STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000 Bldg. 00		N 000		
	This visit was for a complaint investigation of a home health agency. Survey dates: 3-3, 3-4, 3-9, 3-10, 3-12, -3-13, 3-16, and 3-17-2015. Complaint #: IN00160254; Substantiated - State deficiencies related to the allegation are cited. Unrelated deficiencies are cited. Facility #: 012508 Medicaid Vendor: 201050820 Surveyor: Deborah Franco, RN, PHNS Census: 154 Unduplicated skilled admissions last 12 months Current Census: 22 Skilled patients 32 Home Health Aide only patients 54 Total Quality Review: Joyce Elder, MSN, BSN, RN March 27, 2015			
N 408	410 IAC 17-10-1(d) Licensure			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Rule 10 Sec. 1(d) Disclosure of ownership and management information must be made to the department at the time of the home health agency's initial request for licensure, for each survey, and at the time of any change in ownership or management. The disclosure must include the names and addresses of the following: (1) All persons having at least five percent (5%) ownership or controlling interest in the home health agency. (2) Each person who is: (A) an officer; (B) a director; (C) a managing agent; or (D) a managing employee; of the home health agency and evidence supporting the qualifications required by this article. (3) The corporation, association, or other company that is responsible for the management of the home health agency. (4) The chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency. Based on interview and document review, the agency failed to ensure changes in management were disclosed to the Indiana State Department of Health (ISDH) for 1 of 1 agency, creating the potential to affect all the agency's patients. Findings include	N 408	A letter & all required documentation was submitted to ISDH on 3/23/2015 to update the Director of Nursing & Alternate Director of Nursing for the organization. In the future timely notification will be made to ISDH to update a any changes in management. It will be the responsibility of the administrator to ensure that all notifications are submitted in a timely 	03/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. During interview on 3-3-15 at 11:10 AM, the administrator, Employee A, indicated the new nursing supervisor was Employee C with date of hire 3-2-2015. The previous nursing supervisor left without notice on 1-2-15. The position has been vacant since 1-2-15. Employee D, the alternate nursing supervisor, had been responsible for the duties of nursing supervisor until Employee C was hired. The administrator indicated the agency had not sent a letter to ISDH regarding the change in management. 2. On 3-13-15 at 8:40 AM, ISDH staff indicated they had checked the system. As of 3-13-15 at 8:40 AM, ISDH had not received a letter of notification regarding the departure of the nursing supervisor on 1-2-2015.		manner. 	
N 444 Bldg. 00	410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on observation, review of lists and	N 444	Agency began a focused PDCA Performance Improvement	03/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reports provided by the agency, and interview, the administrator failed to organize and direct the agency's functions by not being able to timely provide after written request, access to electronic and/or paper clinical records during the survey; failed to timely provide a list of patients with start of care date, primary diagnosis, and services provided; failed to timely provide a list of discharged patients for the prior 6 months; failed to provide an accurate list of discharged patients for the prior 6 months; failed to timely provide an accurate list of clinician visit schedules the week of 3-9 to 3-13-15; failed to provide an accurate list of active patients; failed to timely provide governing body meeting minutes from 2014; failed to timely provide agency annual program evaluation for 2014; failed to timely provide meeting minutes of the group of professional personnel for 2014; failed to provide, after request and prior to exit, a copy of the plan of care for clinical record 8 and the first page of the plan of care for clinical record 7; failed to provide the Home Health Agency Report Form within 24 hours of written request; and failed to provide the agency policy(ies) related to standards of documentation and clinical record, all on-going functions of the agency.		Project on 10/21/14 to address issues surrounding previous Electronic Medical Record/ documentation system. (Copy submitted to ISDH surveyor on 3/17/15.) The team included the Administrator, Executive Director, Director of Nursing, & other members of the Admin & Clinical team. The purpose was to determine whether the current systems have the capability to meet agency clinical, operational and financial management needs & whether there are comparably priced Agency management systems available that would better meet the needs of the organization. The review included analyzing what steps could be taken immediately to utilize the system in its current capacity while possible search & implementation of another system was underway. During the review it was determined that system was not meeting the needs of the organization. Problems noted included, inadequate data validation, lack of cohesive workflow, lack of in-depth employee training material, inefficient/ineffective clinical documentation, inadequate orders & documentation tracking. Incorrect or inefficient reporting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: 1. On 3-3-15 at 12:00 noon, a list of documents requested for the complaint investigation was given to the administrator. The administrator signed for receipt of this document. 2. On 3-3-15 at 3:20 PM, the administrator provided a list of active patients. On 3-9-15 (time not recorded) the alternate administrator indicated the list was incorrect. She indicated 2 of the patients on the list had been discharged on 11-24-14 and 2-16-15. She indicated the patient in clinical record 4 was active. The administrator indicated in interview on 3-12-15 at 1:30 PM patient in clinical record 4 had been been discharged on 1-17-15. 