actions to ensure that this deficiency is corrected and will recur with weekly reporting checks. Administrator will mo for 100% compliance by review each chart with home visits completed week prior. This re will be completed weekly. Administrator will review all ch for completion by 11/29/19 Patient #7 Chart reviewed and last date H services were provided was 4/19/19. Shift on 4/20/19 was cancelled due to caregiver bei sick, client stated she would h granddaughter help her for the day. Shift for 4/21 was unable staff and client stated she would be good without anyone since was Easter. Documentation for 4/22, 4/23, & 4/25 states they were unable to find replacement for the usual caregiver. 4/25/1 Client called and stated she mo looking for a new provider. Discharge order was sent to M on 5/7/19 but had not been sig by MD. All charts have been reviewed for unauthenticated	tient ders, eted ble e ll not nitor wing eview harts HHA ave to uld it or ent 19 o ras	DATE	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CC A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLII VE NURSING ANE	BR D HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256		
X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
TAU	Supervisory visit	note dated 07/17/19, section #15 OSHA kit in the home".		supplemental orders and re-sent to MDs for validation signatures.		
	am with employed program manager home assessment to ensure the hom and services were would then be giv obtain an order fro initial comprehens include putting ha start of care order, assessment was co be called to get an case manager, ind spill kit for infecti mouthpiece as we surveyor an exam a red hazard bag. brought to each ho further stated "The don't know where On 09/11/19 at 12 confirmed that the physician for patio 05/22/19. During an intervite administrator indi supervisory note co OSHA kit in the h should be one in t 4. Clinical record completed on 09/1 recertification per	conducted on 09/11/19 at 10:50 eF, who indicated that the would go out and complete a prior to accepting each patient e environment was appropriate needed. That assessment en to the case manager to om the physician to complete the sive assessment, which would nds on the patient prior to the . Once the initial comprehensive ompleted, the physician would . order to admit. Employee F, icated that the OSHA kit was a ous fluids and had a CPR II. Employee F showed the ple of one, which also contained Employee F stated "one is ome on admission." Employee F is patient does not have one; it is. I've only seen her once." :00 PM, the administrator re was only one order from the ent #2 and that it was dated for ew on 09/12/19 at 2:25 PM, the cated that she saw the lated 07/17/19 that stated "No ome." She agreed that there he home.		Adminsitrator will review each chart when home visits are done to ensure all changes have supplemental order sent to MD for signature. Adminstrator will check weekly to ensure all sent orders have been authenticated by MD re-sent to MD for signature. Administrator will review client schedules weekly to ensure that schedule/services provided match the order in the plan of care. If it does not match that there is documentation to support the changes. Patient #1 Chart has been reviewed and on clarification has been sent to MD to ensure plan of care matches the services being provided. All employees have been re-educat and received in-service on all documentation must be reviewed by nurse and uploaded into the office chart to match home chart Clinical Manager will review all documentation of the home nurs to ensure all orders are being followed and documented accurately. All skilled charts reviewed to ensure the proper documentation and matches the plan of care.	or k or der ed u e	

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	BR) HEALTHCARE SERVICES, INC	9840 \	TADDRESS, CITY, STATE, ZIP COD WESTPOINT DRIVE, SUITE 4 NAPOLIS, IN 46256	400	
(X4) ID PREFIX TAG	SUMMAR (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN BE PRIATE	(X5) COMPLETIC DATE
	per week. Review the last date of car 04/17/19. The rec further aide visits A communication reviewed on 9/12/ update you all on yesterday and said anymore because company. I told h she finds a replace A communication reviewed on 09/12 patient #7 to verify said that we shoul we need to dischar no longer wants to Review of physici "discharge client f due to client switc company;" no phy An interview was PM with the office last day of direct, An interview was PM with the office that time the office (aide) called off ff Patient called and she was mad and w We could not disc in place." The offi were missed visits	w of aide visit notes evidenced re provided by the aide was ord failed to evidence any were provided. note, dated 4/26/19 was 19, which stated "Wanted to patient #7. She called me I she doesn't need our services she is looking for another rer we can continue to staff until ement, but she said no." note, dated 04/29/19 was 2/19, which stated "We called by her waiver services and she d not call her anymore and that rege her as a client because she o deal with us." an order dated 05/07/19 stated from agency effective 05/07/19 thing to another home health resician authentication. conducted on 09/12/19 at 4:15 e manager who indicated that the hands on care was 04/19/19. conducted on 09/12/19 at 5:45 e manager and administrator. At e manager stated "Caregiver and the to find a new company. harge without a new company fice manager agreed that there		the week after the clinical manager completes the ho supervisory visits to ensure changes are sent to MD for signature and that the plan is being followed. see attachments	e any	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COME	(X3) DATE SURVEY COMPLETED 09/13/2019	
	NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC		STREET 2 9840 W INDIAN	400			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
	orders for skilled i days a week, effect included orders for medications "orde document on the M record]." Review of the elect #1 failed to evider provided as ordered note, dated 8/13/2 nurse, was the firs services. The clin documentation to	eriod of 7/15/19 to 9/12/19, with nurse services, 8 hours a day, 5 etive 7/15/19. The plan of care r the skilled nurse to administer red by the physician and MAR [medication administration etronic medical record for patient nee skilled nurse visits were ed. The first skilled nurse visit 019, by employee I, a registered t documentation of skilled nurse ical record failed to evidence explain why skilled nurse completed as ordered on the					
	skilled nurse visits Tuesdays, Wednes beginning 8/13/20 skilled nurse visit 20, 21, 22, 27, and 2019. The skilled evidence documer	etronic medical record evidenced s were made 3 days a week, on sdays, and Thursdays, 19. The record evidenced notes dated August 13, 14, 15, 128, and September 3, 4, and 5, nurse visit notes failed to natation of the medications and eeding were administered by he visit.					
	reviewed with the confirmed that ski provided 3 times a on the plan of care the record failed to	:10 PM, the clinical record was administrator. The administrator lled nurse services were week and not 5 days a week as e. The administrator indicated be evidence documentation that updated and the plan of care					
	-	on 9/12/19 at 4:30 PM, the office the patient was accepted and					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	^R HEALTHCARE SERVICES, INC		9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 JAPOLIS, IN 46256)	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
G 0574 Bldg. 00	the case was to be 7/16/2019, and fai orientation, therefor nurse for the case. communication be primary care giver 5:45 PM, the administered by the visit. Employee A not turned into the completed the visit provided by surver 410 IAC 17-13-1 (Completed the visit provided the visit provided by surver 410 IAC 17-13-1 (Completed the visit provided by surver 410 IAC 17-13-1 (Completed the visit provided the visit provided the visit provided the visit provided by surver 410 IAC 17-13-1 (Completed the visit provided the visit provided the visit provided the visit provided the visit provided the visit provided by surver 410 IAC 17-13-1 (Completed the visit provided the visit fall precautions (provided th		G 0	574	The Administrator will provide Comprehensive Assessment In-service to reeducate all Clii Managers on the specifics of patient specific interventions of measurable outcomes in rega pain precautions, falls and aspiration requirements has b completed by 11/4/19. Administrator will be responsi for monitoring these corrective actions to ensure that this deficiency is corrected and will recur with weekly reporting checks. Administrator will mo for 100% compliance by revie each chart with home visits completed week prior. This re	nical with ard to been ble e Il not onitor ewing	11/29/201

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SUR COMPLETE 09/13/201	D
	PROVIDER OR SUPPLIEI	R HEALTHCARE SERVICES, INC	9840	I ADDRESS, CITY, STATE, ZIP COD WESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256)	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDERIC DI AN OF CORDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	CO	OMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	certification period	of 05/20/19-07/18/19 and for		will be completed weekly.		
	certification period	of 07/19/19 - 09/16/19 indicate		Administrator will review all ch	narts	
	aspiration precaution	ons. The plan of care failed to		for completion by 11/5/19.		
		lized, measurable interventions		see attachments		
	with goals/ outcom	es.				
				Pt #2 failed to have individual	ized,	
	An interview with	the administrator was		measurable interventions with		
	conducted on 09/12	2/19 at 2:25 pm where the		outcomes/goals. Plan of care		
	administrator stated	d "if the nurse would have		updated with appropriate		
	checked them, then	they would be there." She		interventions and measurable		
	agreed that there w	ere no interventions, no		goals/outocomes.		
	outcomes or goals	documented.		All charts being reviewed to		
				ensure appropriate intervention	ons	
	3. Review of Patie	nt #7's clinical record indicated		with measurable goals/outcon	nes.	
	a primary diagnosis	s of rheumatoid arthritis with				
	rheumatoid faction	. Other pertinent diagnoses		Admisnistrator has provided		
	include essential pr	imary hypertension, anxiety		Comprehensive Assessment		
	disorder, anemia, c	hronic pain syndrome, type II		in-service to re-educate all cli	nical	
	diabetes mellitus, a	nd mixed incontinence.		managers on importance of		
				appropriate interventions and		
		itled "Pain Assessment" dated ted "worst pain level over last		measurable goals/outcomes.		
	48 hours - 8".			Administrator will be responsi	ble	
				for monitoring these corrective	e	
		of care for start of care date		actions to ensure that this		
		ertification period of 12/19/18 to		deficiency is corrected and wi	ll not	
		ssional services order section		recur with weekly reporting		
		"She has chronic widespread		checks. Administrator will mo		
		lained that she will be		for 100% compliance by revie	wing	
		pain medication when she		each chart with home visits		
		ock box for her narcotic pain		completed week prior. This re	eview	
		past experiences of her		will be completed weekly.		
		g stolen from her." The safety				
		bage 3 of 4) stated "fall		Patietn #7 has been discharge	ed	
	-	plan of care failed to evidence		and are unable to fix this		
		lividualized measurable goals		deficiency for this chart.		
		and the safety measures		All charts being reviewed to		
	section failed to ev	idence pain precautions.		ensure appropriate document	ation	
				of pain assessment.		
	Review of the form	titled "Pain Assessment"		All clinical managers re-educa	ated	

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

Event ID:

If continuation sheet Page 41 of 112

PRINTED: 11/19/2019 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MO5T11 Facility ID: 014118

DEPARTMENT OF HEA

	T OF HEALTH AND HU R MEDICARE & MEDIC					RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 09/13/2019	
	1	HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256		(X5)
PREFIX TAG	(EACH DEFICIEN REGULATORY OF	CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) with Comprehensive Assessm		COMPLETION DATE
	patient has obtained get her pain medica	l a new lock box so she can		in-service to be sure to docum completely all pain assessmen and notify MD of any increase uncontrolled pain.	nent hts	
	explained that she w medication when sh for per narcotic pair experiences of her n her." Documented Additionally, the pl recently received a medication and will next visits." The Sa of 4) stated "fall pro-	 /19, page 2 of 4 stated "She vill be prescribed stronger pain ne receives a keypad lock box n medications due to past nedications getting stolen from pain score was +8/10. an of care stated "She has lockbox for her pain request more from her doctor afety Measures section (page 3 ecautions." The plan of care nterventions or individualized 		Clinical Managers have been educated on falls, aspiration a pain interventions to be added the plan of care as appropriate with measurable goals/outcom to monitor. Administrator will be responsit for monitoring these corrective actions to ensure that this deficiency is corrected and will	l to e nes ble e	
	 measurable goals for safety measures see precautions. 4. On 09/11/19 at 1 precautions policy of 1 pm, the administriction did not have a separation of the s	2:30 pm a copy of the fall was requested. On 09/11/19 at ator indicated that the agency rate fall precautions policy and ed in the comprehensive		recur with weekly reporting checks. Administrator will mo for 100% compliance by revier each chart with home visits completed week prior. This re will be completed weekly.	nitor wing	
	administrator on 09	s conducted with the /11/19 at 2:25 pm. She stated re plans. It means that they				

have a copy of the fall risk assessment." G 0584 Bldg. 00 G 0584 For client #7 Client has been Based on record review, the agency failed to discharged, unable to verify ensure the skilled nurse put new orders in writing medication change and get order to be sent to the physician for signature in 1 of 4 at this time. Event ID: MO5T11 Facility ID: 014118 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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11/05/2019

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	^R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE	
	closed records revi Findings include: The clinical record 12/19/18, was revi diagnosis is rheum faction. Other per essential primary h anemia, chronic pa mellitus, and mixe Skilled nurse visit section, page 2 of changed since last pharmacy for accu 4, interventions/ in "fingersticks with	ewed. (Patient #7) of Patient #7, start of care ewed and indicated a primary atoid arthritis with rheumatoid tinent diagnoses include typertension, anxiety disorder, in syndrome, type II diabetes d incontinence. note, dated 03/12/19, medication 4, indicated that "medication visit" and "Pt (patient) to call check and new med." Page 3 of structions section stated accucheck." The clinical record any new physician orders for hedication.		All charts are being reviewed t ensure all medication changes have supplemental order sent MD with MD validation signatu All current employees have be in-serviced on updating medica profile with each visit and send supplemental order for all changes. All charts will be reviewed by Administrator with following ea visit to ensure updates of medication profile and supplemental orders sent to M for validation signature. Administrator will ensure reeducation to all internal staff regarding review of all medicat with Comprehensive Assessm In-service, completed by 11/4/19. Administrator will monitor for 100% compliance M reviewing each chart with hom visits completed week prior. T review will be completed week see attachments	o to re. en ation ling ich D tions ent by e his	
G 0590						
Bldg. 00	failed to ensure the was decided the pa nursing services as (Patient #6), chang	view and interview, the agency e physician was notfied when it tient declined to have skilled ordered per the plan of care ges in feeding supplements nrelieved pain (Patient #7) for 3	G 0590	The Administrator will provide Comprehensive Assessment In-service to reeducate all Clin Managers on the specifics of changes needing an order and must be authenticated by physicians, patient preference	1	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K167	A. BUILDING <u>00</u> B. WING		COMPLETED 09/13/2019	
		D	STREET	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE			VESTPOINT DRIVE, SUITE 400		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC	INDIAN	NAPOLIS, IN 46256		
(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	COMPLET	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	of 8 records review	ved.		requirements has been comple	ted	
	T . 1			by 11/4/19.		
	Findings include:			The Administrator will provide I		
	1 4 hours shown			meeting patient's needs in-serv		
		ation was completed on m, for patient #2. During the		to all internal staff in regards to		
		ent was given a carton of Boost		documenting on all missed shif		
	to drink.	ent was given a carton of Doost		and inability to meet client need completed by 11/4/19.	.5.	
	to unitk.			Administrator will be responsib	ما	
	Plan of care review	v for certification period of		for monitoring these corrective		
	05/20/19 - 07/18/1	-		actions to ensure that this		
		ction (page 2 of 4) stated		deficiency is corrected and will	not	
		four times a day." And		recur with weekly reporting		
		ements section (page 3 of 4)		checks. Administrator will mon	nitor	
	stated "Pediasure f	our times a day."		for 100% compliance by review	ving	
				each chart with home visits		
	Record review of p	plan of care for certification		completed week prior. This rev	view	
	-	- 09/16/19 was completed.		will be completed weekly.		
		ction (page 2 of 4) stated				
		four times a day." And				
	_	ements section (page 3 of 4)				
	stated "Pediasure f	our times a day."		Patient #2 failed to notify MD o	f	
	D	00/11/10 1:1		client using Boost instead of		
		s completed on 09/11/19, which y updated physician order for		Pediasure.	aant	
		mented communication with the		Supplemental order has been s		
	-	e the order from Pediasure to		to MD for Boost or Pediasure a plan of care has been updated		
	Boost.	e the order from r cutastre to		show client can have Pediasure		
	20000			Boost.		
	Interview with em	ployee K, RN, on 09/11/19,				
		ost and only use Pediasure		Charts will be reviewed after ea	ach	
	when we run out o	-		home supervisory visit to ensur	re	
				compliance with notifying MD c		
	2. A review of rec	ord #6 with a start of care		any changes to the plan of care		
		ced a "Home Health Certification				
		for the certification period of		All clinical managers have		
		2019, with orders for skilled		received the Comprehensive		
	-	hours per day 5 days a week		Assessment In-service to		
		tification period. The clinical		re-educate them on MD must b		
	record failed to ev	idence skilled nursing services		notified of any changes/update	s to	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE			9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC		INDIAN	IAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	·	rdered and communication			the plan of care.		
	notes to explain wh	y services were not provided.					
					Administrator will be responsible	e	
	During an interview			for monitoring these corrective			
	office manager, indicated patient #6 did not				actions to ensure that this		
		ervices due to the primary care			deficiency is corrected and will r	not	
	-	meeting multiple nurses, they			recur with weekly reporting		
	did not want other	individuals in the home.			checks. Administrator will monit		
					for 100% compliance by reviewi	ng	
		ord of Patient #7, start of care			each chart with home visits		
		ewed and indicated a primary			completed week prior. This revi	ew	
	-	atoid arthritis with rheumatoid			will be completed weekly.		
	-	inent diagnoses include					
		ypertension, anxiety disorder,			Patient #6		
		in syndrome, type II diabetes			Failed to evidence documentation	on	
	mellitus, and mixed	l incontinence.			for why services were not		
	Dian of some for som	tification namial af 02/17/10			documented.		
		tification period of 02/17/19 -			Chart has been updated to show	v	
		f 4 stated "She explained that bed stronger pain medication			documentation with mom		
	-	a keypad lock box for per			requesting to hold off on skilled	н	
		cations due to past experiences			nurse starting due to no hoyer li in the home. Documentation of		
		getting stolen from her.			when mom decided services we		
		core was +8/10. Additionally,			no longer needed due to she wa		
	-	ted "She has recently received			going to stay home with him.	15	
	~	ain medication and will request			going to stuy nome with him.		
	more from her doct				All charts being reviewed to		
					ensure all communication with		
	The clinical record	of Patient #7, start of care			client/primary caregiver is		
		ewed and indicated a primary			documented.		
		atoid arthritis with rheumatoid					
	-	inent diagnoses include			All employees received in-service	ce	
	-	ypertension, anxiety disorder,			not meeting client needs to		
		in syndrome, type II diabetes			re-educate on steps and		
	mellitus, and mixed				documentation needed when		
					unable to meet needs of client.		
	Review of an Aide	Daily Visit Sheet for patient #7,					
	date of 03/28/19 wa	as reviewed. The document			Administrator reviewing schedul	es	
	stated "gave her a c	uick sink bath because of			and documentation weekly to		
	pain."				ensure plan of care is being	1	