3. On 3-9-15 at 12:15 PM, a list of documents requested for the full extended complaint investigation was given to the administrator. The administrator signed for receipt of this document. Based on review of policy, job description review, review of personnel files, and interview, the administrator failed to ensure 3 of 4 Home Health Aides (J, M, N) had complete competency skills evaluations in their personnel files; failed to ensure the agency established competency prior to		functionality. In addition the system lacked an efficient coordination/messaging mechanism to communicate patient related issues to clinical team members. In meetings with senior management of the EMR it became apparent that they lacked the ability and/or willingness to make workflow & system modifications based on the needs of the organization. Agency management conducted demonstrations of 6 EMR systems, some of which had been reviewed as a part of previous search efforts. One EMR was selected with an implementation date beginning on 2/9/2015. Agency Go Live Date was 3/1/2015. Implementation is expected to last 120 days (2/9/15 – 6/8/15). A File was created that includes; Governing Body Minutes, PAC meeting Minutes & Annual Program Evaluation. These will be provided in a timely manner upon request. A report is available in the EMR that includes Start of Care Date, Primary Diagnosis & Services provided. This report will be provided in a timely manner upon request. A list of discharged patients has been assembled from the previous EMR systems & is available in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	date of first patient care for for 1 of 4 HHA's (N); and failed to evidence orientation and receipt of job description for 1 of 1 office managers (L) whose personnel file was reviewed. 4. On 3-10-15 at 9:15 AM, the surveyor requested the nursing supervisor unlock a cabinet in her office the alternate administrator had indicated was the secure location for paper clinical records and clinical records waiting to be scanned. The alternate administrator had indicated the electronic clinical record and this file cabinet contained all the the agency clinical records. 28 of the 62 files with names of patients on them were not on the list of active patients. The alternative administrator indicated these were files of documents waiting to be scanned. The folder for patient in clinical record 1 contained documents dated back to 11-24-14. The file cabinet did not contain fax cover sheet documentation of transmittal of orders and plans of care. 5. On Monday 3-16-15, the surveyor arrived at the agency at 9:30 AM. Employee T, a client experience advocate, indicated the administrator was on the phone and no other management personnel were available to assist the surveyor with the survey process.		the current EMR. This report will be provided in a timely manner upon request. There will be a minimum of 2 people in the agency that have been trained on data retrieval of all EMR systems. Upon request access to clinical records will be granted in a timely manner. The Administrator will be responsible for ongoing monitoring & compliance. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6. On 3-16-15 at 10:00 AM, the administrator came to the conference room. The surveyor requested to review today, in addition to clinical records, 2014 governing body meeting minutes, 2014 agency evaluation, QAPI, complaint log 2014, and group of professional personnel meeting minutes from 2014. 7. On 3-16-15 at 10:40 AM, a computer was provided for the surveyor to access Kantime electronic clinical records. The surveyor requested access to Devero to review clinical records. The administrator indicated clinical records in Devero would be produced on paper. The surveyor provided a list of names of clients and requested the complete clinical record of any patients in Devero (clinical records 1 and 3 had already been reviewed in Axxess) to include all agency documentation. After request, no tutorial was provided for the surveyor and a request for a demonstration of how to use the Kantime system was declined by the administrator and alternate administrator. Surveyor request for copy capability was declined. The administrator requested the surveyor keep a list of documents to be printed from Kantime. 8. On 3-16-15 at 1:30 PM, a list of documents the surveyor requested to review, which had previously been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided to the agency administrator on 3-9-15 at 12: 15 PM, was given to the administrator. The administrator signed for receipt of this document. 9. On 3-16-15 at 1:54 PM, a list of discharged patients for the last 6 months was provided. The names of patients in clinical records 4 and 5 were not on the list. The administrator indicated in interview on 3-12-15 at 1:30 PM these patients had been discharged on 1-17-15. The administrator could not explain why the names did not appear on the discharged list. 10 On 3-12-15 at 2:30 PM, clinician schedule for 3-13-15 was provided. The schedule had physical therapist, Employee S, schedule for 9:00 AM visits with 3 patients. The administrator indicated on 3-16-15 at 2:45 PM the schedule puts times in the visit slots which are not accurate. After the visit has been made and a visit note is entered in the system, the schedule updates to indicate actual visit times. 11. On 3-16-15 at 2:30 PM, surveyor requested from the administrator documents not provided on paper for clinical record 11 (active patient), start of care 12-5-14, certification period reviewed 12-5-14 to 2-2-15, printed from			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Devero on 3-12-15. The printed clinical record presented on 3-12-15 failed to evidence: referral form, interim order for skilled nursing services, skilled nursing visit notes, physical therapy visit notes, medication reconciliation report, all plans of care (for review of 60 day summaries), discharge plans (487), and recertification OASIS comprehensive assessment. The documents were not provided prior to exit. 12. On 3-17-15 at 5:00 PM, the administrator provided a list of visit schedules for 3-9, 3-10, 3-11, and 3-12-15. Upon request to view the updated clinician visit schedule from 3-13-15, the administrator stated the schedule was not yet updated with actual visit times. He could not state how long it takes the system to update the clinician schedule with actual visit times. The administrator indicated the agency is still working with the provider of this system to improve the processes. 13. On 3-17-15 at 2:30 PM, a paper copy of clinical record 10, requested on 3-16-15 at 10:30 AM was presented. 14. On 3-17-15 at 2:30 PM, a paper copy of clinical record 4, requested on 3-16-15 was presented.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	15. On 3-17-15, at the exit conference, approximately 5:15 PM, the following documents were provided: governing body meeting minutes 2014, group of professional personnel meeting minutes 2014, agency annual evaluation 2014, chart audits 2014, list of active patients with start of care, primary diagnosis, and services, quality assurance performance improvement program and data 2014 and the Home Health Agency Report Form . Copies of agency documents were provided at surveyor request. A copy of the plan of care for clinical record 8 was not provided. A copy of the first page of the plan of care for clinical record 7 was not provided. Both plans of care documentation had been requested. Copies of the agency policy(ies) related to standards of documentation and clinical record, were not provided at exit.			