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

Event ID:

MO5T11 Facility ID: 014118

If continuation sheet Page 45 of 112

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	e (X5) COMPLET DATE	
	Communication ne completed by the s stated "Client requ changed to sink ba and she does not f Review of an Aide date of 03/29/19 w stated (1) Assist w her walker to take her bed. She was her hands and arm Mobility Assist, "T her." (3) Skin Car not want anything Pain assessment, c "worst pain level of clinical record fail	ote, dated 03/28/19 was supervisory case manager that lested her bathing type be th as her shower is upstairs eel safe climbing stairs." The Daily Visit Sheet for patient #7, vas reviewed. The document ith Ambulation, "Helped with her to the bathroom and back to unable to hold on because of s were in a lot of pain. (2) Foo much pain for me to move e "She was in some pain and did on her." lated 04/12/19, documented over last 48 hours - 9." The ed to evidence that the ified of the patient's ongoing		followed as ordered. Patient #7 has been discharged unable to fix deficiency in this chart. All charts being reviewed to ensure proper follow up and notification to MD of change in ADLs/health assessment such change in ADLs due to increased/unrelieved pain. All clinical managers received in-service to re-educate comprehensive assessment to include weekly review of daily w sheets to ensure anything unusual is followed up on and notified. All HHAs to receive in-service Abnormal Observation/Unusua Findings to re-educate they new to notify office of any unusual findings during their care so that may be addressed right away. Clinical Manager to follow up o these issues and ensure MD is notified and plan of care update Administrator will be responsibl for monitoring these corrective actions to ensure that this deficiency is corrected and will recur with weekly reporting checks. Administrator will mon for 100% compliance by review each chart with home visits completed week prior. This rev will be completed weekly.	d as visit MD l ed at it n sed. le not itor ving	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	^R HEALTHCARE SERVICES, INC	;	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 40 IAPOLIS, IN 46256	400	
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
G 0592					see attachments		
Bldg. 00	ensure the revised preference for bath based on the comp closed records revi- Findings include: Record review for "Nutritional Risk 4 was reviewed india risk (score range 3 comprised of "has makes it hard to ea does not always ha foods needed, take (over the counter) always physically and has no caregiv review for certifica the nutritional requ nutritional risk." N "provide education instructions, consu consult with physi dietary supplemen monitoring and inst	view, the agency failed to plan of care included patient ing and failed to be developed rehensive assessment in 1 of 4 ewed. (Patient #7) patient #7, a form titled Assessment" dated 12/19/18, cating a risk score of 30, medium 0-55). This score was tooth/ mouth problem which it (dentures, does not wear), we enough money to buy s 3 or more prescribed or OTC medications per day, is not able to cook and/or feed self er to assist." The Plan of care ation period 12/18/18-02/16/19, iirements stated "Medium Medium risk score stated b, appropriate dietary It with dietitian as needed, cian and discuss need for at (tablet or liquid). Continue attructions as indicated."	G	0592	Patient#7 Client has been discharged, are unable to update plan of All charts being reviewed to ensure that every section of plan of care accurate and up date with any changes in assessment to include all assessments and patient preference. The Administrator will provid Comprehensive Assessment In-service to reeducate all C Managers on the specifics of changes needing an order a must be authenticated by physicians for patient prefer requirements has been com by 11/4/19. Administrator will be respon for monitoring these correcti actions to ensure that this deficiency is corrected and v recur with weekly reporting checks. Administrator will m for 100% compliance by rev each chart with home visits completed week prior. This will be completed weekly.	i care. the b to le t linical f nd ence pleted sible ve vill not nonitor iewing	11/29/201

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPL A. BUILDING B. WING	e construction G <u>00</u>	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	984	ET ADDRESS, CITY, STATE, ZIP COD 0 WESTPOINT DRIVE, SUITE 4 IANAPOLIS, IN 46256	.00	
(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 CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE PRIATE	(X5) COMPLETION DATE
	score of 10, low ri was comprised of OTC (over the cou frequently has pro constipation." The certification period nutritional require: nutritional risk." 6 stated "She isn't pl own personal care "Patient #7 has no outside of agency A communication manager, dated 03 sink bath" Red baths was started of failed to evidence The Plan of Care f 04/18/19-06/16/19 section (page 2 of	sk (score range 0-25). This score "takes 3 or more prescribed or inter) medications per day, blems with diarrhea or e Plan of care review for d 02/17/19-04/17/19, the ments stated "Medium 50-day summary (page 2 of 4) hysically able to provide her cook her own meals" and willing or able caregivers name" note from the RN, case /28/19 stated "Client requesting cord review evidenced sink on 3/26. The clinical record MD notification of the change. for certification period of typofessional services order 4) stated "HHA (home health all ADLs (activities of daily hing (shower).		Administrator will review all for completion by 11/29/20 see attachments		
G 0640						
Bldg. 00	failed to: ensure the program that was of improvement and quality indicators, events, and other a enable the agency HHA (home health	eview and interview, the agency are was a quality assurance capable of showing measurable must measure, analyze and track including adverse patient aspects of performance that to assess processes of care, n aide) services, and operations, cator data to monitor the	G 0640	Administrator created new including falls and hospitaliz new process to include qua QAPI meetings and minute Administrator provided train logs and new process on 10/29/19. Administrator will conduct a survey to include willingness report adverse events and	zation. Interly s. hing of	11/05/201

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		15K167	B. WING		09/1	13/2019	
NAMEOEI	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP	COD		
NAME OF	I KO VIDEK OK SOTTELE		9840 V	VESTPOINT DRIVE, SU	JITE 400		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC	INDIAN	NAPOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	effectiveness and s	safety of services and quality of		willingness to sugges	t		
		dentify opportunities for		improvements by 11/2			
		lement performance		Administrator will trac			
	· · ·	vities based on high risk, high		demographics quarte	•		
	~	n-prone, implement performance		from Matrix in QAPI b	• •		
	· •	vities with consideration to		Administrator will ree			
	-	nce, and severity of problem		internal staff in regard			
		ediate action of identified		grievance/incidents w			
		d potentially threaten the		•			
	-			Investigation of Mistre			
	-	of patients, to track adverse		Neglect and Abuse in			
	-	rder to implement preventive		be completed on 11/4			
	_	t performance improvement		Administrator will er			
		ort to measure success of		reeducation to all cli			
		that improvements are		managers regarding			
		quality improvement projects,		reports with Compre			
		blementation of an agency-wide,		Assessment In-servi			
		sessment and performance		completed by 11/4/19			
		ram that includes priorities for		Administrator will m			
		and patient safety. These		100% compliance by	reviewing		
		otential to impact all forty-our		each chart with hom	e visits		
		s for 1 of 1 agency. The		completed week price	or. This		
	cumulative effect	of these systemic problems		review will be compl	eted		
	resulted in the hon	he health agency's inability to		weekly.			
	ensure the provisio	on of quality health care in a		See attachment			
	safe environment.			="" span="">			
	Findings include:						
	1. The agency pol	icy entitled "Quality					
		nance Improvement," dated					
		ted (1) "Data will be collected to					
	· ·	o monitor its performance"; (2)					
		used for data collection include					
	-	Staff perception of risks to					
		ggestions for improving safety					
		ff willingness to report					
	-	erse events, (c) Utilization of					
		opinion and needs, (e) Adverse					
		f processes and services, (f)					
	Infection control s	urveillance and reporting of					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CO A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	^R HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP CO /ESTPOINT DRIVE, SUIT IAPOLIS, IN 46256			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETI	
TAG	 individuals and organeeds, expectation individuals and organeeds, expectation individuals and organeeds, expectation individuals and organeeds, expectation of care Client diagnosis and Environmental conclients, (k) Focus of improved outcome services and hospi (3) Data will be symeasure process a client." 2. Agency policy dated July 26, 201 incidents and the i agency's performa Incident reports ar supervisors and a further action is new is reviewed by the team determines o improvement or w (3) Aggregated resperformance improvement or w (3) Aggregated resperformance improvement or w inprovement or w appropriately at A the event, complet cause analysis focus processes, develop implementing chare effectiveness of chinstructions stated non-reportable sem referred to as "nea investigated using 	R LSC IDENTIFYING INFORMATION ganizations served, (g) The s and satisfaction of ganizations served, (h) e, treatment and services, (i) ad demographics, (j) aditions of the organization or on indicators related to es - use of emergent care tal admissions/readmissions; stematically collected to and outcomes of each individual entitled "Incident Reporting", 8, stated (1) "The reporting of nvestigation are part of the nee improvement program. (2) e reviewed by appropriate determination of whether eeded is made. After the report administrator, the leadership poportunities for performance hether to continue monitoring. ults are part of the annual ovement plan evaluation." icy entitled "Sentinel Events," 19, purpose stated "To respond LL sentinel events by reporting ing a timely, thorough, root using on systems and ing an action plan, nges and monitoring anges," and special "Both reportable and tinel events, sometimes r misses", are intensely principles of root cause oping an action plan."	TAG	DEFICIENCY)		DATE	

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V)) M		ISTRUCTION	(V2) DATI	E SURVEY
			. ,			<u> </u>	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		ILDING	00		PLETED
	15K167 B. WING			09/13	3/2019		
NAME OF	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
					STPOINT DRIVE, SUITE	400	
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC		INDIANA	POLIS, IN 46256		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE	COMPLET
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	4. Record review o	f quality assurance/					
		vement documentation was					
	completed on 09/10	/19.					
	The section entitled	"2018" was blank.					
	The section entitled	"2019", "Quarter 1 was blank.					
	· ·	two performance improvement					
	* ÷ ź	/15/19, documented					
		ed: Under 50% of PA client					
	· ·	return. Corrective Action					
		eturn rate of over 50%. How					
		ed and by whom? Case					
	-	lient satisfaction surveys with					
		sit. The office manager and					
	-	Il monitor how many we have g the binder on a bi-weekly					
	-	ive Action Completed: Reach					
		rate by the end of quarter 2."					
		ls of the actions and					
		it was ongoing. One included					
		Indy North Quarter 2 2019,					
		its Q2 (quarter 2) Indy North"					
	stated "1, schedule						
	Quarter 3 dated 06/	19/19, documented "Deficiency					
	Identified: Multiple	e extra supervisory visits					
	missed. Corrective	Action Needed: Agency					
	clinical manager to	continue to review visit					
	schedules upon adm	ission and recertification					
	completion as well	as pull weekly office visit					
	schedules to ensure	all visits are scheduled to be					
	completed. How w	ill this be monitored and by					
	whom? Agency cli	nical manager to monitor. Date					
		Completed: Ongoing." One					1
		entitled "Missed Visit Log"					
	was blank.						
	5. The following in	cident report documents were					

	T OF DEFICIENCIES F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/13/2019	
	OVIDER OR SUPPLIE	R HEALTHCARE SERVICES, I	NC	9840 V	ADDRESS, CITY, STATE, ZIP VESTPOINT DRIVE, SU VAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE	
	provided by the ag evidence that these investigated, track into the agency's O preventable measu Incident report dat hospitalization Incident report dat Incident report dat Incident report dat hospitalization Incident report dat hospitalization Incident report dat wound. Incident report dat wound Incident report dat wound Incident report dat emergency room v Incident report dat	ed 01/06/19, patient #5, ed 01/14/19, patient #15, ed 01/25/19, patient #11, fall ed 01/26/19, patient #11, fall ed 01/26/19, patient #11, fall ed 01/29/19, patient #16, ed 02/27/19, patient #17, ed 03/12/19, Patient #10, new ed 03/24/19, Patient #7, new ed 04/01/19, patient #3, risit ed 04/02/19, patient #3, risit ed 04/04/19, patient #3,						

PRINTED:	11/19/2019
FORM API	PROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			COMF	e survey pleted 3/2019
NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC		984		TY, STATE, ZIP COD T DRIVE, SUITE 4 N 46256	400		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREF TAC	IX (EACH CO CROSS-RE	VIDER'S PLAN OF CORRECTI RRECTIVE ACTION SHOULE FERENCED TO THE APPRO DEFICIENCY)	DE	(X5) COMPLETIO DATE
	Incident report day emergency room	ted 04/30/19, patient #3, visit					
	Incident report dat emergency room	ted 05/01/19, patient #23, visit					
	Incident report day emergency room	ted 05/09/19, patient #24, visit					
	Incident report dat hospitalization	ted 06/04/19, patient # 18,					
	Incident report dat	ted 06/18/19, patient #12, fall					
	Incident report dat	ted 06/20/19, patient #13, fall					
	Incident report dat hospitalization	ted 06/24/19, patient # 19,					
	Incident report dat hospitalization	ted 06/24/19, patient #3,					
	· ·	ted 06/25/19, patient #14, fall on for broken vertebrae.					
	Incident report dat hospitalization	ted 07/16/19, patient #21,					
	Incident report dat	ted 08/04/19, patient # 11, fall					
	Incident report dat hospitalization	ted 08/15/19, patient #22,					
	Incident report dat hospitalization	ted 08/19/19, patient #20,					
	Incident report dat hospitalization	ted 09/04/19, patient #12,					

STATEMENT OF DEFINAND PLAN OF CORRECT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		CC	(X3) DATE SURVEY COMPLETED 09/13/2019 		
NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC			STREET A 9840 WI INDIAN					
	CH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
Compla incorpor quarter: Activity 12/19/13 fell, no Activity 01/02/13 incident Compla patient # [patient # [patient # [patient # [patient # [patient # [name] u has been trust she doesn't i kind of name] v down th her not fed, sho so those this care us time Activity 03/27/19	int/ Grieva rated into t Tracking 3, patient # incident re Tracking 3, patient # report for int/ Grieva #3, docume at 3, docume at 4, d	Activity Tracking Log, Ince documents that failed to be the QAPI programs for each Log, Complaint/ Grievance date 410, aide left early and patient port form completed. Log, Complaint/ Grievance date 425, missing property; no m completed. Ince dated 03/14/19, related to ented "I received a call from s balling her eyes out. Basically, ning and her do not get along. [name of aide]. She works at a MA (medical assistant) and tient care for a long time so I hat she is doing. Patient cause she bought the wrong tain) Dew and because [aide ke a box of incontinent supplies a different house (agency told I asked patient if she is being I kept clean and she said yes, ggest concerns. I will replace patient request, but it will take w, hire, and train someone." Log, Complaint/ Grievance date te J, back injury while lifting t report form completed. Log, Complaint/ Grievance date 426, swollen wrist/ unknown report form completed.						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		C	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC		9840 W	ADDRESS, CITY, STATE, ZIP CC ESTPOINT DRIVE, SUIT APOLIS, IN 46256		
(X4) ID PREFIX	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORR	ECTION DULD BE	(X5) COMPLETIO
TAG	,	REAL MOST BETREEPED BTTOLE		TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	DATE
1110	06/21/19, patient #	419, altercation with aide tte), no incident report form		1110			DAIL
	documented "Care	nce dated 08/13/19, patient #27, giver [sent] text - I can no					
	in that environment to much out of me	tient #27. I refuse to put myself at. Him and Ms. [patient] want . I have to hear them argue and					
	He needs more hel means I have to re	screaming episodes plus more. p than I can give him. If that sign then I am sorry. \$12 isn't he agency failed to evidence a					
	documented "Patie us again because a 5:15 PM. She is s also said that ever wants us to replace schedule she need patient are coming	nce dated 09/05/19, patient #28, ent #28 is threatening to leave ide isn't able to do 7:15 am - cheduled for 7:30-5:30 PM. She ything else is great, but she e her ASAP if she can't do the s. Neither the aide nor the to an agreement with the times. h staffing all of her hours at this					
		sure what else to do to keep the					
	11:45 a.m. with th administrator. The the agency did not control policy. The inclusive in the inc	as conducted on 9/10/19 at e office manager and e office manager indicated that have a separate infection e office manager stated "It is all cident reporting policy," dated said interview, the surveyor					
	confirmed that all Performance Impr Performance Impr documents were p Process minutes w	Quality Assessment/ ovement Quality Assessment/ ovement (QAPI) plans/ rovided. Quality Assessment/ ere also requested. The office nistrator both confirmed that					

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILD	IPLE CONSTRUCTION ING <u>00</u>	OMB NO. 093 (X3) DATE SURVEY COMPLETED 00/13/2010		
		15K167	B. WING		09/1	09/13/2019	
	PROVIDER OR SUPPLIEI VE NURSING AND	REALTHCARE SERVICES, INC	9	REET ADDRESS, CITY, STATE, ZIP CO 840 WESTPOINT DRIVE, SUIT IDIANAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		D PROVIDER'S PLAN OF CORRE FIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP AG DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
	manager further ind will mention or dis Assessment/ Perfor the Monday mornin was not a Quality A Improvement (QAI 8. An interview wa p.m. with the admin program manager r The program manag	A, was provided. The office licated that sometimes the team cuss an issue for Quality mance Improvement (QAPI) in ag staff meetings, but there assessment/ Performance PI) meeting. As conducted on 9/11/19 at 2:00 histrator, office manager and egarding the incident reports. ger stated "I guess the nurse the incident reports."					
0680							
Bldg. 00	review, the agency control practices we gloves and handwa and failed impleme control program for identification, prev- investigation of inf diseases. These pra- impact all forty-our agency. The cumu problems resulted i inability to ensure i		G 0680	Administrator updated H In-service and will reedu home health aids and Cl Managers by 11/29/19. Administrator updated Handwashing Policy on 10/31/19. See attachment for Hand and Infection Control Po Administrator will ensure current and new hire HH receive the HHA Skills In	cate all inical dwashing licies. e all l aides will	11/29/20	
G 0682							
Bldg. 00							

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>) DATE SURVEY COMPLETED 09/13/2019
	PROVIDER OR SUPPLIE	^R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256	
ADAPTI (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY O Based on observati review, the agency control practices w gloves and handwa a client during 1 of Findings include: The "OSHA Infect Plan" policy, dated "Handwashing poli provided by Emplo The current policy Control/Exposure 0 (facility's name) sh procedures for the infection control pp policies shall confor Accreditation stand currently accepted practiceSPECIAI infection control pp be limited to: a. V	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION on, interview and record failed to ensure infection ere followed in the use of ishing during personal care of '3 home visits. (Client 4) ion Control/Exposure Control March 21,2012, and the icy," dated 7/2/2018, was byee B on 9/12/19 at 3:07 p.m. "OSHA Infection Control Plan" was "POLICY all maintain policies and care of clientsand for ractices by employees; these prm with OSHA regulations, lards, local and state laws, and standards of L INSTRUCTIONS 1. Client rocedures shall include, but not Wearing and changing gloves as		APOLIS, IN 46256 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Administrator updated HHA Skills In-service and will reeducate all home health aids and Clinical Managers by 11/29/19. Administrator updated Handwashing Policy on 10/31/19. See attachment for Handwashing and Infection Control Policies. Administrator will ensure all current and new hire HH aides w receive the HHA Skills In-service This Home Health Aide will in reference to this visit will be in-serviced on proper hand washing/alcohol gel use and infection control. This caregiver will also be re-comped by contract nurse to determine if appropriate for Home Health Aide shifts. Agency will ensure that all home	9 ill ·
	necessary during the delivery of client caref. Frequent hand washing by home health care employees: * Before and after the provision of direct client care. *After handling soiled or contaminated materials*After removing gloves" The "Handwashing policy" was "Purpose To prevent the spread of infection by contaminated hands. To remove soil and transient organisms from the hands and to reduce total microbial counts over timeThe Center for Disease Control (CDC) recommends routinely washing hands in the following situations:*After caring for a clientProcedure13. Rinse hands and wrists thoroughly, keeping hands down and elbows up. 14. Dry hands thoroughly from fingers to wrists			health aides will have home observation within first 30 days o employment as home health aide and annually to ensure proper technique is followed with all hon health aide skills. Administrator will monitor that all current and new home health aides receive the HHA Skills in-service and that they are observed in the home with in first 30 days and then annually after. See attachments	e ne

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Event ID:

MO5T11 Facility ID: 014118

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COI	(X3) DATE SURVEY COMPLETED 09/13/2019		
	PROVIDER OR SUPPLIE	ER D HEALTHCARE SERVICES, INC	984	EET ADDRESS, CITY, STATE, Z 0 WESTPOINT DRIVE, S IANAPOLIS, IN 46256				
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFI2	PROVIDER'S PLAN OF	ON SHOULD BE	(X5) COMPLETI		
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG			DATE		
	and forearms 15	Discard paper towel in waste						
		urn off water faucet using a						
	· ·	welInstant Hand Antiseptic						
		rubbing hands together until the						
		timately 10-15 seconds"						
	skin is dry, upprox	initiately 10 15 seconds						
	On 9/10/19 from 1	.0:46 a.m. to 1:35 p.m., Client 4's						
		nducted. Upon entering the						
		and Employee M were present						
		to finish her breakfast, which						
	-	eal. She was lying in her bed						
		al gown with wet and soiled						
	· ·	erneath her shoulders to her						
		e client finished eating the bowl						
		ested to complete her oral care.						
		s Employee M prepared and						
	-	he equipment for oral care to						
		rush with toothpaste, an emesis						
		ip. After the client was						
		ete this task, Employee M						
	-	oment and returned it to the						
		the contents. No change of						
		ng or handgel use was						
	-	e same gloves Employee M						
		hange the bath water basins						
		reen washing the client's hair						
		ient. During this bath when the						
		be covered up, Employee L						
	-	rom the electric wheelchair (w/c)						
		sident with the cover. No						
		lgel was observed used by						
	-							
		positioning the cover on the						
		noving this cover during the						
		ient was turned onto her right						
		wet, soiled mattress and sheets,						
		donned a new pair of gloves.						
		I was observed to cleanse the						
		ss on the left side of the bed						
		pes. With the same gloved						
	hands Employee N	A was observed to wash the						

STATEMENT OF DEFICIEN AND PLAN OF CORRECTIO	· · ·	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 09/13/2019	
NAME OF PROVIDER OR S	UPPLIER BAND HEALTHCARE SERVICES,	9840	TADDRESS, CITY, STATE, ZIP COD WESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256)	
PREFIX (EACH I	MARY STATEMENT OF DEFICIENCIE EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
 the upper by Next, Emplikitchen, ren wash and ri handwashir cleansing th towel from the abdomin Employee N used a squir of gloves w were still w was completed same glove: returning th Employee N kitchen sinh hand, shook towels were completed. indicated or care. She in completed a 410 IAC 17 6 0684 Bldg. 00 Based on refailed imple program for prevention, and commutivation. 	cord review and interview, the agency ment an agency-wide infection control the surveillance, identification, control and investigation of infectious nicable diseases for 1 of 1 agency.	G 0684	Infection Control Due to nursing turnover, incident/infection logs were ke up to date accurately in 2018 Infection Control policy has b attached. All clinical manager have been re-educated with in-services to be more thorou with incident and infection reporting and follow up. Logs	een rs gh	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 09/13/2019
	PROVIDER OR SUPPLIE	^R HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, S 9840 WESTPOINT DE INDIANAPOLIS, IN 46	RIVE, SUITE 400
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O Performance Impro	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ovement," dated April 25, 2019,	PREFIX (EACH CORREC CROSS-REFEREN TAG Incident have	(X5) (X5) COMPLETION ITIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY) DATE been updated to information and
	agency to monitor may be used for da following: (f) Infec reporting of indivi- (3) Data will be sy measure process an client." Review of the poli Reporting", dated	Il be collected to allow the its performance"; (2) "Data that ita collection include the etion control surveillance and duals and organizations served; stematically collected to ad outcomes of each individual cy entitled "Incident 07/26/18, did not include any ng infection control.	follow up. Al added to the All incidents Administrator proper docur up is reporter All infections quarterly with minutes to re	will be reported n QAPI meeting and eport trends and nplemented to
	envelope for 2018, 2019 was complete control binder for 2 entitled "Infection North, Quarter 1, 2 eye infection, with was nothing for qu infection control b form entitled "Infe section marked Q3 quarter 1 or quarte		reeducation Manager reg control with Assessment completed b Administrate infection log Managers w that proper o being mainta will be repor	-
	April 1st, 2019 to . 06/24/19, (1) Patie room, was hospital infection; (2) Patie room, was hospital	cident log, dated (Quarter 2) June 30th, 2019, indicated on nt #3 went to the emergency lized for a urinary tract ent #19 went to the emergency lized for a urinary tract of the urinary tract infections tion control log.		o decrease those be implemented
	a.m. with the office The office manage	conducted on 9/10/19 at 11:45 e manager and administrator. r indicated that the agency did e infection control policy. The		

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Event ID: MO5T11 Facility ID: 014118

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PRINTED: 11/19/2019 FORM APPROVED

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K167		(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION (X. 00	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) Completio Date	
	incident reporting said interview, the infection control p (quality assessmer plans/documents v manager and admi everything had, wa An interview was p.m. with the adm program manager dated 06/24/19. Ir administrator indic urinary tract infect the administrator f Form, dated 06/24 that stated "Client transfer to bedside (emergency room) have UTI (urinary	conducted on 9/11/19 at 2:00 nistrator, office manager and regarding the incident reports, regards to Patient #3, the rated they were not aware of the ion. In regards to Patient #19, ound the Transfer Summary /19, completed by employee E reports falling while trying to commode. Went to ER to be assess and was found to tract infection)." The team why the infection control log				
G 0710 Bldg. 00						
	failed to ensure ca provided prior to t plan of care (Patie nutritional suppler of care (Patient #2 was in place per ag failed to ensure sk provided as ordere #1), and failed to e gastronomy tube f	view and interview, the agency re and services were not he physician approving the nt #2), failed to ensure nent was provided per the plan), failed to ensure an OSHA kit gency policy/ and plan of care, illed nursing visits were d per the plan of care (Patient nsure medications and eeding were administered per atient #1), and for 2 of 2 active	G 0710	Patient #2 Chart reviewed and processes p in place to prevent any future services being provided without physician order. Clinical Managers will notify scheduling staff when VSOC is received so that services can be scheduled. All employees re-educated with in-service to ensure that MD ord obtained prior to any service bein provided. Supplemental order h been sent to MD for Boost or	er ng	

	R MEDICARE & MEDIC				OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	i de la constante de	X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
15K167		B. WING		09/13/2019	
AME OF F	PROVIDER OR SUPPLIE	3		ADDRESS, CITY, STATE, ZIP COD	
				ESTPOINT DRIVE, SUITE 400	
DAPTI	/E NURSING AND	HEALTHCARE SERVICES, INC	INDIAN	IAPOLIS, IN 46256	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	skilled records revi	ewed.		Pediasure. All employees have	e
				been educated on maintaining	
	Findings include:			accurate supplies and	
				documentation, ensuring that e	ach
	1. A review of pol	icy entitled "Admission		home has these supplies listed	
	Criteria", dated 03/	20/18, section 5 stated "No		All nurses to have extra gloves	,
	patient is admitted	for services without an order		sanitizer and OSHA kits, and C	PR
	from a physician."			masks to replace those missing	j
				supplies provided by Adaptive	
	2. A review of pol	icy entitled "Clinical		immediately. RN will send	
	Documentation/ M	issed Shifts", dated February		supplemental order for all upda	ted
	14, 2014, section #	2 stated "A separate note shall		changes to the plan of care to	
	be completed for ea	ach visit/shift and signed and		ensure that the plan of care	
	dated by the approp	priate professional."		matches what is in the home a	nd
				being provided to the client.	
	3. A home observa	tion was completed on		All charts are being reviewed to	
	09/11/19 at 6:50 an	n, for patient #2. During the		ensure that services did not be	gin
	home visit, the skil	led nurse offered the patient a		prior to MD order.	
	carton of Boost to a	drink. During this time,			
	Employee K was in	nterviewed in regards to the		All charts are being reviewed b	y
	Boost being provid	ed versus the Pediasure that		the Administrator after each vis	it
	was ordered. Empl	loyee K stated "we use Boost		to ensure order received from I	ИD
	and only use Pedia:	sure when we run out of		prior to services being provided	l.
	Boost." During thi	s visit, surveyor asked			
	employee K, RN to	see the OSHA kit. Employee K		The Administrator will provide	
	stated "I have no id	lea what that is."		Comprehensive Assessment	
				In-service to reeducate all Clini	cal
	-	ew for certification period of		Managers on the specifics patie	ent
	05/20/19 - 07/18/19	-		preferences, supplemental orde	ers,
		ction (page 2 of 4) stated		physician authorization	
		four times a day" and		requirements has been comple	ted
	-	ements section (page 3 of 4)		by 11/4/19.	
		our times a day." The section			
		lical supplies]/ Supplies (page 3		Administrator will be responsible	e
		kit" as one of the supplies in		for monitoring these corrective	
		The plan of care failed to		actions to ensure that this	
	evidence instruction	n to use Boost supplement and		deficiency is corrected and will	not
		e supplement when the patient		recur with weekly reporting	
	is out of Boost. Th	e plan of care indicated the		checks. Administrator will mon	itor
	registered nurse ob	tained verbal start of care		for 100% compliance by review	ring

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	PRINTED:	11/19/2019
	FORM AP	PROVED
	OMB NO.	0938-039
(X3	3) DATE SURVE	Y

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K167			JILDING	00	COM	e survey pleted 3/2019
	PROVIDER OR SUPPLIEI	R HEALTHCARE SERVICES, INC	;	9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE APOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPE	LD BE ROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	orders on 10/22/19 Review of the clini Skilled Nurse Visit 05/21/19. Review 05/22/19 stated "Ad 05/20/19. Spoke w office on 05/22/19 start of care) for SN 5/20/19 to 7/18/19 verbal start of care completed on 05/22 skilled nursing serv from the physician. Further record revic certification period completed. Gastro stated "Pediasure 2 Nutritional Require stated "Pediasure for DME [durable med of 4) stated "OSHA the patient home. T evidence an order f was for Pediasure. Supervisory visit n documented "no Of An interview was c am with employee program manager v home assessment p to ensure the home and services were r would then be give obtain an order fron initial comprehensi	cal record evidenced two notes dated of 05/20/19 and of the physician order on dmission completed on rith [NAME] RN at physician's at 9:57 am for VSOC (verbal V (skilled nurse) services." The plan of care evidenced that a date was documented as 2/19. The agency provided vices prior to obtaining orders			each chart with home visi completed week prior. The will be completed weekly. Administrator will review a for completion by 11/29/1 Patient #1 Chart reviewed and docum has been updated to show communication with prima caregiver that she was oak wait after skilled nurse did show up for orientation. If reported that she was oak for new skilled nurse as a someone providing the se and wanted to give them appropriate notice that the no longer needed. All char been reviewed to ensure are being provided as or Administrator will ensure reeducation to all internal regarding safe and appro transfer when the client's exceed the capabilities of with HHA Not Meeting Pa Needs In-service to be co on 11/4/19. Administrator review all client admission to ensure 100% compliant skilled charts reviewed to the proper documentation matches the plan of care. Administrator will review a the week after the clinical manager completes the h supervisory visits to ensure changes are sent to MD f signature and that the plan	all charts all charts all charts any ary ary ary ary ary ary ary ar	

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Event ID:

MO5T11 Facility ID: 014118

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TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMI	PLETED
		15K167	B. WING		09/1	3/2019
JAME OF	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP C		
				WESTPOINT DRIVE, SUI	TE 400	
ADAPTI		HEALTHCARE SERVICES, INC	INDI	ANAPOLIS, IN 46256		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORI	RECTION	(X5)
REFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE A	IOULD BE PPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		Once the initial comprehensive		is being followed.		
		mpleted, the physician would				
	-	order to admit. Employee F,				
		cated that the OSHA kit was a		Chart has been review		
	*	ous fluids and had a CPR		clarification has been s		
	-	1. Employee F showed the		to ensure plan of care i		
		ble of one, which also contained		the services being prov		
	-	Employee F stated "one is		employees have been		
	-	me on admission." Employee F		and received in-service		
		s patient does not have one;		documentation must be		
	don't know where	it is. I've only seen her once."		by nurse and uploaded		
				office chart to match ho		
		00 PM, the administrator		Clinical Manager will re		
		re was only one order from the		documentation of the h	ome nurse	
	· · ·	nt #2 and that it was dated for		to ensure all orders are	-	
	05/22/19.			followed and document	ted	
				accurately.		
	-	w on 09/12/19 at 2:25 PM, the				
		cated that she saw the		All skilled charts review		
		ated 07/17/19 that stated "No		ensure the proper docu		
		ome." She agreed that there		and matches the plan of	of care.	
	should be one in th					
		ord for patient # 1, with start of		Administrator will review		
		019, included a plan of care for $\frac{1}{12}$		the week after the clinic		
	-	priod of 7/15/19 to 9/12/19, with		manager completes the		
		nurse services, 8 hours a day, 5		supervisory visits to en	•	
	-	tive 7/15/19. The plan of care		changes are sent to MI		
		r the skilled nurse to administer		signature and that the	plan of care	
		red by the physician and		is being followed.		
		IAR [medication administration		Administrates will as	uanta all	
	record]."			Administrator will reedu		
	Deview of the close	trania medical record for patient		internal staff and skilled		
		tronic medical record for patient ce skilled nurse visits were		regarding documentation		
		d. The first skilled nurse visit		medication, beginning		
	-	019, by employee I, a registered		supplemental orders, p		
		t documentation of skilled nurse		preference, missed shi		
		ical record failed to evidence		ensuring OSHA kits are		
		explain why skilled nurse		home with Comprehen		
		completed as ordered on the		Assessment, Home Sa	-	
	services were not o	completed as ordered on the	1	Evaluation, and Not Me	eung	