N 446 Bldg. 00	410 IAC 17-12-1(c)(3) Home health agency administration/management Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on review of policy, job	N 446	All employee files have been audited for completed skills checks per 	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	description review, review of personnel files, and interview, the administrator failed to ensure 3 of 4 Home Health Aides (J, M, N) whose files were reviewed had complete competency skills evaluations in their personnel files; failed to ensure the agency established competency prior to date of first patient care for for 1 of 4 HHA's (N); and failed to evidence orientation and receipt of job description for 1 of 1 office managers (L) whose personnel file was reviewed. Finding included: 1. "Agency policy "Categories / Qualification of Personnel", undated, copyright 2003 The Corridor Group, states under competency, "Home Health Aide: Individuals must demonstrate their competency, within orientation, according to the orientation checklist and the activities delineated in the CMS (Centers for Medicare and Medicaid Services) competency testing." 2. Agency policy "Orientation", undated, copyright 2003 The Corridor Group, states "Orientation content for all personnel will include the following as applicable and appropriate to the care and service provided: ... job related responsibilities ... baseline skills assessments as applicable to the job		patient assignments. Employees with incomplete competencies were evaluated for the appropriate skills per company policy. A contractor will be utilized to conduct Home Health Aide competency evaluations through March 16, 2017. All newly hired Home Health Aides will have a complete competency evaluations before providing care to agency patients. And all current staff members have been skills checked and competency tested. A revision to the agency policy has been implemented and states that all patient care employees will be skills checked and competency tested in the required areas prior to being assigned a patient so that the patient will receive the safe, appropriate care. Agency will continue to use the skills check form developed by the Indiana Association of Home and Hospice Care Inc. but will delineate between the required areas & areas that are not mandated. The administrator will oversee the review of 100% of all new hire personnel before they are approved to provide patient care, with monitoring ongoing. Administrator will be responsible for maintaining compliance with this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	classification ...performance standards ... documentation requirements ... " 3. Agency job description for Home Health Aide (HHA), copyright The Corridor Group, Inc., 2003, states the position qualifications for HHA include "meets the requirements in accordance with state and federal law" ... responsibilities include "baths ... oral hygiene, ... skin care to prevent breakdown ... shampoos ... assisting the patient with toileting activities ... planning and preparing nutritious meals ... taking and recording oral, rectal, and axillary temperatures, pulse respiration and blood pressure when ordered (with appropriate completed/demonstrated skills competency) ... assisting in ambulation and exercise according to the plan of care ... performing range of motion ... assisting the patient in the self-administration of medication ... doing patient's laundry, as appropriate ... adhering to organizations documentation and care procedures and standards of personal and professional conduct ... " 4. HHA J, date of hire (doh) 2-11-15, and date of first patient contact 2-16-15 contained a competency evaluation with Indiana Home and Hospice Care, Inc. in the upper left hand corner, dated 2-16-15. All competencies had been marked as		standard 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	completed 2-16-15. For mobility, the entries under the transfer skill are transfer assist, transfer with wheelchair, and transfer bed-to-chair, these 3 had not been checked as completed. For Personal Care-Oral, entries under dentures and gum care had not been checked as completed. For Bath, the entries under Tub and Sponge had not been checked as completed. For Shampoo-the entries under bed; sink; and bathtub had not been marked as completed. For Bodily functions, the the entries under toileting bathroom, bedpan, urinal, bedside commode, ex-dwelling catheter, and catheter had not been checked. Employee J had not signed and dated the form. 5. Review of personnel file of Employee L, office manager, had a date of hire of 9-8-14. The file failed to evidence a job description for which the employee had accepted and signed for receipt, and failed to evidence orientation to the position of office manager. 6. HHA M has a date of hire (doh) 10-17-14, and date of first patient contact 10-18-14. HHA M's personnel file contained a competency evaluation with Indiana Home and Hospice Care, Inc. in the upper left hand corner, dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10-18-14. For mobility, the entries cane, walker, crutches had not been checked. For Bodily functions, the the entries under toileting bedpan, urinal, bedside commode, ex-dwelling catheter, and catheter had not been checked. For Fluid balance, intake or output, measurement, was marked as N/A. For medication assistance, competent client, mentally incompetent client, both had been marked N/A. 8. HHA N, has a date of hire (doh) 11-18-14, date of first patient contact 11-19-14. HHA N's personnel file contained a competency evaluation with Indiana Home and Hospice Care, Inc. in the upper left hand corner, dated 11-21-14. For mobility, the entry crutches had not been checked. For Personal care, bed bath had not been marked as completed. For Bodily functions, the entries under toileting-ex-dwelling catheter and catheter had not been checked. 9. The Administrator, Employee A, indicated on 3-4-15 at 2:30 PM, the agency procedure is to have an RN competency HHA's during one patient care visit and that one patient would not present the opportunity to competency all the areas required. The administrator indicated agency expectation is all			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	employees receive orientation to their job position and a job description when hired. No further documentation was provided prior to exit.			
N 458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based personnel file review and interview, the agency failed to ensure a criminal background check was performed as per IC 16-27-2 for 1 of 10 active personnel files reviewed (Employee M) and personnel files included job description for which the employee had signed for acceptance and receipt for 2 of 13 personnel files	N 458	All employee files have been reviewed to ensure they contained a criminal background & a signed job description according to company policy. All personnel will receive an orientation related to the job duties assigned in accordance will company policy. 100% of active personnel files have been reviewed to ensure that all active employees have job related	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed (L and M). Findings included: 1. Personnel file of Employee M, home health aide, failed to evidence a criminal background check as required by IC 16-27-2 and failed to evidence a job description for which the employee had signed for acceptance and receipt. 2. Personnel file of Employee L, office manager, failed to evidence a job specific orientation and job description for which the employee had signed for acceptance and receipt. 3. On 3-12-15 at 2:30 PM, the administrator and the alternate administrator indicated agency expectation is all employees receive for orientation to their job position and a job description when hired. The administrator was unable to provide any further documentation prior to exit.		orientation documented & a job description per company policy. The administrator will oversee the review of 100% of all new hire personnel files to ensure compliance with this standard. Monitoring will be ongoing. The administrator will be responsible for maintaining compliance with this standard.	
N 462 Bldg. 00	410 IAC 17-12-1(h) Home health agency administration/management			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on policy review, personnel file review and interview, the agency failed to ensure personnel files included a physical examination not more than 180 days prior to direct patient contact in 1 of 10 direct care givers whose personnel records were reviewed (M). The findings include: 1. Agency policy "Categories/Qualifications of Personnel", undated, states " all new personnel who will be in contact with pateints and rehires who have not been employed by the organization over six (6) months, must undergo a physical screening before they are employed or re-hired." 2. Personnel file of Employee M, evidenced the individual had been hired on 10-17-14 as a home health aide, first date of patient contact 10-18-14. The file evidenced a physical examination by a physician dated 11-14-14, after the date	N 462	All personnel files were reviewed to ensure that all personnel with direct patient contact have a physical examination on file dated within 180 days of first patient contact in accordance with company guidelines. The administrator will oversee the review of 100% of all new hire personnel files to ensure compliance with this standard. Monitoring will be ongoing. The administrator will be responsible for maintaining compliance with this standard. 	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of first patient contact. 3. Personnel file of Employee N, evidenced the individual had been hired on 11-19-14 as a home health aide, first date of patient contact 11-19-14. The file evidenced a physical examination dated 11-26-14, after the date of first patient contact. 4. On 3-12-15 at 2:30 PM, the administrator indicated he was not aware the agency policy did not require the physical examination to be within 180 days of first patient contact per state rules.			
N 464 Bldg. 00	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact;			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on policy review, review of personnel files, and review of Centers for Disease Control (CDC) tuberculosis (TB) skin testing guidelines, the agency failed to ensure TB skin tests for direct care providers were read between 48 and 72 hours for 3 of 14 non-positive TB skin test responders' personnel files reviewed (E, I, and M). The findings include: 1. Agency policy "Infection Control Plan", undated, copyright 2003 The Corridor Group, states the purpose of the policy is "to delineate an infection control plan to meet the following goals ... Comply with all applicable local, state, and federal regulations, including, but not limited to ... CDC guidelines." 2. Personnel record E, registered nurse, date of hire 4-18-13, contained a TB skin test report with injection on 2-14-13 and read 2-17-13. The time of the injection and the time of the reading were not recorded. 3. Personnel record I, Speech Therapist, date of hire 6-3-14, contained a TB skin	N 464	Employee Personnel Record Audit from has been modified to include time of administration & reading of TB tests. All TB records of clinical personnel records were reviewed to ensure that they included time of administration & reading of tests. Employees without the time documented were sent for retests. Monitoring will be ongoing. The Administrator will be responsible for compliance with this standard. 	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	test report with injection on 3-10-14 and read 3-12-14. The time of the injection and the time of the reading were not recorded. 4. Personnel record M, home health aide, date of hire 10-17-14, contained a contained a TB skin test report dated 11-15-13 for injection, and reading on 11-19-13, the document failed to evidence the time the injection was given and the time the reading was made. A TB skin test report with date of injection on 11-24-14 failed to evidence the site of the intradermal injection, failed to document the time injected, and failed to document the time read on 11-26-14. 5. CDC Guidelines for Control and Prevention of TB "Tuberculosis Skin Testing Fact Sheet", last reviewed/updated September 2012 , states, "The skin test reaction should be read between 48 and 72 hours after administration ..."			
N 484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on review of policy, observation, clinical record review, and interview, the agency failed to ensure the registered nurse coordinated services timely with other providers regarding patient's request for physical therapy for 1 of 1 (7) home visits where patient requested additional services. Findings include: 1. Agency policy "Care Planning Process", undated, copyright 2003 The Corridor Group, states "All clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, included, but not limited to: changes in patient condition ... patient treatment choices ... action to be taken to meet the patient goals ... " 2. During home visit observation on 3-13-15 at 10:15 AM, patient 7 indicated his legs felt heavy and that he had good results from physical therapy services in the past. He asked Employee D, the registered nurse, to refer him for physical	N 484	Changes in patient condition & requests for additional service will be documented in the clinical chart & communicated to the patients’ Primary Care Physician in a timely manner. All other members of the patients care team will be notified of changes and/or patient requests for additional services. All RN case managers have been inserviced on the importance of recording and notifying the Primary Care Physician of any requests for additional services, changes or reported changes in a patient’s condition immediately or within 24 hours of becoming aware of such changes depending on the urgency of the change. All skilled clinicans will be responsible for notifying the physician on their assigned patients and reporting such changes to the Director of Nursing. At a minimum, 25% of active patient charts will be audited monthly to monitor compliance with this standard. When 100% of audited	04/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	therapy services. 3. Clinical record 7, start of care 2-24-15, contained a plan of care for the certification period 2-24 to 4-24-15 with diagnoses of atrial fibrillation, chronic kidney disease, and diabetes mellitus type 2. Orders included Skilled Nursing 2 times a week. The nursing visit note from 3-13-15 failed to evidence patient report of "heavy legs" and the patient's request for physical therapy services. Nursing visit notes from 3-13 and 3-17-15 failed to evidence care coordination with the attending physician or physical therapist regarding patient experiencing heaviness in the legs and patient's request for physical therapy services made on 3-13-15. 4. On 3-17-15 at 9:15 AM, request was made to the administrator for any documentation regarding the patient's request for physical therapy on 3-13-15. No further documentation was provided prior to exit.		charts have been found in compliance for 3 consecutive months the reviews will be incorporated into the quarterly chart audits of which a minimum of 10% will be continued to be reviewed for compliance. Director of Nursing will be responsible for maintaining compliance with this standard 	