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/13/2019
	PROVIDER OR SUPPLIE	^R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE IAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLET
	skilled nurse visits Tuesdays, Wednes beginning 8/13/20 skilled nurse visit 20, 21, 22, 27, and 2019. The skilled evidence document gastronomy tube f the nurse, during t On 9/10/2019 at 2 reviewed with the confirmed that ski provided 3 times a on the plan of care the record failed to the physician was revised. During interviews manager indicated the plan of care was the case was to be 7/16/2019, and fai orientation, therefor nurse for the case. communication be primary care giver 5:45 PM, the admi record failed to ev liquid nutrition and administered by th visit. Employee A not turned into the	10 PM, the clinical record was administrator. The administrator lled nurse services were week and not 5 days a week as . The administrator indicated o evidence documentation that updated and the plan of care on 9/12/19 at 4:30 PM, the office the patient was accepted and as established and the nurse for gin the following day, led to arrive for her first day of ore, the agency did not have a Employee A indicated the tween the agency and the was in her agency emails. At nistrator relayed that the clinical idence documentation of the d the medications that were e nurse during the skilled nurse indicated the documents were agency by the nurse that ts. No information was		Client's Needs In-services completed by 11/8/19. Administrator will monitor 100% compliance by revi each chart with home visi completed week prior. Th will be completed weekly. See attachments	for ewing ts nis review

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	N (X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K167	A. BUILDING <u>00</u> B. WING		00	COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	_	9840 V	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 4 IAPOLIS, IN 46256	400	
(X4) ID PREFIX TAG G 0716	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
Bldg. 00	professional failed clinical notes were pediatric clinical re Findings include: Policy entitled "Fl- 2012, stated "Ager appropriate flow sl client assessment, made " and "A turned into the offi will be maintained Record review of p 09/12/19, included 08/31/19. Plan of c 07/19/19-09/16/19 services to provide An interview with conducted on 09/1 stated "Skilled nur for time period 09/	owsheets", dated August 1, hey personnel shall use heets to document ongoing care, and needs when visits are ll originals (white copies) will be ce weekly and the yellow copy in the home chart." Datient #2, completed on skilled nursing notes through care certification period of indicated skilled nursing e care 5 days a week. the office manager was 2/19 at 3:20 pm, where she se should have turned in notes 01/19 - 09/07/19 by Monday, has not turned them in and that	G 07	716	Patient #2 Copies of skilled nurse flow have been uploaded to clie office chart. All skilled client charts have reviewed to ensure all care been provided as ordered. of skilled flowsheets and M have been uploaded after b reviewed by clinical manag Clinical manager will review completeness and initial af review and upload to client electronic office record. Administrator will ensure reeducation to all Clinical Managers and skilled nur- regarding documentation being submitted and uplo in a timely manner with Comprehensive Assessm In-service, completed by 11/5/19. Administrator will review s client charts to ensure that nurse documentation has b uploaded to client office ch weekly for 100% accuracy completion.	nt's e been has Copies ARs being er. v for ter ses not aded ent killed skilled been art	11/05/2019
G 0718							
Bldg. 00		view and interview, the skilled to ensure the physician was	G 07	718	Patient #2 Failed to ensure the physic was notified of changes in		11/05/2019

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIF A. BUILDII B. WING	PLE CONSTRUNG <u>00</u>	· · · · · · · · · · · · · · · · · · ·	x3) date s comple 09/13/2	ETED
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	98	40 WESTP	ss, city, state, zip cod POINT DRIVE, SUITE 400 IS, IN 46256		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREF	TX (E	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE	=	(X5) COMPLET
TAG		R LSC IDENTIFYING INFORMATION	TA		DEFICIENCY)		DATE
		s decided the patient declined			plements.		
		sing services as ordered per the		Cha	art reviewed and processes	put	
	· · ·	nt #6), changes in feeding		in pl	ace to prevent any future		
	·	nt #2), and unrelieved pain		serv	ices being provided without	t	
	(Patient #7) for 3	of 8 records reviewed.		phys	sician order. All employees	i.	
				re-e	ducated with in-service to		
	Findings include:			ensu	ure that MD order obtained		
				prior	r to any service being		
	1. A home observ	ation was completed on		prov	vided. Supplemental order h	has	
	09/11/19 at 6:50 at	n, for patient #2. During the		beer	n sent to MD for Boost or		
	home visit the pati	ent was given a carton of Boost		Pedi	iasure. All employees have	÷	
	to drink.			beer	n educated on updating plar	n of	
				care	with all changes and notify	/ing	
	Plan of care review	for certification period of		the I	MD of changes. RN will se	nd	
	05/20/19 - 07/18/1	9 was completed.		supp	plemental order for all updat	ted	
	Gastrointestinal se	ction (page 2 of 4) stated		char	nges to the plan of care to		
	"Pediasure 237 ml	four times a day." And		ensu	ure that the plan of care		
	Nutritional Requir	ements section (page 3 of 4)		mate	ches what is in the home an	nd	
	stated "Pediasure f	our times a day."		bein	g provided to the client.		
		olan of care for certification			harts are being reviewed by	-	
	^	- 09/16/19 was completed.			Administrator after each visi	-	
		ction (page 2 of 4) stated			nsure order received from N		
		four times a day." And ements section (page 3 of 4)		prior	r to services being provided	i.	
	stated "Pediasure f			The	Administrator will provide		
		2			prehensive Assessment		
	Record review was	s completed on 09/11/19, which			ervice to reeducate all Clinic	cal	
		vupdated physician order for			agers on the specifics patie		
		nented communication with the			erences, supplemental orde		
		e the order from Pediasure to			sician authorization	/	
	Boost.				irements has been complet	ted	
				-	1/5/19.		
		ployee K, RN, on 09/11/19,					
		est and only use Pediasure			inistrator will be responsible	е	
	when we run out o	t Boost."			nonitoring these corrective		
					ons to ensure that this		
		ord #6 with a start of care			ciency is corrected and will i	not	
		ed a "Home Health Certification			r with weekly reporting		
	and Plan of Care"	for the certification period of		cheo	cks. Administrator will moni	itor	

FPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/19/2019 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 COMPLETED 00 B. WING 09/13/2019 15K167 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256 ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 7/02/2019 to 8/30/2019, with orders for skilled for 100% compliance by reviewing nursing services 8 hours per day 5 days a week each chart with home visits throughput the certification period. The clinical completed week prior. This review record failed to evidence skilled nursing services will be completed weekly. were provided as ordered and communication Administrator will review all charts notes to explain why services were not provided. for completion by 11/5/19 During an interview on 9/10/2019 at 3:20 PM, the Patient #6 office manager, indicated patient #6 did not Failed to ensure the physician receive any nurse services due to the primary care was notified when it was decided giver decided, after meeting multiple nurses, they the patient declined to have skilled did not want other individuals in the home. nursing services as ordered per the plan of care. 3. The clinical record of Patient #7, start of care Chart has been updated to show 12/19/18, was reviewed and indicated a primary documentation with mom diagnosis is rheumatoid arthritis with rheumatoid requesting to hold off on skilled faction. Other pertinent diagnoses include nurse starting due to no hover lift essential primary hypertension, anxiety disorder, in the home. Documentation of anemia, chronic pain syndrome, type II diabetes when mom decided services were mellitus, and mixed incontinence. no longer needed due to she was going to stay home with him. Plan of care for certification period of 02/17/19 -04/17/19, page 2 of 4 stated "She explained that All charts being reviewed to she will be prescribed stronger pain medication ensure all communication with when she receives a keypad lock box for per client/primary caregiver is narcotic pain medications due to past experiences documented. of her medications getting stolen from her. Documented pain score was +8/10. Additionally, All employees received in-service the plan of care stated "She has recently received not meeting client needs to a lockbox for her pain medication and will request re-educate on steps and more from her doctor next visits." documentation needed when unable to meet needs of client. Pain assessment, dated 04/12/19, documented "worst pain level over last 48 hours - 9." The Administrator reviewing schedules clinical record failed to evidence that the and documentation weekly to physician was notified of the patient's pain. ensure plan of care is being followed as ordered. Patient #7 Failed to ensure MD was notified MO5T11

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

Event ID:

Facility ID: 014118

If continuation sheet

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11/19/2019

PRINTED:

FORM APPROVED

	R MEDICARE & MEDI				OMB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K167		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 JAPOLIS, IN 46256	
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				of patient's pain. Patient has be discharged and are unable to fi this deficiency for this chart. All charts being reviewed to ensure appropriate documentat of pain assessment. All clinical managers re-educate with Comprehensive Assessment in-service to be sure to docume completely all pain assessment and notify MD of any increased uncontrolled pain.	x tion ed ent ent s
				Clinical Managers have been educated on falls, aspiration an pain interventions to be added to the plan of care as appropriate with measurable goals/outcome to monitor.	to
				Administrator will be responsibl for monitoring these corrective actions to ensure that this deficiency is corrected and will recur with weekly reporting checks. Administrator will mon for 100% compliance by review each chart with home visits completed week prior. This rev will be completed weekly. Administrator will review all cha for compliance by 11/5/19 See attachments	not itor ing riew
G 0750					
Bldg. 00		view and interview, the agency Jome Health Aide was	G 0750	Administrator will ensure all competencies will be completed by a contract nurse in the home	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 2	(3) DATE SURVEY COMPLETED 09/13/2019
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 JAPOLIS, IN 46256	
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
	ensure that all pros (HHA) staff perfor with a patient and demonstrate comp home health aide r the aide application State Department of administrator on Ju current administrat continuing educati (HHA) annual in-s failed to ensure the was updated and ad preference for bath home health aide of ordered by the phy of care for shower, home health super completion of bath the plan of care. T (Patient #5, 7) out reviewed and 23 (I PP, SS, TT, UU, V BBB, CCC, DDD, health aide person cumulative effect of resulted in the agen patients received a	rming a bed bath, failed to pective home health aide med all tasks, in their entirety not simulated, as required, to etence for placement on the egistry and failed to ensure that as submitted to the Indiana of Health, after a change in me 07, 2019, was signed by the or, failed to ensure the on for the Home Health Aides ervices met the requirements, home health aide care plan ecurately reflected patient ing, failed to ensure that the nly provided services that were sician and included in the plan and failed to ensure that the <i>v</i> ision of the aide for ing was provided according to hese practices impacted 2 of 7 sampled patient records Employee M, P, Q, R, GG, JJ, OO, V, WW, XX, YY, ZZ, AAA, EEE, FFF, GGG) out of 23 home heal files reviewed. The of these systemic problems ney's inability to ensure opropriate Aide care and ld result in the agency not ealth care.		prior to HHA application submission. Administrator has updated all license applications with current Administrator signatures. Administrator will review this monthly and quarterly with checklist. Administrator will ensure all internal staff are reeducated wit Comprehensive Assessment In-service in regards to proper competency requirements by 11/4/19	
G 0754 Bldg. 00	interview, the agen Health Aide was co	on, record review, and cy failed to ensure a Home ompetent in performing a bed the visits conducted. (Employee	G 0754	Clinical Manager will be individually counseled and retrained on 11/4/19 by Administrator regarding competency assessment of Hor	11/29/201

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/13/2019	
NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC			2	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE	
	M) Findings include: The "Competency provided by Emplo This current policy "POLICY compet during the intervie and ongoing throug INSTRUCTIONS self-assessment of description. This a determine the orien required by each p assessment checkli will be used by the document the com demonstration of s EVALUATION O tests including wri observation of skill determined by the assessmentsHorr Skills competency aide with client,1 areas marked with observation of the performance of the bath The "Perso Home health Aide Employee B on 9/ test was taken by a knowledge. The r assessment of their Employee M's hire work area was as a term care facility.	Assessment" policy was byee C on 9/11/19 at 1:02 p.m. indicated the following: ency of all staff will be assessed w process orientation program gh out employmentSPECIAL 1. All employees will complete a the skills area for their job assessment will be used to intation and specific training erson. 2. The skills st and the orientation checklist supervisor/preceptor to pletion of satisfactory killsCOMPETENCY F HOME CARE STAFF2. Skill tten tests and direct I will be completed as agency policies and individual e Health Aide Competency: 2. is evaluated by observing the NOTE: The following subject an * must be evaluated after Home Health Aide's e tasks with a client*Bed onal Care Attendant (PCA)/ Exam" was provided by 11/19 at 1:25 p.m. This written new hire to determine their new employee may do a self			Health Aides. Administrator reeduca Clinical Managers of a clients and home safe meeting 10/29/19. Administrator updated checklist to ensure for assessment of whethe employee is appropria comped and added to Health Aide registry or Administrator reeduca internal staff on detern eligibility for competen in-serivce attached on Nurses must sign off c skills checklist whethe is appropriate for comp assessment to be add registry or not Administrator and Offic will review all PCA skil of any new hires that t is followed. All new co will be completed in th a patient by contracted Administrator will revier registry applications all competency check offs process is being follow to ensure that any iney caregivers are not pro- services or being subr HHA registry.	ted all assessing ty in PCA Skills accurate er an te to be Home n 10/31/19 ted all nining acy with 11/4/19 on the PCA r employee petency ed to ce Manager Ils checklist his process mpetencies the home with d nurse. ew all HHA nd skills s to ensure ved weekly xperienced viding		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CO A. BUILDING B. WING	COMPI	(X3) DATE SURVEY COMPLETED 09/13/2019			
	PROVIDER OR SUPPLI	ER) HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIO DATE		
	Skills Check List to surveyor on 9/1 indicated on this of knowledgeable an specified skills of incontinent care, a On 9/10/19 from 1 visit observation v of Patient 4 and E perform a bed bath bath, Employee M remove gloves thr handwashing or h care was complete handwash, turn th and shake her han no paper towel or hands. The Patier bowel movement At the time for the Employee L (RN) short period. Emp and returned at 12 the RN was not pr observed to cleans chest area and upp cleansing did not clean sheets were client's female roo remaining incontin wipes to cleanse t observed complete during this visit. I Employee L infor present to watch F	ided a document titled, "PCA - CNA, HHA" and was provided 2/19 at 4:55 p.m. Employee M locument that she was d experienced to perform the a sponge bath / bed bath, and handwashing. 10:46 a.m. to 1:35 p.m., a home was conducted at the residence Employee M was observed to h with Patient. During this bed I was observed to don and oughout the care with no andgel use observed. After ed, Employee M was observed to e water off with her wet hand ds in attempt to dry them with other means present to dry her at was incontinent of urine and during the bed bath observation. e rectal care and perineal care, indicated she had to leave for a bloyee L (RN) left at 12:35 p.m. :46 p.m. During this time that resent, Employee M was se the Patient's back, lateral left ber buttocks only. This include the rectal area. As the positioned on the bed, the ommate acknowledge the nent bowel movement and used he area. No perineal care was ed by Employee M on this client Prior to exiting the home visit, med the client she had been Employee M give her a bath. 1:40 a.m. to 12:09 p.m., during an ee L admitted she had left the						