N 488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped. (j) The five (5) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on policy review, clinical record review, and interview, the agency failed to provide 5 days notice of discharge for 1 of 3 (5) closed clinical records reviewed. Findings include: 1. Agency policy "Discharge Criteria and Process", undated, copyright 2003 The Corridor Group, states, "The organization	N 488	The Agency policy is to notify the patient verbally or in writing of the decision to terminate or reduce services within 1 visit or a minimum of 5 days prior to the time of change in service is to occur (i.e. prior to the last scheduled visit). Skilled clinicians were in-serviced on the company Discharge policy. During quarterly chart review, 10% of discharged patient charts will be reviewed to ensure compliance with this standard until 100% compliance	04/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	will verbally notify the patient of the decision to terminate or reduce services within 1 visit or a minimum of 5 days prior to the time of change in service is to occur (i.e. prior to the last scheduled visit) ... an update to the comprehensive assessment, including OASIS data elements, will be completed, as required by regulation" 2. Clinical record 5, start of care 11-18-14, contained a plan of care for the certification period 11-18-14 to 1-16-15 with orders for skilled nursing and home health aide services. The last skilled nursing visit was on 12-30-14. The clinical record failed to evidence 5 day notice to the patient of discharge on 1-17-15. 3. On 3-12-15 at 1:30 PM, the administrator indicated patient in clinical record 5 had not been recertified as the end of the first certification period, although the patient continued to need services. The agency had not had a registered nurse complete an OASIS/comprehensive assessment during the 5 day window for recertification. The administrator indicated the patient was considered discharged 1-17-15 when the certification period expired.		is maintained for 3 consecutive Quarters. The Director of Nursing will be responsible for maintaining compliance with this standard. Monitoring will be ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on policy review, review of clinical records, and interview, the agency failed to ensure services were provided according to physician orders in the plan of care (POC) for 6 of 10 clinical records reviewed (1, 5, 6, 8, 9, and 10) and failed to obtain physician orders for HHA visits for 2 of 8 (4, 5) clinical records reviewed of patients receiving HHA services creating the potential to affect all of the agency's 54 current patients. Findings include: 1. Agency policy "Care Planning Process", undated, copyright 2003 The Corridor Group, states, "The plan of care will be based upon the physician's ... orders ... deviation from ordered duration and/or frequency will be communicated to the physician via phone or fax." 2. Clinical record 1, start of care (SOC) 8-22-14, contained a plan of care (POC)	N 522	Each patient shall have a completed, current written Plan of Care signed that covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. All services rendered will be according to the written signed Plan of Care unless there has been verbal orders obtained. All verbal orders will be documented and sent to the physician for signature, including new medications both prescribed and OTC, herbal remedies and specific nursing, therapy and home health aide orders for frequency and care to be provided. Should a sudden need arise for altering the present Plan of Care a 	04/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for the certification period 8-22-14 to 10-20-14. Orders included Home Health Aide (HHA) visits 10 hours a day, 7 days a week for 9 weeks. The clinical record failed to evidence HHA visits were made on 8-23, 8-24, 8-29, 8-30, and 8-31-14. The clinical record failed to evidence notification to the attending physician of the 5 missed visits. 3. Clinical record 4, SOC 11-18-15, contained a plan of care for certification period 11-18-14 to 1-16-15 including orders for HHA services 7 hours day, 7 days a week. Services were placed on hold 1-11-15. HHA visits were made on 1-12, 1-13, 1-14, 1-15, and 1-16-15. 4. Clinical record 5, SOC 11-18-15, contained a POC for certification period 11-18-14 to 1-16-15. Orders included skilled nursing visits each 2 weeks for medication management and set up and HHA 7 hours a day/7 days a week. Skilled nursing (SN) visit notes from 12-2, 12-16, and 12-23-14 failed to evidence medication set up. The clinical record failed to evidence a SN visit the week of 1-11 to 1-16-15. The administrator indicated on 3-12-15 at 1:15 PM, HHA, Employee N, had continued to provide services for patient in clinical record 5 after the certification		Verbal Order will be obtained from the patient's physician and dually noted in the patient's chart and documented on an order to be signed by the physician. All Case Managers were in-serviced on the requirements of care planning & obtaining verbal orders as required by company policy. The Case Managers will be responsible for assuring all Care Plans are updated as needed. An order will be obtained for visits outside the stated frequency on the Plan of Care, including PRN visits. The Director of Nursing will be responsible for monitoring and maintaining compliance with this standard through daily Quality Assurance record reviews. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	period expired on 1-16-15 expired. The administrator indicated the patient was discharged effective 1-17-15. The HHA, Employee N, made 19 days of visits between 1-17 and 2-4-15. The administrator indicated no order for HHA services was obtained for the period of visits from 1-17-15 to 2-4-15. A new episode of care began on 2-5-15 per verbal order of the attending physician which included HHA services. 5. Clinical record 6, SOC 1-10-14, contained a POC for the certification period 1-5 to 3-5-15. Orders included Physical Therapy (PT) visits 2 times a week for 9 weeks. The clinical record failed to evidence 2 PT visits the weeks of 1-11 to 1-17-15, 1-25 to 1-31-15, and 2-1 to 2-7-15. The clinical record evidenced only 1 PT visit each of these weeks. 6. Clinical record 8, SOC 12-11-14, contained a POC for the certification period 2-9 to 4-9-15. The POC included orders for HHA visits 4 hours a day, 6 days a week, for 8 weeks. The clinical record failed to evidence HHA visits 2-9 to 3-1-15. 7. On 3-16-15 at 3:00 PM, the administrator indicated the HHA notes for CR 8 had been recorded in telephony.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The agency converts these telephony visit dictations into a computer record of dates, hours, and services provided. The administrator confirmed the HHA visit notes for 2-9 to 3-1-15 had not been uploaded into the electronic clinical record system, Kantime, as of 3-16-15. After request, a copy of the plan of care and a copy of the HHA documents (produced from telephony for 2-9 to 3-1-15) were not provided prior to exit. 8. Clinical record 9, SOC 11-10-2014, contained a plan of care (POC) for the certification period 1-9 to 3-9-15 including PT 1 time a week until 1-15-15 then 2 times a week for 9 weeks, HHA visits 3 hours a visit, 2 days a week for 1 week, then 7 days a week for 8 weeks. The clinical record failed to evidence HHA visit notes for 1-18, and from 2-7 to 3-9-15, and failed to evidence 2 PT visits the week of 1-25 to 1-31-15 (1 visit). 9. On 3-16-15 at 3:00 PM, the administrator indicated the HHA notes for CR 9 had been recorded in telephony. The agency converts these telephony visit dictations into a computer record of dates, hours, and services provided. The administrator confirmed the HHA visit notes for 1-18, and 2-7 to 3-1-15 had not been uploaded into the electronic clinical record system as of 3-16-15. After			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	request, a copy of the HHA documents (produced from telephony for 2-7 to 3-1-15) were not provided prior to exit. 10. Clinical record 10, SOC 1-27-15, contained a POC for the certification period 1-27 to 3-27-15. The POC included orders for skilled nursing (SN) visits 1 time a week for 1 week, then 2 times a week for 8 weeks. The clinical record evidenced SN visits by Employee D on 2-17, 2-20, and 2-21-15. The clinical record failed to evidence a physician order authorizing the 3rd SN visit the week of 2-15 to 2-21-15. 11. The administrator indicated on 3-16-15 at 10:00 AM, clinical records 9 and 10 were maintained in an electronic clinical record, Devero, for which the agency no longer has a contract. The administrator provided paper copies of these clinical records on 3-17-15 at 10:45 AM and 2:30 PM respectively. On 3-17-15 at 2:30 PM, the administrator indicated the paper clinical records copies provided were complete clinical record with all agency documents.			