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15K167	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X3 00	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIEI	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 VAPOLIS, IN 46256		
ADAP IN (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OI house during the cl tasks (rectal and pe her. Employee's "COM -HHA," dated and s Employee L on 9/1 Employee B on 9/1 competency checkl "Successfully Com control / Hazardous Sponge, Safe Trans ambulation." On 9/12/19 at 4:00 Employee B indica position would take indicated the new h were comfortable v would be the nurse	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION ient's personal care, and these rineal care) were not seen by PETENCY ASSESSMENT - signed electronically by 0/2019, was provided by 1/19 at 12:28 p.m. This ist indicated Employee M pleted" the skills of "Infection is Waste, Bathing Bed /	ID PREFIX TAG	APOLIS, IN 46256	(X5) COMPLETIC DATE	
	Employee C indica Aide's testing for th was allowed in order	-				
6 0768						
Bldg. 00	failed to ensure that aide (HHA) staff po- entirety with a patie	view and interview, the agency t all prospective home health erformed all tasks, in their ent and not simulated, as strate competence for	G 0768	Agency failed to ensure that all prospective home health aide sta performed all tasks in their entire with a patient and not simulated to demonstrate competence for placement on the home health	ty	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COM	3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	STREET 9840 V INDIAN		00		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	TION .D BE .OPRIATE	(X5) COMPLETI DATE	
	placement on the F failed to ensure the submitted to the Ir Health, after a cha 2019, was signed I 19 of 19 aide comp GG, JJ, OO, PP, S AAA, BBB, CCC, The findings inclu The Indiana State conducted an initia The results of the s from providing its and competency e of 2 years beginnin of compliance with at 42 CFR 484.14, Administration; 42 Professional Perso Acceptance of Pat Supervision; 42 CFR Services, 42 CFR CFR 484. 55, Com Patients. The ISDH received the agency had a c administrator was employee C becam During an intervie at 3:15 PM, she re date of work for en with the last date s 2019.	nome health aide registry and at the aide applications diana State Department of nge in administrator on June 07, by the current administrator for petencies reviewed. (Employees S, TT, UU, VV WW, XX, YY, ZZ, DDD, EEE, FFF, GGG)		registry and failed to ensu- the aide applications had administrator signature or registry applications after 2019. All employees have been in-serviced to be sure cur Administrator is on the reg applications. All prospective home hea to comped in the home wi tasks to be completed witt without needing prompting re-direction with skills bef submitted to registry. All will be completed with cor nurse. All contract nurses have expirations tracked a to ensure that contracts a current and up to date. Administrator updated con all Comp Nurses and they signed by 11/8/19. Administrator updated HI- license application with cu Administrator will review t monthly for accuracy with checklist. Administrator will ensure f competency will be compl the home with a contact m prior to HHA application submission.	are that the new in the June 7, rent gistry lith aides th all h patient g or ore being comps intract s will annually re htract for y will be IA urrent his form		
	with the last date s 2019. During an intervie	he saw a patient was July 11,		the ho prior t	ome with a contact n to HHA application	ome with a contact nurse o HHA application	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	COM	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R R HEALTHCARE SERVICES, INC	9840 V	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 40 INDIANAPOLIS, IN 46256			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETIC	
	predetermined exp contract failed to a completion of the A contract was pro [CN02], with actii was with Adaptive locations. The con expectations for the competencies. During interviews office manager ind nurse and aide wo and that the agence office manager ind competency testin office and that the managers from oth completed the com patient homes with relayed that she di to determine that a had not observed b may determine an the agency nurses same individual to The following aide corresponding app evidenced the follo Employee file GG competency with G application was su 5/23/2019.	e competency files and their lication to the state agency					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	A. BL	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		COM	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC	;	9840 WI	DDRESS, CITY, STATE, ZII ESTPOINT DRIVE, S APOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETIC	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
	application was sub 5/23/2019.	mitted to the state agency on						
	Employee file OO	evidenced an in lab only						
		NO2, dated 7/18/19 and						
		cation was submitted to the						
	state agency with th	e signature of the previous						
	administrator, empl	oyee E, and dated 7/18/2019.						
		videnced an in lab only						
		NO2, dated 8/29/19 and						
		cation was submitted to the						
		e signature of the previous						
	administrator, employee	oyee E, and dated 8/29/2019.						
		videnced an in lab only						
		NO2, dated 8/29/19 and						
		cation was submitted to the						
		e signature of the previous						
	administrator, empl	oyee E, and dated 8/29/2019.						
		videnced an in lab only						
		NO2, dated 7/11/19 and						
		cation was submitted to the						
		e signature of the previous						
	administrator, empl	oyee E, and dated 7/11/2019.						
	· ·	evidenced an in lab only						
		NO2, dated 8/08/19 and						
		cation was submitted to the						
		e signature of the previous						
	administrator, empl	oyee E, and dated 8/08/2019.						
		evidenced an in lab only						
		NO2, dated 8/29/19 and						
		cation was submitted to the						
		e signature of the previous						
	administrator, empl	oyee E, and dated 8/29/2019.						
	Employee file WW	evidenced an in lab only						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167		JILDING	NSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 09/13/2019	
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PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE PROPRIATE	COMPLETIC	
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		cation was submitted to the						
		ne signature of the previous						
	administrator, empl	oyee E, and dated 8/01/19.						
	Employee file XX	evidenced an in lab only						
		NO2, dated $8/15/19$ and						
		cation was submitted to the						
		ne signature of the previous						
		oyee E, and dated 8/15/2019.						
	Employee file VV							
		evidenced the application was te agency with the signature						
		ninistrator, employee E, and						
	was dated 8/08/19.	inistrator, employee E, and						
	Employee file ZZ e	videnced an in lab only						
		NO2, dated $8/22/19$ and						
		cation was submitted to the						
		ne signature of the previous						
		oyee E, and dated 8/22/2019.						
		A evidenced an in lab only						
		NO2, dated 8/29/19 and						
	evidenced the appli	cation was submitted to the						
	0 5	ne signature of the previous						
	administrator, empl	oyee E, and dated 8/29/2019.						
	Employee file BBE	evidenced an in lab only						
		NO2, dated 8/29/19 and						
		cation was submitted to the						
		ne signature of the previous						
		oyee E, and dated 8/29/2019.						
	Employee file CCC	evidenced an in lab only						
		NO2, dated 7/11/19 and						
		cation was submitted to the						
		ne signature of the previous						
		oyee E, and dated 7/11/2019.						
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	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		OMB NO. 0938-039 X3) DATE SURVEY	
	VT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	<u>00</u>	COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY (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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	competency with G evidenced the appl state agency with t administrator, emp Employee file EEF competency with G evidenced the appl state agency with t administrator, emp Employee file FFF competency with G evidenced the appl state agency with t administrator, emp Employee file GGG competency with G evidenced the appl state agency with G	D evidenced an in lab only CNO2, dated 7/11/19 and ication was submitted to the he signature of the previous loyee E, and dated 7/11/2019. E evidenced an in lab only CNO2, dated 6/27/19 and ication was submitted to the he signature of the previous loyee E, and dated 6/27/2019. evidenced an in lab only CNO2, dated 7/11/19 and ication was submitted to the he signature of the previous loyee E, and dated 7/11/2019. G evidenced an in lab only CNO2, dated 8/15/19 and ication was submitted to the he signature of the previous loyee E, and dated 8/15/19 and ication was submitted to the he signature of the previous loyee E, and dated 8/15/19. (A)				
G 0774						
Bldg. 00	failed to ensure the Home Health Aide the requirements for inservices for 3 of	a and record review, the agency continuing education for the s (HHA) annual inservices met or 8 of the 12 required 3 HHAs reviewed for these byee P, Employee Q, and	G 0774	Failed to ensure that continuing education for the Home Health Aides annual inservices met requirements. All Home Health Aides will rece in-services to cover all requirements. All home health aide files will be reviewed to ensure the requirements have been met. Any Home health aides that have not received all	ive	

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/13/2019 15K167 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256 ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE On 9/10/19 at 9:22 a.m., the HHA inservices were requirement topics will receive the provided by Employee B. These 1 hour inservices following in-services to get those included the following topics: OSHA, Culture covered. All of this information is also covered with a skills day Diversity, Handling Complaints, Abuse, Patient's Bill of Rights, Infection Control, Disaster competency annually. Planning, Abnormal Observations, Working with a Non-compliant Client, Ethical Dilemma in Healthcare, Neglect, Specific Communication Administrator has attached Needs, and Quality Improvement totaling 13 current required in-service that hours. These inservices were completed by covered areas of vital signs, basic Employee P (hire date of 4/18/17), Employee Q elements of body function, fluid (hire date of 3/4/18), and Employee R (hire date of intake, and changes in client 8/28/18). condition that require notification of a supervisor. This In-service On 9/11/19 at 1:30 p.m., Employee C provided the titled Recognizing and Reporting identified inservice information for each inservice Normal Observations has been a obtained from Employee O (Director of Home Care required and completed in-service Operations). This provided information was as for 2019. follows: OSHA (all abut OSHA), Culture Diversity (understanding of culture diversity), Administrator implementing all Grievances/Complaints (handling complaints), current HHA's receive the following Patient's Rights (Patient's Bill of Rights), Infection in-services by 11/29/19 to ensure Control (infection control in home care), total compliance: Helping with Emergency/Disaster Planning (disaster planning), Activities of Daily Living, Compliance Program (working with a Understanding Falls Risks, non-compliant Client), Ethics (Ethical Dilemma in Nutrition for the Elderly, and Healthcare), and Communication Barriers Caregiver Basics Traiing. See (understanding special communication needs). attachments These inservices failed to evidence the content of Administrator will ensure that all the required inservice information to include vital new hire HHAs receive all required signs, changes in a client's condition requiring in-services. notification to the supervisor, understanding of the basic elements of body functioning, Administrator will monitor that all maintaining a clean, safe, and healthy required in-services are completed environment, appropriate and safe techniques in annually for all Home Health personal hygiene, grooming, transfer/ambulation, Aides. normal range of motion and positioning, adequate nutrition and fluid intake, medication assistance, and/or any other task the home health agency

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Event ID:

MO5T11

Facility ID: 014118

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/19/2019 FORM APPROVED

SUMMARY EACH DEFICIEN EGULATORY OI choose to have (12/19 at 5:44 oyee C ackno cy's identified rements for th attion of HHAs AC 17-14-h(1 d on record re e the home he	HEALTHCARE SERVICES, IN STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> e the home health aide perform. p.m., during an interview wledged this Home Health inservices did not meet the e required continuing		9840 W INDIAN ID PREFIX TAG	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 JAPOLIS, IN 46256 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Patient #7 Failed to ensure the home health aide care plan was updated and	(X5) COMPLETION DATE 09/13/201
EACH DEFICIEN EGULATORY OL choose to have (12/19 at 5:44 oyee C ackno cy's identified rements for th ation of HHAs AC 17-14-h(1 d on record re e the home he	ICY MUST BE PRECEDED BY FULL <u>R LSC IDENTIFYING INFORMATION</u> the home health aide perform. p.m., during an interview wledged this Home Health inservices did not meet the e required continuing) view, the agency failed to alth aide care plan was		PREFIX TAG	Patient #7 Failed to ensure the home health aide care plan was updated and	COMPLETION DATE
/12/19 at 5:44 oyee C ackno cy's identified rements for th ation of HHAs AC 17-14-h(1 d on record re e the home he	 p.m., during an interview wledged this Home Health inservices did not meet the e required continuing) view, the agency failed to alth aide care plan was 	G 0'	798	Failed to ensure the home health aide care plan was updated and	09/13/201
rence for bath wed. (Patient ngs include: mmunication 1 ger, dated 03/ path"	ing in 1 of 4 closed records #7) note from the RN, case 28/19 states "Client requesting Plan failed to be updated prior			accurately reflected patient preference for bathing. Chart was reviewed and noted that the HHA service plan dated and time stamped 3/28/19 matches the communication note that the client preferred a sink bath. Clinical manager was notified of the patient's preference to receive sink bath, documented it in communications and updated the HHA service plan at that time. All HHA timesheets are being reviewed weekly to note any such changes/updates and Home Health Aides will be re-educated to notify office of any changes including patient preference so that plan of care and service plan can be updated at that time by 11/29/19.	
ł	HA Service I	ath" HA Service Plan failed to be updated prior .7/19 for a sink bath.	HA Service Plan failed to be updated prior	HA Service Plan failed to be updated prior	HA Service Plan failed to be updated prior 17/19 for a sink bath. Clinical manager was notified of the patient's preference to receive sink bath, documented it in communications and updated the HHA service plan at that time. All HHA timesheets are being reviewed weekly to note any such changes/updates and Home Health Aides will be re-educated to notify office of any changes including patient preference so that plan of care and service plan can be updated at that time by

	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	II TIDI E CO	ONSTRUCTION	X3) DATE	B NO. 0938-039	
	OF CORRECTION	IDENTIFICATION NUMBER	r í	ILDING	00		COMPLETED 09/13/2019	
11.1212.11.1	or conduction	15K167	B. WI		<u></u>			
		D		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	ĸ		9840 V	ESTPOINT DRIVE, SUITE 400			
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC		INDIAN	IAPOLIS, IN 46256			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					time stamped (3/28/19) to mate	ch		
					communication dated 3/28/19 updated HHA Service plan with			
					updated client preference for	1		
					bathing.			
					Clinical Managers will continue	to		
					review time sheets weekly to	10		
					ensure compliance with updati	na		
					plan of care/HHA service plan.	9		
G 0800								
Bldg. 00								
Blug. 00			G 08	300	Administrator will ensure		11/04/201	
	Based on record re	eview and interview, the agency			reeducation to all internal staff	on		
	failed to ensure vis	sits were provided as ordered			documentation of missed shifts	;		
	-	for 2 of 5 home health aide			with Not Meeting Patient's Nee	ds		
	only records review	wed. (Patient 5 and 7)			In-service completed by 11/4/1			
	Findings include:				HHA (Home Health Agency) wi provide documentation daily as			
	T munigs menude.				why services are not provided a			
	1. On 9/12/19 at 4	:58 p.m., Employee B indicated			ordered and document			
		y for missed visits only the			communication between agence	CV .		
	provided procedur	e.			and patient/primary caregiver	5		
					under the shift that was schedu	uled		
		isit Notification to MD (Medical			as well as in			
		olicy was provided by the			activities/communications. HH/			
	-	n 9/10/19 at 4:10 p.m. This			(Home Health Agency) will prov			
		cated "For any Patients that			documentation of communication	on		
	-	(number) of hours [greater			between agency and patient's			
	faxed to the MD."	ssed visit notification will be			physician who is responsible for the home health plan of care in			
	function to the MD.				activities/communications.	•		
	3. Patient 5's clini	cal record was reviewed on			Follow-up documentation will b	e		
		n. This Patient's diagnoses			provided daily that includes how			
	-	not limited to, Type 2 Diabetic			and when the patient and/or			
		pinal stenosis, chronic diastolic			primary caregiver were notified	of		
		rtension, neurogenic bladder,			staffing status. Review of daily	,		
	and chronic kidney	v disease, Stage 4. The Start of			visit sheets to be completed			

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 COMPLETED 00 B. WING 09/13/2019 15K167 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256 ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Care was 9/10/18. The Plan of Care for the weekly by Clinical Manager by certified period of 7/7/19 through 9/4/19 was to either reviewing individual daily provide 3-5 hours a day for 5 to 7 days per week. visit sheets or running Service The HHA was to assist with all Activities of Daily Plan Task Frequency Variance Living to include, but not limited to, bathing, hair Report. Clinical Manager will care, incontinence care and light housekeeping. document in Communications/QA that every shift has been reviewed The week of 8/25/19 to 8/31/19 included a HHA visit on 8/26 (Monday), 8/28 (Wednesday), and weekly. 8/29 (Thursday) only. All documentation must be signed by the individual making the entry On 9/12/19 at 3:30 p.m., during an interview with individuals first initial of first Employee B indicated the HHA had moved a name. last name and title. If after 15 days, the HHA (Home scheduled visit day during the week of 8/25/19 to 8/31/19 to 8/31/19 (Saturday). She also indicated Health Agency) is unable to meet the HHA then called in on 8/31 (Saturday), and no the needs of the patient, the replacement was found. The agency failed to agency will offer to assist transfer evidence any further information related to the to another HHA (Home Health missing 2 days of the HHA's home visits. Agency) that is able to meet the needs of the patient by providing On 9/12/19 at 3:50 p.m., during an interview them with a list of providers in the Employee C indicated if 50% of approved visits area. and over 1 hour or more in a week were missed, a The Administrator/Operations supplemental order was to be sent to the Manager will check weekly for this physician. documentation and verify in 4. Patient #7 clinical record was reviewed and activities/QA under the office that evidenced a plan of care for certification period of missed shifts and grievances were 02/17/19-04/17/19, indicated within the reviewed for concerns. This note professional services orders section that the aide will be printed and placed in the will assist with bathing (shower). QAPI binder weekly. Review of the Home health aide Plan of Care Please see attached correct Service Plan, dated 01/16/19, indicated tub/shower service plan made on 3/28/19 for for bath. patient 7 for compliance. Communication note, dated 03/28/19 was Please see attached Missed Shift completed by the supervisory case manager that policy. stated "Patient requested her bathing type be changed to sink bath as her shower is upstairs and she does not feel safe climbing stairs." The clinical record failed to evidence a physician order MO5T11 Facility ID: 014118

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PRINTED:

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	onstruction 00		SURVEY LETED	
		15K167	B. WING	<u> </u>	09/13	13/2019	
	PROVIDER OR SUPPLIE VE NURSING AND	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256)		
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION e failed to be updated to	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE	
G 0818	Review of the hom for care dates from indicated the patien	e in patient preference. The health aide daily visit sheets 03/26/19 through 04/17/19, nt was given a sink bath. The ailed to follow the plan of care.					
Bidg. 00	failed to notify the for 1 of 4 closed cl (Patient #7) Findings include: The clinical record 12/19/18, was revi- diagnosis is rheum faction. Other perf essential primary h anemia, chronic pa mellitus, and mixed Review of an Aide date of 03/28/19 w stated "gave her a d pain." The note an the home health aid the patient's pain. Communication no completed by the s stated "Client requ changed to sink ba and she does not for	view, the home health aide case manager of patients pain inical records reviewed. of Patient #7, start of care ewed and indicated a primary atoid arthritis with rheumatoid tinent diagnoses include typertension, anxiety disorder, in syndrome, type II diabetes d incontinence. Daily Visit Sheet for patient #7, as reviewed. The document quick sink bath because of d record failed to evidence that de notified the case manager of te, dated 03/28/19 was upervisory case manager that ested her bathing type be th as her shower is upstairs tel safe climbing stairs." No he clinical record addressing	G 0818	The Administrator will provide Comprehensive Assessment In-service to reeducate all Clii Managers on the specifics for and review of daily visit record weekly requirements has bee completed by 11/4/19.Administrator will prov Abnormal Observation/Unusu Findings In-service for all HH, specify that they call a Clinica Manager with every abnorma observation or unusual finding completed by 11/29/19. Abnormal Observation/Unusu Findings In-service upon hire.	nical pain ds n vide al As to I I J	11/29/2019	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULT A. BUILD B. WING	IPLE CONSTRUCTION ING <u>00</u>	СОМ	e survey pleted 3/2019
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9	TREET ADDRESS, CITY, STATE, ZIP C 840 WESTPOINT DRIVE, SU NDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		D PROVIDER'S PLAN OF COR EFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 0940	date of 03/29/19 w stated (1) Assist w her walker to take her bed. She was her hands and arm Mobility Assist, "" her." (3) Skin Car not want anything failed to evidence notified the case n An interview cond with the administr	e Daily Visit Sheet for patient #7, vas reviewed. The document ith Ambulation, "Helped with her to the bathroom and back to unable to hold on because of s were in a lot of pain. (2) Too much pain for me to move e "She was in some pain and did on her." The note and record that the home health aide nanager of the patient's pain. ucted on 09/12/19 at 5:45 pm ator and office manager were in agreement that there mmunicate.				
Bldg. 00	failed to ensure the agency was accura the clinical manag communication and were conducted, fa place for tracking assessed, and a tim ensure care and se to the physician ap to ensure nutrition the plan of care, fa place per agency p ensure home healt visits were provide care, and failed to	eview and interview, the agency e organizational chart for this ite, complete, and in writing, er failed to ensure nong staff and with physicians uiled to ensure a system was in referrals, to ensure patients were nely start of care, failed to rvices were not provided prior oproving the plan of care, failed al supplement was provided per iled to ensure OSHA kit was in oblicy and plan of care failed to h aide visits and skilled nursing ed as ordered per the plan of ensure medications and eeding were administered per	G 0940	 Administrator updated Organization Chart for Agency for clarification 11/8/19. Please see a Administrator updated Organization Chart for on 11/1/19. This will b monthly with checklist Administrator added tr information to our date Matrix for monthly trac contract expiration for Administrator updated contracts to be signed 11/8/19. Administrator will ensu Clinical Manager are r 	Indianapolis non attached. The Agency be updated in place. acking base, sking of nurses. all nurse by ure all	11/08/201

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		c -)	PLETED
		15K167	B. WING	<u></u>	_	3/2019
			STRE	EET ADDRESS, CITY, STATE, ZIP (COD	
	PROVIDER OR SUPPLIE			0 WESTPOINT DRIVE, SU	ITE 400	
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC	IND	IANAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	the plan of care, fa	iled to ensure a current written		on referral tracking wit	th	
	contract was in pla	ce for the contracted		Comprehensive Asses	ssment	
	Registered Nurse (RN), Contract RN 01, who was		In-service and the ope	rations staff	
	completing the Ho	me Health Aide's competency		with the Plan of Care	 Operations 	
	of skills, prior to p	lacement on the Indiana State		In-service to be compl	eted by	
	Registry, and faile	d to offer skilled services to new		11/4/19.		
	patients, following	their certification survey dated				
	6/15/2018. The cu	imulative effect of these				
	systemic problems	resulted in the home health				
	agency's inability	o ensure apatient rights were				
		could result in the agency not				
		health care for all 44 current				
	patients in 1 of 1 a					
	Findings include:					
	On 9/9/19 from 10	:30 a.m. to 11:05 a.m., the				
		e was completed with				
		indicated the co-owners were				
	the Governing Boo					
	On 9/12/19 at 9:50	a.m., Employee C provided the				
		Organizational Chart." This				
	· ·	ded no identifying personnel.				
		his chart started with the				
	-	with the attached breakdown				
		or of Clinical Operations" and				
		prate Operations and Training,""				
	-	linical Managers (ACM's)" and				
	e	Managers (CM's)" indicating 2				
		l lastly, to the "Clients." The				
	-	ext breakdown branching off				
	-	ng Body" was the position of				
		care Operations/ Territory				
		agers" leading to the				
	•	gers (OM's) indicating 1 per				
		diana), and then, to the				
		rs (PM's) indicating 2 to 4 per				
		Caregivers." The last position				
		the "Director of Human				
	l orcandowii was to	the Director of Human				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	ì í	JILDING	DNSTRUCTION C	COMPLI	3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	;	9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETION DATE	
	Supervisor" to "Hu lastly, to "Personn per office. The Or specific to the Indi who reports to the Supervisors within failed to show that Indianapolis office Body. On 9/12/19 at 9:50 provided a second Organizational Ch personnel for the O one area clinical m (HR) supervisor ar were included for	a)(1)						
G 0962 Bldg. 00								
Bidg. UU	 interview, the clinic communication and were conducted for reviewed (#2, 6, 7) Findings include: 1. A home observeon 09/11/19 at 6:50 and 100/11/19 	ion, record review, and cal manager failed to ensure nong staff and with physicians r 3 of 8 clinical records ation was completed on n, for patient #2. During the ent was given a carton of Boost	G 0'	962	Patient #2 Supplemental order has been s to MD for Boost or Pediasure. Clinical Managers have been in-serviced and re-educated to update MD with any changes to POC including patient preference and update POC to reflect thes changes. The Administrator will provide Comprehensive Assessment In-service to reeducate all Clinic Managers on the specifics patie	All ce e cal	11/04/201	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K167	A. BU B. WI	VILDING NG	00	COMPL 09/13/	
JAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC			VESTPOINT DRIVE, SUITE 400 JAPOLIS, IN 46256		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
				-	preferences, supplemental ord	ers,	
	Plan of care review	v for certification period of			physician authorization		
	05/20/19 - 07/18/1	9 was completed.			requirements has been comple	eted	
		ction (page 2 of 4) stated four times a day." And			by 11/4/19.		
	Nutritional Require	ements section (page 3 of 4)			All charts are being reviewed b	v	
	stated "Pediasure f				the Administrator after each vis	-	
		-			to ensure order and notification		
	Record review of p	blan of care for certification			sent to MD for any changes to		
	-	- 09/16/19 was completed.			POC for any changes.		
	Gastrointestinal se	ction (page 2 of 4) stated			The Administrator will provide		
	"Pediasure 237 ml	four times a day." And			Comprehensive Assessment		
	Nutritional Require	ements section (page 3 of 4)			In-service to reeducate all Clini	ical	
	stated "Pediasure f	our times a day."			Managers on the specifics pati		
					preferences, supplemental ord	ers,	
		s completed on $09/11/19$, which			physician authorization		
		updated physician order for			requirements has been comple	eted	
		mented communication with the			by 11/4/19.		
	Boost.	e the order from Pediasure to			Patient #6		
	DOOSI.				Documentation from interoffice		
	Interview with em	ployee K, RN, on 09/11/19,			emails showing communication		
		ost and only use Pediasure			with primary caregiver and her wishes to wait on services until		
	when we run out o	5			she received a hoyer lift in the		
	when we run out o	. 1900st.			home is in chart.		
	2. A review of rec	ord #6 with a start of care			All charts have been reviewed	to	
		ed a "Home Health Certification			ensure services are being prov		
		for the certification period of			as orderd.		
		2019, with orders for skilled			Administrator will ensure		
		hours per day 5 days a week			reeducation to all internal staff		
		tification period. The clinical			regarding safe and appropriate		
	record failed to evi	dence skilled nursing services			transfer when the client's need		
	were provided as o	rdered and communication			exceed the capabilities of the H	HHA	
	notes to explain wh	hy services were not provided.			with HHA Not Meeting Patient		
					Needs In-service to be completed	ted	
		w on 9/10/2019 at 3:20 PM, the			on 11/4/19. See attachments		
		dicated patient #6 did not			Administrator will review all clie	ent	
		services due to the primary care			admission charts to ensure 100	0%	
		r meeting multiple nurses, they			compliance.		
	did not want other	individuals in the home.			Patient #7		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 09/13 /	ETED
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE JAPOLIS, IN 46256	400	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE OPRIATE	(X5) COMPLETI DATE
	 12/19/18, was revi diagnosis is rheum faction. Other per essential primary h anemia, chronic pa mellitus, and mixe Plan of care for ce 04/17/19, page 2 o she will be prescri when she receives narcotic pain medi of her medications Documented pain the plan of care sta a lockbox for her p more from her doc Pain assessment, d "worst pain level of clinical record fail physician was noti Review of an Aide date of 03/28/19 w stated "gave her a pain." The note ar the home health ai the patient's pain. Communication no completed by the s stated "Client requi changed to sink ba and she does not for 	tification period of 02/17/19 - f 4 stated "She explained that bed stronger pain medication a keypad lock box for per cations due to past experiences getting stolen from her. score was +8/10. Additionally, ted "She has recently received ain medication and will request		Patietn #7 has been disch and are unable to fix this deficiency for this chart. All charts being reviewed ensure appropriate docum of pain assessment. All clinical managers re-ed with Comprehensive Asse in-service to be sure to do completely all pain assess and notify MD of any incre- uncontrolled pain. Clinical Managers have be educated on falls, aspirati- pain interventions to be ac- the plan of care as approp- with measurable goals/our to monitor. All current and new home aides will be educated on nurse and office staff know change in client preference health immediately so that be followed up with MD ar care updated. Administrator will be respond for monitoring these correl actions to ensure that this deficiency is corrected and recur with weekly reportion- checks. Administrator will for 100% compliance by re- each chart with home visit completed week prior. The will be completed weekly.	to nentation ducated essment cument seased or een on and dded to oriate tcomes health letting w of any es or t it can nd plan of onsible ctive d will not g monitor eviewing is	

	R MEDICARE & MEDIC					OMB NO. 0938-039 (X3) DATE SURVEY	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, í	JLTIPLE CO IILDING	ONSTRUCTION 00	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	15K167	A. BC B. WI		00	09/13/	
			D. WI			00/10/	_0.0
NAME OF I	PROVIDER OR SUPPLIE	ξ			ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC	:		IAPOLIS, IN 46256		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCI		DATE
		Daily Visit Sheet for patient #7, as reviewed. The document					
		th Ambulation, "Helped with					
		her to the bathroom and back to					
		nable to hold on because of					
		were in a lot of pain. (2)					
		oo much pain for me to move					
		"She was in some pain and did					
		on her." The note and record					
	failed to evidence t	hat the home health aide					
	notified the case ma	anager of the patient's pain.					
	An interview condu	ucted on 09/12/19 at 5:45 pm					
		tor and office manager					
	indicated that they	were in agreement that there					
	was a failure to con	nmunicate.					
	410 IAC 17-12-2(g)					
0964							
3ldg. 00							
			G 0	964	Administrator updated referra		11/04/20
		and document review, the			process and will provide		
	e	iled to ensure a system was in			reeducation with Plan of Care		
	-	eferrals, to ensure patients were			Operation In-Service by 11/4/		
		ely start of care for 1 of 1			Administrator will monitor refe process by reviewing non bind		
	agency.				and admissions weekly.		
	The findings includ	e:			and admissions weekly.		
	During the entrance	e conference on 9/09/2019 at					
	e	ce manager indicated referrals					
		vices, go to a program					
	•	es the initial contact with					
		The physician is contacted for					
		ake the initial assessment and					
		es to start staffing within 5					
	-	lanager, if the agency does not					
	complete the initial	assessment within 48 hours,	1		1		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE (A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIEF	HEALTHCARE SERVICES, INC	STREET 9840 V INDIA	ор Е 400		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION De called for another verbal	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE COMPL	
	indicated the referra and not admitted, w On 9/11/2019 at 10 provided and indica information availab admitted. The bind personal services an services. During interviews of Employee B, the of agencies do not kee agency receives, re- multiple inquires a	PM, the office manager als for home health services				
	referrals go to a not checks eligibility at with the patient, wh referred, by phone of the referral informat nurse [RN] case mat she does not keep a once the agency det is given to the RN of [employee A] does information. Rec record indicated the					

ENTERS FOI	R MEDICARE & MEDI	AID SERVICES			OMB NO. 0938-03	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		15K167	B. WING		09/13/2019	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	R	9840 V	VESTPOINT DRIVE, SUITE 400		
ADAPTI	/E NURSING AND	HEALTHCARE SERVICES, INC		NAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDEDIS DI AN OF CODDECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_ COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
	Review of the physical	sician order on 05/22/19 stated				
		eted on 05/20/19. Spoke with				
	-	ysician's office on 05/22/19 at				
	9:57 am for VSOC	(verbal start of care) for SN				
	(skilled nurse) serv	vices "				
	Paviaw of Intaka/I	Referral Form indicated the date				
		$\frac{20}{19}$ with no time documented.				
		20/19 with no time documented.				
	Review of Medica	History/Functional				
	Assessment indica	ted the date of assessment to				
	be 05/20/19.					
	Review of Skilled	Nurse Visit notes included care				
	dates of 05/20/19 a	und 05/21/19.				
	An interview was	conducted on 09/11/19 at 10:50				
	am with employee	F, who indicated that the				
	program manager	goes out and completes a home				
	assessment prior to	accepting each patient to				
	ensure the home en	vironment is appropriate and				
	services are needed	d. That assessment is then				
	given to the case n	nanager to get an order from the				
	physician to comp	ete an initial comprehensive				
		includes putting hands on the				
	· ·	start of care order. Once the				
	-	ive assessment is completed,				
	the physician is ca	led to get an order to admit.				
	On 09/11/19 at 12:	00 pm, the administrator				
	confirmed that the	re was only one order from the				
	physician for patie 05/22/19.	nt #2 and that it was dated for				
0000						
6 0968						
Bldg. 00						
			G 0968	Patient #2	11/04/20	
		on, record review and		Chart reviewed and processes	put	
	interview, the clini	cal manager failed to ensure		in place to prevent any future		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 40 VAPOLIS, IN 46256	00	
		· · · · · · · · · · · · · · · · · · ·				
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	I E RIATE	(X5) COMPLET DATE
		vere not provided prior to the		services being provided with	nout	
		ng the plan of care (Patient #2),		physician order. Clinical		
		tritional supplement was		Managers will notify schedu	lina	
		an of care (Patient #2) and		staff when VSOC is received	-	
		blace per agency policy and plan		that services can be schedu		
	-	killed pediatric reviewed, failed		All employees re-educated		
		alth aide visits and skilled		in-service to ensure that MD		
	nursing visits were	provided as ordered per the		obtained prior to any service	e being	
	plan of care for 1 (Patient #1) out of 1 active		provided. Supplemental or	der has	
	skilled nursing for	an adult and 1 (Patient #7) out		been sent to MD for Boost o	r	
	of 2 closed records	reviewed of patients receiving		Pediasure. All employees h	ave	
		only, and failed to ensure		been educated on maintaini	ng	
	-	astronomy tube feeding were		accurate supplies and		
	-	ne plan of care (Patient #1), and		documentation, ensuring that		
	for 1 of 1 active sk	illed nursing records reviewed.		home has these supplies list		
				All nurses to have extra glov		
	Findings include:			sanitizer and OSHA kits, and		
				masks to replace those miss	-	
	-	icy entitled "Admission		supplies provided by Adaptiv	ve	
		/20/18, section 5 stated "No		immediately. RN will send		
	•	for services without an order		supplemental order for all up		
	from a physician."			changes to the plan of care	ιο	
	2 A review of pol	icy entitled "Clinical		ensure that the plan of care matches what is in the home	and	
	-	lissed Shifts", dated February			anu	
		2 stated "A separate note shall		being provided to the client. All charts are being reviewe	d to	
		ach visit/shift and signed and		ensure that services did not		
	-	priate professional."		prior to MD order.	bogin	
		ation was completed on		All charts are being reviewe	-	
		n, for patient #2. During the		the Administrator after each		
		lled nurse offered the patient a		to ensure order received from		
		drink. During this time,		prior to services being provid	ded.	
		nterviewed in regards to the				
		led versus the Pediasure that		The Administrator will provid		
	-	loyee K stated "we use Boost		Comprehensive Assessmen		
		sure when we run out of		In-service to reeducate all C		
		is visit, surveyor asked		Managers on the specifics p		
	stated "I have no id	o see the OSHA kit. Employee K lea what that is."		preferences, supplemental of physician authorization	orders,	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/13/2019			
	PROVIDER OR SUPPLIE	^R HEALTHCARE SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE		
	A plan of care revi 05/20/19 - 07/18/1 Gastrointestinal se "Pediasure 237 ml Nutritional Requir stated "Pediasure f DME [durable mean of 4) stated "OSHA the patient home. evidence instruction to use the Pediasur is out of Boost. Th registered nurse of orders on 10/22/19 Review of the clin Skilled Nurse Visi 05/21/19. Review 05/22/19 stated "A 05/20/19. Spoke v office on 05/22/19 start of care) for SI 5/20/19 to 7/18/19 verbal start of care completed on 05/2 skilled nursing ser from the physician Further record revi certification period completed. Gastro stated "Pediasure f DME [durable mean of 4) stated "OSHA the patient home.	ew for certification period of 9 was completed. ction (page 2 of 4) stated four times a day" and ements section (page 3 of 4) our times a day." The section dical supplies]/ Supplies (page 3 A kit" as one of the supplies in The plan of care failed to on to use Boost supplement and e supplement when the patient ne plan of care indicated the otained verbal start of care		requirements has been comp by 11/4/19. Administrator will be respons for monitoring these corrective actions to ensure that this deficiency is corrected and we recur with weekly reporting checks. Administrator will me for 100% compliance by revie each chart with home visits completed week prior. This re will be completed weekly. Administrator will review all c for completion by 11/29/19 Patient #7 Chart reviewed and last date services were provided was 4/19/19. Shift on 4/20/19 wa cancelled due to caregiver be sick, client stated she would granddaughter help her for th day. Shift for 4/21 was unable staff and client stated she would staff and client stated she would us taff and client stated she would staff and client stated she would staff and client stated she would is taff and client stated she would staff and client stated she would staff and client stated she would be good without anyone since was Easter. Documentation 4/22, 4/23, & 4/25 states they were unable to find replacement for the usual caregiver. 4/25. Client called and stated she would looking for a new provider. Discharge order was sent to on 5/7/19 but had not been s by MD. All charts have been reviewed for unauthenticated supplemental orders and re-s to MDs for validation signature	ible /e fill not onitor ewing review charts HHA seing have to build e to build e to build e it for / lient /19 no was MD igned lisent			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION (X. 00	3) DATE SURVEY COMPLETED 09/13/2019
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 W	ADDRESS, CITY, STATE, ZIP COD /ESTPOINT DRIVE, SUITE 400 IAPOLIS, IN 46256	
X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIO
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Supervisory visit i documented "no C An interview was am with employee program manager home assessment i to ensure the home and services were would then be give obtain an order fro initial comprehenss include putting ha start of care order. assessment was co be called to get an case manager, ind spill kit for infecti mouthpiece as we surveyor an examp a red hazard bag. brought to each ho further stated "Thi don't know where On 09/11/19 at 12 confirmed that the physician for patie 05/22/19. During an intervie administrator indis supervisory note d OSHA kit in the h should be one in the 4. Clinical record	note dated 07/17/19, section #15 DSHA kit in the home". conducted on 09/11/19 at 10:50 eF, who indicated that the would go out and complete a prior to accepting each patient e environment was appropriate needed. That assessment en to the case manager to om the physician to complete the sive assessment, which would nds on the patient prior to the Once the initial comprehensive ompleted, the physician would order to admit. Employee F, icated that the OSHA kit was a ous fluids and had a CPR II. Employee F showed the ple of one, which also contained Employee F stated "one is ome on admission." Employee F is patient does not have one; it is. I've only seen her once." :00 PM, the administrator re was only one order from the ent #2 and that it was dated for wo n 09/12/19 at 2:25 PM, the cated that she saw the lated 07/17/19 that stated "No ome." She agreed that there he home review for patient #7 was		Administrator will review each chart when home visits are done to ensure all changes have supplemental order sent to MD for signature. Administrator will check weekly to ensure all sent orders have been authenticated by MD re-sent to MD for signature. Administrator will review client schedules weekly to ensure that schedule/services provided mator the order in the plan of care. If it does not match that there is documentation to support the changes. Patient #1 Chart has been reviewed and orn clarification has been sent to MD to ensure plan of care matches the services being provided. All employees have been re-educat and received in-service on all documentation must be reviewed by nurse and uploaded into the office chart to match home chart Clinical Manager will review all documentation of the home nurs to ensure all orders are being followed and documented accurately. All skilled charts reviewed to ensure the proper documentation and matches the plan of care.	or ck or ch der der d d d d d d e d d d e
	completed on 09/1	2/19. The plan of care for		manager completes the home	
	recertification per				1