N 524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on policy review, review of clinical records, and interview, the agency failed to ensure the plan of care contained all required elements for 1 of 7 active clinical records reviewed (2) and for 2 of 3 closed records reviewed (4 and 5). Findings include: 1. Agency policy "Care Planning Process", undated, copyright 2003 The Corridor Group, states, "A written plan of care will be initiated within five (5) days of start of care and updated every 60 days or as patient's condition warrants" ... "	N 524	Each patient shall have a completed, current written Plan of Care signed that covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. All services rendered will be according to the written signed Plan of Care unless there has been verbal orders	04/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The clinical plan of care includes: Pertinent primary and secondary diagnoses, food or drug allergies, homebound status, goals/outcomes to be achieved, patient's mental status, functional limitations, activities permitted, safety measures, nutritional requirements, medications and treatments, specific procedures to be performed by therapies, including amount, frequency, and duration, supplies and equipment required, discharge or referral plans, discharge teaching, frequency and duration of visits, prognosis, rehabilitation potential, other appropriate items such as precautions and contraindications." 2. Agency policy "Verification of Physician Orders", undated, copyright 2003 The Corridor Group, states, "To ensure that accurate physician ... orders are obtained in accordance with applicable law and regulation ... (regarding telephone orders) ... The original of the order form will be delivered to the physician ... for signature ... Signed orders will be in the clinical record within 30 days of initiation of care or interim order, unless otherwise specified by applicable state law and regulation." 3. On 3-4-15 at 3:00 PM, Clinical record		obtained. All verbal orders will be documented and sent to the physician for signature, Including new medications both prescribed and OTC, herbal remedies and specific nursing, therapy and home health aide orders for frequency and care to be provided. Should a sudden need arise for altering the present Plan of Care a Verbal Order will be obtained from the patient's physician and dually noted in the patient's chart and documented on an order to be signed by the physician. All Case Managers were in-serviced on the requirements of care planning & obtaining verbal orders as required by company policy. The Case Managers will be responsible for assuring all Care Plans are updated as needed. An order will be obtained for visits outside the stated frequency on the Plan of Care, including PRN visits. The Director of Nursing will be responsible for monitoring and maintaining compliance with this standard through daily Quality Assurance record reviews. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2, start of care (SOC) 2-5-15, contained a document titled "Home Health Certification and Plan of Care" for the certification period 2-5 to 4-5-15 with orders for skilled nursing and home health aide services. The plan of care (POC) failed to evidence pertinent secondary diagnoses of incontinence and asthma, nutritional requirements, allergies, mental state, treatments and orders for disciplines with frequencies, and goals/rehabilitation potential/discharge plan. The plan of care listed a nebulizer as durable medical equipment and patient medication of albuterol-ipratropium 2.5 mg-0.5 mg/3 mL inhalation solution twice a day (asthma medication). The "Home Health Certification and Plan of Care" in field locator 25 "Date HHA Received Signed POT" was the date 2-27-15. A. Clinical record 2 contained a HHA care plan 2-5-15 with secondary diagnosis of asthma and allergy status of no known allergies. B. On 3-10-15 at 4:30 PM, and 3-16-15 at 4:30 PM, the surveyor met with Person W, LPN for the attending physician of patient in clinical record 2. Regarding episode of care with certification period 2-5 to 4-5-15:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1). Person W indicated the attending physician was not notified that agency had missed the recertification assessment for this patient 1-12 and 1-16-2015 (a previous episode of care for the same patient reviewed as clinical record 5) resulting in expiration of the patient's certification period without recertification (discharge). 2). Person W provided a verbal order to the agency about 2-5-15 to evaluate patient in clinical record 2 for nursing and home health aide services. 3.) Person W indicated the physician had not received a plan of care for his signature authorizing services and frequency of visits, medications, and any indicated treatments for patient in clinical record 2 (SOC 2-5-15). 4.) On 3-16-15 at 4:30 PM, the surveyor met with person W at the attending physician's office. Person W indicated no further documentation had been located in medical records by Person V, medical records employee. Person W indicated it is her habit to send an email to the medical records department describing documents being forwarded for scanning. She was unable to locate any such emails regarding this patient (clinical record 2 / 5) from 11-14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

to 3-16-15.