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

Event ID:

MO5T11 Facility ID: 014118

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PRINTED: 11/19/2019 FORM APPROVED

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	HEALTHCARE SERVICES, INC	9840 V	CADDRESS, CITY, STATE, ZIP COD WESTPOINT DRIVE, SUITE 40 NAPOLIS, IN 46256	0	
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETI
TAG	orders for aide ser per week. Review the last date of car 04/17/19. The rec	vices to be provided 5-7 days v of aide visit notes evidenced e provided by the aide was ord failed to evidence any	TAG	changes are sent to MD for signature and that the plan o is being followed.	f care	DATE
	reviewed on 9/12/ update you all on p yesterday and said anymore because s company. I told h she finds a replace A communication reviewed on 09/12 patient #7 to verify said that we should we need to dischar no longer wants to Review of physici "discharge client f due to client swite company;" no phy An interview was PM with the office last day of direct, 1 An interview was PM with the office that time the office (aide) called off fu Patient called and she was mad and w We could not disc in place." The offi	note, dated 4/26/19 was 19, which stated "Wanted to patient #7. She called me she doesn't need our services she is looking for another er we can continue to staff until ment, but she said no." note, dated 04/29/19 was /19, which stated "We called y her waiver services and she d not call her anymore and that ge her as a client because she deal with us." an order dated 05/07/19 stated from agency effective 05/07/19 hing to another home health sician authentication. conducted on 09/12/19 at 4:15 e manager who indicated that the hands on care was 04/19/19. conducted on 09/12/19 at 5:45 e manager and administrator. At e manager stated "Caregiver and to send anyone as wanted to find a new company. harge without a new company ice manager agreed that there		Clinical Managers will communicate with office staff when VSOC is received from MD to start/continue services Services will not be schedule until VSOC is obtained. Supplemental order for VSOC be sent to MD for signature validating approval of service Administrator will monitor this weekly with review of all char that had home visit for that w p="" by="" completion="" for= weekly. administrator="" completed="" this="" prior. =" week="" visits="" home="" wi chart="" each="" reviewing=" compliance="" 100%="" monitor="">	" the s. d C will ss. s ts eek. "" th=""	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	` ´	ILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	ER HEALTHCARE SERVICES, INC		9840 WE	DDRESS, CITY, STATE, ZIP COD ESTPOINT DRIVE, SUITE APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETIO DATE
	the certification peo orders for skilled i days a week, effect included orders for medications "orde document on the M record]." Review of the elect #1 failed to evider provided as ordered note, dated 8/13/2 nurse, was the first services. The clin documentation to	019, included a plan of care for eriod of 7/15/19 to 9/12/19, with nurse services, 8 hours a day, 5 etive 7/15/19. The plan of care r the skilled nurse to administer red by the physician and MAR [medication administration etronic medical record for patient nee skilled nurse visits were ed. The first skilled nurse visit 019, by employee I, a registered t documentation of skilled nurse ical record failed to evidence explain why skilled nurse completed as ordered on the					
	skilled nurse visits Tuesdays, Wednes beginning 8/13/20 skilled nurse visit 20, 21, 22, 27, and 2019. The skilled evidence documer	etronic medical record evidenced s were made 3 days a week, on sdays, and Thursdays, 19. The record evidenced notes dated August 13, 14, 15, 128, and September 3, 4, and 5, nurse visit notes failed to nation of the medications and eeding were administered by he visit.					
	reviewed with the confirmed that ski provided 3 times a on the plan of care the record failed to	:10 PM, the clinical record was administrator. The administrator lled nurse services were a week and not 5 days a week as b. The administrator indicated b evidence documentation that updated and the plan of care					
	During interviews	on 9/12/19 at 4:30 PM, the office					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167		JILDING	ONSTRUCTION 00	COM	b) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC		9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 4 JAPOLIS, IN 46256	100		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
G 0978 Bldg. 00	 the plan of care was the case was to be primary care giver 5:45 PM, the admit record failed to evoliquid nutrition and administered by the visit. Employee A not turned into the completed the visit provided by survey Based on interview failed to ensure a completed the control of the contr	the patient was accepted and as established and the nurse for gin the following day, led to arrive for her first day of ore, the agency did not have a Employee A indicated the tween the agency and the was in her agency emails. At inistrator relayed that the clinical idence documentation of the d the medications that were e nurse during the skilled nurse indicated the documents were agency by the nurse that ts. No information was y exit on 9/13/19. v and record review, the agency current written contract was in acted Registered Nurse (RN), tho was completing the Home petency of skills, prior to ndiana State Registry, for 1 of 1 evious survey conducted by the artment of Health, exit date ve Home Health, was precluded own home health aide training valuation program for a period ng 6/01/2017, due to being out h the Conditions of Participation Organization, Services, and 2 CFR 484.16 Group of	G 0	978	Administrator added trackir information to our date bas Matrix for monthly tracking contract expiration for nurs Administrator updated all n contracts to be signed by 1	e, of es. urse	11/08/201	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	Α.	MULTIPLE CO BUILDING WING	ONSTRUCTION <u>00</u>	_	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	BR) HEALTHCARE SERVICES, INC		9840 V	ADDRESS, CITY, STATE, ZIP (VESTPOINT DRIVE, SU JAPOLIS, IN 46256			
(X4) ID PREFIX	SUMMAR	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	E	(X5) COMPLETIC
	Acceptance of Pat Supervision; 42 C Services, 42 CFR CFR 484. 55, Com Patients. 2. On 9/9/19 from entrance conference Employee C. She a registered nurse indicated newly hi written test and a si If they pass the wr complete a competing a review of the 01 and the agency's off 3. A review of the 01 and the agency's off 3. A review of the 01 and the agency's off 3. A review of the 01 and the agency's off and	 annel; 42 CFR 484.18, ients, Plan of Care, and Medical FR 484.30, Skilled Nursing 484.48 Clinical Records, and 42 aprehensive Assessment of a 10:30 a.m. to 11:05 a.m., the ce was completed with indicated the agency contracted for the aide competencies. She ired individual, complete a self assessment skills check list. ritten test, the new hire would tency skill test in the laboratory if ce with the contracted nurse. e contract between Contract RN titled, "Independent Contractor igned by RN Contract 01 and aninistrator at the time). The 1. Term. This Agreement shall term of 1 year beginning on erminated earlier in accordance ent." 11:20 a.m., during an interview, ated the agency did not renew Contract RN 01. Employee B did continue to complete the a for new hires, without a expiration of the contract 20 individuals whose completed by Contracted RN 01 Employee C on 9/11/19 at 10:30 uded the following new HHAs eir "Competency Assessment" 						

ENTERS FOI	R MEDICARE & MEDIO	CAID SERVICES			ON	IB NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	LETED
		15K167	B. WING		09/13	/2019
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD WESTPOINT DRIVE, SUITE	400	
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, IN		NAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	D BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	5/9/19; #T, #X, #Y	Y, #cc, #ff, and #ll completed on				
	4/4/19; #U comple	ted on 10/18/18; #V completed				
	on 8/1/18; #W con	ppleted on 3/8/19; #Z completed				
	on 4/11/19; #bb, #	gg, #hh, and #jj completed on				
		pleted on 8/16/18; #ee				
		2/18; and #mm completed on				
	9/27/18.	r i i i i i i i i i i i i i i i i i i i				
	410 IAC 17-12-2(d	1)				
0982		,				
0002						
Bldg. 00						
			G 0982	Agency failed to offer skille	эd	11/04/201
		and record review, the agency		services for new patients.		
		ed services to new patients,		Agency has 2 current skille		
	-	tification survey dated		clients. A 3rd pediatric ski		
	6/15/2018, for 1 of	1 home health agency.		client was admitted 9/12/1		
	The findings inclu	dad		client was discharged on 1		
	The findings inclu	uea.		due to hospitalization durin		
	$1 Om \ 0/00/2010 d$	following the entroped		recertification window. Th		
		following the entrance		will be re-admitted once re	turnea	
		ice manager provided the total		home if primary caregiver		
		filled patients since the agency		agreeable.		
		fication, surveyed by an				
		nization on 6/15/2018. The two		Patient #6		
		e Patient 1 with start of care		Documentation from interc		
		and Patient 2 with SOC of		emails showing communic		
		ice manager indicated the		with primary caregiver and		
		home health aide services,		wishes to wait on services		
		ealth aide, that they enjoyed the		she received a hoyer lift in	the	
		had not sought out to provide		home is in chart.		
	skilled nursing server	vices.		Office manager did not ha		
		1.112 1.4		correct information when s		
		ord #6 with a start of care		that it was after multiple nu		
		d a Home Health Certification		that they did not want othe	e r	
		or the certification period of		indivisuals in the home.		
		2019, and included orders for		All charts have been revie		
		vices 8 hours per day 5 days a		ensure services are being	provided	
	week throughput th	ne certification period. The		as ordered.		1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(X3) DATE SURVEY COMPLETED 09/13/2019		<u>00</u> C 0	B. WING		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	NT OF DEFICIENCIES OF CORRECTION	
		ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256	9840 W	INC	R HEALTHCARE SERVICES, IN	PROVIDER OR SUPPLIE	
(X5) COMPLETION DATE	all of and also afe e e mg to ger nd t all			1	STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ed to evidence that any skilled ere provided, nor explain why the skilled nurse rovided. ary dated 8/21/2019, completed F, stated, "Client will be by and MD [medical director] no longer needed or desired. Illed the office [date not ded to stay home with Patient. er need HHA [home health w on 9/10/2019 at 3:20 PM, the licated patient #6 did not ervices, that after meeting ey did not want other nome to care for Patient 6. these meetings with the patient iver were requested at time of her information was received by view on 9/12/2019 at 5:45 PM, indicated in the Spring of 2018, d 10 skilled patients, prior to urvey by an accrediting urposes of obtaining medicaid he office manager, the last of nts to be discharged, following rvey was Patient 9; the office at they [agency] could not find accept the patient. When v discharge the patient, the	SUMMARY (EACH DEFICIEN REGULATORY OD clinical record faile nursing services we documentation to e services were not p A discharge summa by registered nurse discharged to famil when services are r Patient's mother ca specified] and deci Client will no long agency] services." During an interview office manager, ind receive any nurse s multiple nurses, the individuals in the h Documentation of r and primary care g interview. No furth survey exit 3. During an intervi the office manager the agency admitte their certification s organization, for pu certification. Per th the 10 skilled patie the certification sur manager relayed th another agency to a asked why did they	ADAPTIN X4) ID PREFIX TAG
		ted 10 skilled patients, prior to survey by an accrediting purposes of obtaining medicaid the office manager, the last of ients to be discharged, following survey was Patient 9; the office that they [agency] could not find o accept the patient. When ey discharge the patient, the indicated the agency did not want	the office manager the agency admitte their certification s organization, for pu- certification. Per th the 10 skilled patie the certification sur manager relayed th another agency to a asked why did they office manager ind skilled patients at t 4. Review of the c				

Event ID:

MO5T11 Facility ID: 014118

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PRINTED: 11/19/2019 FORM APPROVED

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	<u>00</u>	COMPLETED	
		15K167	B. WING		09/13/2019	
NAME OF I	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP COD		
ADAPTI	/E NURSING AND) HEALTHCARE SERVICES, INC		VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256		
(X4) ID		Y STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	,	OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
	last certification p	eriod was 7/27/2018 to 9/24/2018				
	with orders for ski	illed nurse weekly for medication				
	· · ·	ent's last date of service was				
	9/11/2018 with dis	scharge date of 9/14/2018.				
G 1008						
Bldg. 00						
-			G 1008	Administrator will provide	11/04/201	
		eview and interview, the agency		reeducation on requirements of		
		e clinical record included		order authentication and discha	rge	
		th primary caregivers and the		summary with Comprehensive		
	agency regarding	-		Assessment for clinical manage		
		nd documentation with the		and Not Meeting Patient's Need	ls	
		n, documentation of eedings by gastronomy tube,		In-services for all internal staff.		
		nt clinical notes, failed to		p>		
		ormation for the patient /		Administrator will review all cha	arts	
		rent and accurate, failed to		for completion by		
	-	rge summary within 5 business		11/5/19. Follow-up documentat	tion	
	days of the patient	's discharge from the agency,		will be provided daily that includ	les	
		re all documentation was		how and when the patient and/o	br	
		enticated with signature, title,		primary caregiver were notified	of	
		These practices impacted 5		staffing status. Review of daily		
		7, 8) out of 8 sampled records		visit sheets to be completed		
		mulative effect of these systemic in the home health agency's		weekly by Clinical Manager by either reviewing individual daily		
		the provision of quality health		visit sheets or running Service		
	care in a safe envi			Plan Task Frequency Variance		
				Report. Clinical Manager will		
				document in Communications/C	QA	
				that every shift has been review	ved	
				weekly. All documentation mus	st	
				be signed by the individual mak	-	
				the entry with individuals first in	itial	
				of first name, last name and		
				title. If after 15 days, the HHA		
				(Home Health Agency) is unable to meet the needs of the patient		
				the agency will offer to assist	•,	