4. Clinical record 5, SOC 11-18-14, the same patient as clinical record 2, for a previous episode of care, contained a plan of care (POC) for the certification period 11-18-14 to 1-16-15 with orders for skilled nursing and home health aide services. Diagnoses included moderate intellectual disability, hypertension, intrinsic asthma, and urinary incontinence. The plan of care failed to evidence nutritional requirements and allergy status. The verbal order in identifier field 23 failed to evidence the signature of the nurse, Employee U, taking the order.

On 3-10-15 at 4:30 PM, the surveyor met with Person W, LPN for the attending physician of patient in clinical records 2 and 5. Regarding episode of care for certification period 11-18 to 1-16 -15:

1.) Person W indicated the attending physician was not notified that agency had missed the recertification assessment for patient in clinical record 5 between 1-12 and 1-16-2015 resulting in expiration of the certification period without recertification.

2.) Person W indicated the physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had received an order regarding patient in clinical record 5, dated 2-26-15 by fax requiring physician's signature. This was a verbal order from 11-17-2014. The order authorized the agency to evaluate patient in clinical record 5 for skilled nursing and home health aide services. The physician signed the order on 3-3-15. The LPN had not yet faxed the order back to the home health agency. 3.) Person W indicated the physician had received a fax dated 2-26-15, requiring physician's signature. This was a verbal order from 11-19-14. This order was for skilled nursing visits for medication management and supervisory visits each 2 weeks, and for home health aide services 7 hours a day, 7 days a week (no duration). The physician signed the order on 3-3-15. The LPN had not yet faxed the order back to the home health agency. 4.) Person W indicated she not recall receiving a plan of care for the 11-18-14 to 1-16-15 certification period for patient in clinical record 5. She indicated the office sends most paper documents to medical records to be scanned into the patient's office record. She stated medical records had left for the day, but she would inquire and call the surveyor if further documentation from the agency regarding patient in clinical record 5 was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	located in the medical records department. 5.) On 3-16-15 at 4:30 PM, the surveyor met with person W at the attending physician's office. Person W indicated no further documentation had been located in medical records by Person V, medical records employee. Person W indicated her habit is to send an email to the medical records department describing documents being forwarded for scanning. She was unable to locate any such emails regarding patient in clinical record 5 from 11-18-14 to 3-16-15. 5. Clinical record 4, SOC 11-18-14, contained a POC for the certification period 11-18-14 to 1-16-15 with orders for HHA services 7 hours a day, 7 days a week. The order failed to evidence a duration of time for the services. The clinical record failed to evidence an interim order specifying the duration of HHA services for the certification period. 6. On 3-4-15 at 5:00 PM, the administrator indicated he was not aware patient in clinical record 2 did not have a complete plan of care accessible to the agency on 3-4-15 when the clinical record was reviewed. The administrator indicated it is the responsibility of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	case manager, Employee D, to ensure the plan of care is initiated in a timely manner. He indicated as administrator of the agency, it is also his responsibility to ensure a copy of a complete POC was sent to the physician for authorization. The administrator indicated when this clinician, Employee D, the RN who was responsible for initiating the plan of care, enters data into her computer, it is saved only on her "side" and does not transmit to the agency until she "syncs" her computer. He was aware Employee D had been having difficulty "syncing" her computer. He indicated she was in the office at least once a week to perform case management duties with agency computers that did not require syncing. The administrator indicated he was unable to provide a list of dates and times Employee D had "synced" her computer while in the field. The administrator could not explain why field locator 25 had the date 2-27-15 entered. He indicated the plan of care had not yet been transmitted to the attending physician.			
N 541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(B) Regularly reevaluate the patient's nursing needs. Based on policy review, clinical record review, and interview, the agency failed to ensure the registered nurse completed the recertification comprehensive assessment during the last 5 days of each 60 day period for 1 of 4 clinical records reviewed receiving services for 60 days (5). Findings include: 1. Agency policy "Initial and Comprehensive Assessment", undated, copyright 2003 The Corridor Group, states the purpose of the policy is, "To provide guidelines for the initial assessment of patients admitted to service and for completing the plan of care ... a comprehensive assessment will be completed within five (5) days of the patient's start of care ... This assessment will measure patient outcomes from data collected at the start of care and at the following defined intervals thereafter: 1. The last five (5) days of every 60 day episode beginning with the start of care date (recertification) ... upon transfer ... significant change in condition resulting in a new case mix ... within 48 hours of the patient's return home from a 24 -hour hospital admission for other than	N 541	All Care Managers have been given written guidelines & in serviced on the requirements of specific time lines for all comprehensive assessments including: admission, transfer; resumption; recertification and discharge OASIS to be completed and returned to the agency. This in-service was under the direction of the Director of Nursing. Monitoring of this standard will be ongoing. The Director of Nursing will be responsible for maintaining compliance with this standard 	04/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diagnostic testing ... at discharge." 2. Clinical record 5, start of care (SOC) 11-18-14, contained a plan of care for the certification period 11-18-14 to 1-16-15 including skilled nursing and home health aide services. The clinical record failed to evidence a recertification assessment during the last 5 days of the certification period. 3. On 3-12-15 at 1:30 PM, the administrator indicated the previous nursing supervisor had left the agency without notice on 1-2-15. The agency did not assign another registered nurse to complete the comprehensive assessment scheduled 1-15-15 for patient in clinical record 5 and the patient needed services continued. The administrator indicated the agency considered patient in clinical record 5 discharged on 1-17-15.			