	R MEDICARE & MEDI		(VA)) (777-			MB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	15K167	B. WING	NG <u>00</u>		3/2019	
		101(10)			-	0/2010	
NAME OF I	PROVIDER OR SUPPLIE	ER		REET ADDRESS, CITY, STATE, ZIP CO			
				40 WESTPOINT DRIVE, SUIT	E 400		
ADAPTIN		HEALTHCARE SERVICES, INC		DIANAPOLIS, IN 46256			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
		NCY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE AF	OULD BE PROPRIATE	COMPLETION	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TA			DATE	
				transfer to another HHA	•		
				Health Agency) that is a			
				meet the needs of the p	•		
				providing them with a list			
				providers in the area. T			
				Administrator/Operation	-		
				will check weekly for thi			
				documentation and veri			
				activities/QA under the			
				missed shifts and grieva			
				reviewed for concerns.			
				will be printed and place	ed in the		
				QAPI binder weekly. see attachments			
				see allachments			
G 1012							
Bldg. 00							
0			G 1012	Patient #2		11/05/201	
	Based on record re	eview and interview, the agency	0 1012	In home nurse failed to	turn in	11,00,201	
		e clinical record included		weekly documentation			
	documentation wi	th primary caregivers and the		Chart has been reviewe			
	agency regarding			documentation has bee			
		d documentation with the		into office and uploaded			
	attending physicia	n, documentation of		chart to match home ch			
		eedings by gastronomy tube,		In-home staff has been			
		nt clinical notes for 3 of 3 skilled		re-educated on the nee	d to turn in		
	clinical records re-	viewed. [1, 2, and 6]		all documentation week	ly for		
				review and to be added	to office		
	Findings include:			chart. Clinical Manager	rs will		
				monitor and review all			
	-	"Flowsheets", dated August 1,		documentation for com	oleteness,		
		ncy personnel shall use		initial and upload to atta	chments.		
		heets to document ongoing					
		care, and needs when visits are		Administrator will review	v weekly all		
		ll originals (white copies) will be		skilled client charts to e	nsure all		
		ice weekly and the yellow copy		documentation has bee	n received		
	will be maintained	l in the home chart."		and uploaded to chart.			
	2. Record review	of patient #2, completed on		Patient #1			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIEI			ADDRESS, CITY, STATE, ZIP COD	J9/13/2019	
		HEALTHCARE SERVICES, INC		VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		skilled nursing notes through		Chart has been reviewed and orde	er	
		are certification period of		clarification has been sent to MD		
	07/19/19-09/16/19	indicated skilled nursing		to ensure plan of care matches		
	services to provide	care 5 days a week.		the services being provided. All		
				employees have been re-educate	d	
	Interview with the	office manager was conducted		and received in-service on all		
	on 09/12/19 at 3:20	PM. At that time, the office		documentation must be reviewed		
	manager stated "Sk	illed nurse should have turned		by nurse and uploaded into the		
	in notes for time pe	eriod 09/01/19 - 09/07/19 by		office chart to match home chart.		
	Monday, 09/09/19,	but she has not turned them in		Clinical Manager will review all		
	and that is a proble	m."		documentation of the home nurse		
	3. Review of clinic	cal record # 1, with start of care		to ensure all orders are being		
	[SOC] 7/15/2019, i	ncluded a plan of care for the		followed and documented		
	certification period	of 7/15/19 to 9/12/19, with		accurately.		
	orders for skilled n	urse services, 8 - 10 hours a		Documentation from interoffice		
	day, 5 days a week	, effective 7/15/19. The plan of		emails has been added to		
	care included order	s for the skilled nurse to		communications to show		
	administer medicat	ions "ordered by the physician		communication with primary		
	and document on th	ne MAR [medication		caregiver and reason for waiting to	o	
	administration reco	rd]." The record failed to		start services was due to a nurse		
	evidence skilled nu	rse visits were provided until		being a no call no show and		
	8/13/19 and failed t	to evidence documentation to		primary caregiver wanting to wait		
	explain why skilled	I nurse services were not		until she could give 2 week notice		
	completed as order	ed on the plan of care.		to the nurse that was currently		
	_			helping her before our services		
	The record evidence	ed the first skilled nurse visit		started with another nurse.		
	was made on 8/13/2	2019 and that skilled nurse				
	visits were made 3	days a week, on Tuesdays,		All skilled charts reviewed to		
	Wednesdays, and T	hursdays, beginning		ensure the proper documentation		
	8/13/2019. The rec	cord evidenced a skilled nurse		and matches the plan of care.		
	visit notes dated Au	ıgust 13, 14, 15, 20, 21, 22, 27,		All employees have been		
		ber 3, 4, and 5, 2019. The		in-serviced to document all		
		otes failed to evidence		communication with client and		
		he medications and tube		primary caregivers. If unable to		
		dministered by the nurse,		staff/meet their needs as ordered		
	during the visit.	2 2		after 15 days, Adaptive will assist		
				with safe transfer to another		
	During interviews	on 9/12/19 at 4:30 PM, the office		agency able to meet the client's		
				needs.		
	manager indicated the patient was accepted and the plan of care was established and the nurse for			I needs		

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/13/2019
PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD WESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256	
VE NURSING AND SUMMARY (EACH DEFICIE) REGULATORY O the case was to beg 7/16/2019, and fail orientation, therefor nurse for the case. communication be primary care giver 5:45 PM, the admin record failed to evil liquid nutrition and administered by th visit. Employee A not turned into the completed the visit provided by survey 4. A review of rece failed to evidence for care were received evidence the physis nurse services were evidenced by the for The Home Health [POC] for the certif 8/30/2019, include verbal start of care orders for skilled re 5 days a week throo The clinical record nursing services were	HEALTHCARE SERVICES, INC STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION gin the following day, led to arrive for her first day of ore, the agency did not have a Employee A indicated the tween the agency and the was in her agency emails. At nistrator relayed that the clinical idence documentation of the d the medications that were e nurse during the skilled nurse indicated the documents were agency by the nurse that ts. No information was y exit on 9/13/19. ord #6 with SOC 7/02/2019, physician orders to provide , prior to the SOC, and failed to cian was notified that skilled e not provided as ordered,			arts y care to rided s s HHA ted ent
the physician was services were not p During an intervie office manager, in receive any nurse s giver decided, afte	provided, and failed to evidence notified when skilled nurse provided. w on 9/10/2019 at 3:20 PM, the dicated patient #6 did not services due to the primary care r meeting multiple nurses, that other individuals in the home.		Administrator will provide reeducation on Comprehensiv Assessment for clinical manag and Not Meeting Patient's Nee In-services for all internal staff. employees will be re-educated that MD must be made aware inability to staff as ordered on p of care and update plan of care	ers ds All of olan

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Event ID:

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STATEME	S FOR MEDICARE & MEDICAID SERVICES EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	<u>00</u>	COMPLETED 09/13/2019	
		R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 40 IAPOLIS, IN 46256	0	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E RIATE	COMPLETIO
	administrator indic assessments for the record and when qu not receive skilled asked employee A, to go through her e communication. N	to further information was very exit on 9/13/2019.		Administrator will monitor for 100% compliance by review each chart with home visits completed week prior. This will be completed weekly. Follow-up documentation will provided daily that includes I and when the patient and/or primary caregiver were notifi staffing status, including notification to MD and supplemental order sent to M If after 15 days, the HHA (Ho Health Agency) is unable to the needs of the patient, the agency will offer to assist tra to another HHA (Home Heal Agency) that is able to meet needs of the patient by provi them with a list of providers i area. The Administrator/Operation Manager will check weekly for documentation and verify in activities/QA under the office missed shifts and grievances reviewed for concerns. This will be printed and placed in QAPI binder weekly. Administrator will review all of for completion by 11/5/19.	ing review II be how ed of AD. ome meet nsfer th the ding in the s or this e that s were note the	

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 00	· · ·	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15K167	B. WING		COMPLETED 09/13/2019	
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP CO		
ADAPTI	VE NURSING AND	HEALTHCARE SERVICES, INC		WESTPOINT DRIVE, SUIT ANAPOLIS, IN 46256	E 400	
(X4) ID		Y STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	COMPLETION DATE
G 1018						
Bldg. 00						
			G 1018	Patient #1		11/19/2019
		eview and interview, the agency ntact information for the patient		Chart has been reviewe		
		rrent and accurate for 1 of 3		sent to MD to clarify new of where services are to		
	-	ations with clinical record		provided.		
	reviews. (#1)			All charts to be reviewed accuracy of contact info		
	Findings include:			The Administrator will pu Comprehensive Assess	rovide	
	A home visit was	conducted on 9/11/2019 at 4		In-service to reeducate		
	PM, the address of	f the home visit was provided		Managers on the specifi	ics	
	by the office mana	ager on 9/10/2019. The Patient's		updating POC with dem		
		ses was not the address on the		requirements has been	completed	
	plan of care, dated	17/15/2019 to 9/12/2019.		by 11/4/19. Administrator will monitor	or for	
	-	visit on 9/11/2019 at 4 PM,		100% compliance by re-	viewing	
	-	istered nurse, employee I,		each chart with home vi		
	~	ided skilled nurse services,		completed week prior.	This review	
		19, every Tuesday, Wednesday,		will be completed		
		had always come to the same the home visit occurred.		weekly. Administrator w all charts for completion		
		ted she was not aware of a		11/5/19. see attachmer		
		the address on the Plan of Care.			113	
		l of patient # 1 was reviewed on				
		icated a start of care date of				
		of care for the certification $\frac{1}{2} \frac{1}{2} \frac{1}{2$				
	· ·	to 9/12/19 failed to include the dress of the patient.				
		M, the administrator was				
		address provided for the home				
		ddress as listed on the plan of				
		strator was observed at a				
	-	ewed the information. The irmed that the patient's address				
		unknown date, the address was				
	, , ,	,				1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMI	(X3) DATE SURVEY COMPLETED	
		15K167	B. W	ING		09/1	3/2019
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC		9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE NAPOLIS, IN 46256	400	
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION and the plan of care was not		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 1022	410 IAC 17-15-1(a	a)(1)					
Bldg. 00	failed to evidence included accurate i the the primary can days, in 3 of 4 clos #6, 7, 8] The findings inclu 1. A review of rec 7/02/2019, failed t needs were met. T and Plan of Care fo 7/02/2019 to 8/30/ skilled nursing ser week throughput the clinical record fail nursing services we documentation to a services were not p A discharge summ by registered nursed discharged to family when services are Patient's mother care	ord #6 with a start of care o evidenced that the patient's he Home Health Certification or the certification period of 2019, evidenced orders for vices 8 hours per day 5 days a he certification period. The ed to evidence that any skilled ere provided, nor explain why the skilled nurse	G 1	022	Patient #6 Failed to document why n services were not provide has been discharged and to add documentation at t No documentation to supp client met with multiple nu All charts have been revie appropriate documentatio unable to meet the clients All communication with cli primary caregiver will be a client chart at time of communication. The Administrator will pro Comprehensive Assessm In-service to reeducate all Managers on the specifics discharge requirements h completed by 11/4/19. Administrator to provide in to all employees unable to client needs. Administrator will monitor 100% compliance by revie each chart with discharge completed week prior. Th will be completed	d. Client not able his time. bort that urses. ewed for n when needs. ent and added to vide ent I Clinical s as been n-service o meet for ewing s	11/05/201
	agency] services."	w on 9/10/2019 at 3:20 PM, the			weekly. Administrator will all charts for completion b 11/5/19.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/13/2019			
	NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC		9840 V	STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN (X5) BE COMPLETI PRIATE DATE			
	office manager, in receive any nurses multiple nurses, th individuals in the l Documentation of and primary care g	dicated patient #6 did not services, that after meeting ey did not want other nome to care for Patient 6. these meetings with the patient jiver were requested at time of her information was received by		Patient #8 Discharge order and summ were sent to MD for authen signature on 8/16/19. Last service was provided was 8 Discharge order and summ were signed by MD and red by HHA on 8/23/19.	ntication shift 3/16/19. nary			
	PM. The record in certification period for aide services 7 start of care was 0 evidenced the last	8 was reviewed on 9/10/19 at 12 aclude a plan of care for the 17/24/19 to 9/24/19 with orders -8 hours, 5 - 6 days per week, 1/30/2019. The record aide visit was completed on ent titled "Discharge Summary,"		All discharged client charts been reviewed to ensure di order and summary have b sent to MD for signature authentication.	ischarge een			
	assumed care of th discharged. The d provided to the ph	icated the family member e patient and the patient was ischarge summary was not ysician until 9/05/2019. provided on 9/10/2019 at 4 PM,		re-educated with in-service Comprehensive Assessme all discharge orders and summaries are to be sent to for authentication within 2 of discharge	nt that o MD			
	an email / fax trans only evidence that physician. The ad manager that creat saves the documer the physician; the	smission and indicated it was the the summary was sent to the ministrator indicated the case es the discharge summary, it as a PDF and then sends to administrator indicated that the		discharge. Administrator will monitor for 100% compliance by review each chart with discharges completed week prior. This will be completed weekly. Administrator will n	ving s review review			
	evidence. 3. Re patient #7, physici "discharge client fi due to patient char	system used does not save the view of clinical record for an order dated 05/07/19 stated rom agency effective 05/07/19 uged to another home health ysician authentication.		all charts for completion by 11/5/19. Patient #7 Discharge order dated 5/7/ no physician authentication Discharge order has been	19 has n.			
	did not include a d	record completed on 09/12/19 ischarge summary.		to MD for authentication. The uploaded to chart once received.	his will it is			
		conducted on 09/12/19 at 5:45 nistrator and office manager.		All discharged charts have reviewed for any unauthent				

	R MEDICARE & MEDI				OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15K167	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIE	R HEALTHCARE SERVICES, INC	9840 V	ADDRESS, CITY, STATE, ZIP COD VESTPOINT DRIVE, SUITE 400 NAPOLIS, IN 46256		
(X4) ID PREFIX	SUMMARY (EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	They reviewed the	R LSC IDENTIFYING INFORMATION clinical record and agreed that arge summary completed. a)(6)	TAG	orders that have been sent to I for authentication. Once receive they will be uploaded to office chart. All clinical managers have beer re-educated with in-service on Comprehensive Assessment the all supplemental orders included discharge orders must be authenticated by MD with signature. Administrator will monitor for 100% compliance by reviewing each chart with discharges completed week prior. This reviewill be completed weekly. see attachments	ed n nat ng	
G 1024						
Bldg. 00	failed to ensure all appropriately auth date, and times for [2 and 7] Findings include: A policy entitled " Orders", dated 07/	eview and interview, the agency documentation was enticated with signature, title, • 2 of 8 clinical records reviewed. Supplemental Physician 25/18, stated "The order must gnature and title of licensed	G 1024	Administrator will provide reeducation regarding authentication of physicians orders with Comprehensive Assessment In-service comple by 11/4/19. Administrator will monitor for 100% compliance by reviewing each chart with home visits completed week prior. This re- will be completed weekly.	1	

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 15K167		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 09/13/2019	
	PROVIDER OR SUPPLIEF	R HEALTHCARE SERVICES, INC	ę	9840 WE	DDRESS, CITY, STATE, ZIP COL ESTPOINT DRIVE, SUITI APOLIS, IN 46256		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PR	ID EFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APF DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
	order is taken" and authenticated and d accordance with ap regulations, as well and must document clinical record, and orders." 1. Clinical record re completed on 09/11 Plan of Care for cer 07/18/19 did not in the staff signature r Plan of Care for cer 09/16/19 did not in the staff signature r Skilled Nurse Visit include a time authout 2. Patient #7, revie 05/07/19, stated "di effective 05/07/19 of another home healt authentication. Review of commun dated 03/28/19, did of authentication fr During an interview 09/11/19 at 3:15 pn requested agency p authentication, the	g order and date and time "(2) Verbal orders must be ated by the physician in plicable state law and as the agency's name policies : the orders in the patient's sign, date and time the eview for patient #2 was /19. tification period 05/20/19 - clude a time authentication for tor the physician signature. tification period 07/19/19 - clude a time authentication for tor the physician signature. note, dated 07/17/19, did not entication for staff signature. w of physician order dated scharge client from agency due to client switching to h company." No physician hication note for patient #7, not include a signature or date om the clinical staff. w with the office manager on h, when authoring surveyor olicy / procedure for office manager relayed that the e a separate authentication					

PRINTED:	11/19/2019			
FORM APPROVED				

				uilding <u>00</u>		x3) date survey completed 09/13/2019		
NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC				STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
N 0000	410 IAC 17-15-1(7)						
Bldg. 00	Medicaid agency.	7	N 0	000				
N 9999								
Bldg. 00	they developed a p to ensure complian requirement, pursu effective 7/01/2017 The findings includ The agency policy Drug Screening Po stated, the testing p		N 9	999	Administrator updated process to reflect regulation of 50% employ drug screening of all employees annually. Administrator will have reached 100% compliance with this by 11/29/19. Randomizer is in place to choose staff randomly at a rate of 50% annually going forward. Administrator will monitor drug screen completion spreadsheet monthly with checklist.	ee		

NTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15K167		(X2) MULTIPLE CC A. BUILDING B. WING	(X3) DA CON	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 09/13/2019				
NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES, INC			STREET ADDRESS, CITY, STATE, ZIP COD 9840 WESTPOINT DRIVE, SUITE 400 INDIANAPOLIS, IN 46256					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF Adaptive will test 5 employee count equal probability th of employees will b On 9/10/2019 at 12 indicated that the a chooses 5 % of the random drug screen home health agency their site, to collect they give the emplo complete; she relay completed in house The agency failed to random drug screen pursuant to the IC At 1 PM, on 9/10/2 provided 8 drug scr	STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 5 % of the previous months end The selection will result in an nat any employee from a group be tested." 2:20 PM, the office manager gency at corporation level, ir employees to collect a n and sends each individual y the employees working at The office manager indicated by es 24 hours to show up and yed that the random screen is	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	performs the drug s At 1:15 PM, the of review, they have of not set up a process employees with dir not licensed under	ealth agency], then that agency screen. fice manager relayed that after letermined that the agency did s to complete 50% of their ect contact with patients and Indiana Code 25 [Indiana Code 16-27-2.5-2(b)(1)(A) and (B)].						

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