N 542	410 IAC 17-14-1(a)(1)(C)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on policy review, observation, clinical record review, and interview, the agency failed to ensure the registered nurse updated the plan of care for 1 of 10 clinical records reviewed (2). Findings include: 1. Agency policy "Care Planning Process", undated, copyright 2003 The Corridor Group, states, "A written plan of care will be initiated within five (5) days of start of care and updated every 60 days or as patient's condition warrants" ... " The clinical plan of care includes: Pertinent primary and secondary diagnoses, food or drug allergies, homebound status, goals/outcomes to be achieved, patient's mental status, functional limitations, activities permitted, safety measures, nutritional requirements, medications and treatments, specific procedures to be performed by therapies, including amount, frequency, and duration, supplies and equipment required, discharge or	N 542	Each patient shall have a completed, current written Plan of Care that covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. All services rendered must be according to the written Plan of Care unless there has been verbal orders obtained. All verbal orders will be documented and sent to the physician for signature. New medications both prescribed and OTC including herbal remedies and specific nursing, therapy and home health aide orders for frequency and care to be provided. Should a sudden need arise for altering the present Plan of Care a Verbal Order will be obtained from the patient's physician	04/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	referral plans, discharge teaching, frequency and duration of visits, prognosis, rehabilitation potential, other appropriate items such as precautions and contraindications ... Clinicians will inform the patient's physician of any changes that suggest a need to alter the plan of care ... the plan of care will be revised as frequently as deemed necessary by the clinicians based on the ongoing assessments of the patient." 2. On 3-4-15 at 3:00 PM, Clinical record 2, start of care (SOC) 2-5-15, contained a document titled "Home Health Certification and Plan of Care" for the certification period 2-5 to 4-5-15. The plan of care (POC) failed to evidence the registered nurse had updated the plan of care to include pertinent secondary diagnoses of incontinence and asthma, the patient's nutritional requirements, allergies, mental state, treatments and orders for disciplines with frequencies, and goals/rehabilitation potential/discharge plan. The plan of care listed a nebulizer as durable medical equipment and patient medication profile included albuterol-ipratropium 2.5 mg-0.5 mg/3 mL inhalation solution twice a day (asthma medication).		and dually noted in the patient's chart and documented on an order to be signed by the physician. The RN Case Managers will be responsible for assuring all Care Plans are updated as needed. Missed visits will be documented in the clinical chart with physician notification in a timely manner. An order will be obtained for visits outside the stated frequency on the Plan of Care, including PRN visits. The Director of Nursing will be responsible for ongoing monitoring and maintaining compliance with this standard through daily Quality Assurance reviews. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on review of policy, observation, clinical record review, and interview, the agency failed to ensure the registered nurse coordinated services timely with other providers regarding patient's request for physical therapy for 1 of 1 (7) home visits where patient requested additional services. Findings include: 1. Agency policy "Care Planning Process", undated, copyright 2003 The Corridor Group, states "All clinicians will consider the conclusions of initial and ongoing assessments in their care planning process, included, but not	N 546	All skilled clinical staff have been inserviced on agency policy for Coordination of Care. The mandatory inservice includes education on (1) recording all changes in condition immediately after being made aware of the change, (2) required actions to address with each patient within 24 hours of the change in condition is reported to the agency and (3) required notification to the agency Director of Nursing, the patient’s physician and other care providers immediately or within 24 hours after the agency is made aware of the patient’s change in condition. Agency has corrected this standard by implementing a	04/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	limited to: changes in patient condition ... patient treatment choices ... action to be taken to meet the patient goals ... " 2. During home visit observation on 3-13-15 at 10:15 AM, patient 7 indicated his legs felt heavy and that he had good results from physical therapy services in the past. He asked Employee D, the registered nurse, to refer him for physical therapy services. 3. Clinical record 7, start of care 2-24-15, contained a plan of care for the certification period 2-24 to 4-24-15 with diagnoses of atrial fibrillation, chronic kidney disease, and diabetes mellitus type 2. Orders included Skilled Nursing 2 times a week. The nursing visit note from 3-13-15 failed to evidence patient report of "heavy legs" and the patient's request for physical therapy services. Nursing visit notes from 3-13 and 3-17-15 failed to evidence care coordination with the attending physician or physical therapist regarding patient experiencing heaviness in the legs and patient's request for physical therapy services made on 3-13-15. 4. On 3-17-15 at 9:15 AM, request was made to the administrator for any documentation regarding the patient's request for physical therapy on 3-13-15.		daily reporting call for skilled staff members to provide report to their supervisor regarding the previous day’s visits. During this reporting call, the Case Managers are responsible for notifying the DON of adverse events with each patient including all reported changes in condition. Monitoring will be ongoing. The Director of Nursing is responsible for compliance with this standard 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	No further documentation was provided prior to exit.			
N 550 Bldg. 00	410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on policy review, clinical record review, and interview, the agency failed to ensure the registered nurse completed the home health aide care plan to include the required elements as per agency policy for 3 of 8 (3, 6, and 9) clinical records reviewed of patients receiving home health aide services. Findings include: 1. Agency policy "Home Health Aide Plan of Care", undated, copyright 2003 The Corridor Group, states, "The home health aide plan of care will be individualized to the specific patient and will include at least: type of services/procedures to be provided, frequency of visits, diagnosis/prognosis, if relevant to care, functional limitations, patient's mental status, activities permitted, nutritional requirements,	N 550	All Home Health Aide Care Plans now include Nutritional requirements. This data now flows directly from the patient assessment & populates onto the home health aide care plan. All Case Managers were in-serviced on the requirements of supervising home health aides. All active patients have been reviewed for scheduled home health aide supervisory visits. Upcoming supervisory visits will be reported during the daily morning meeting. Monitoring will be ongoing. The Director of Nursing will be responsible for compliance with this standard. 	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	specific procedure to be performed, including amount, frequency, and duration, safety measures, including use of specific equipment, instructions for completion of documentation, reporting changes, reporting changes in patient's condition and needs, allergies." 2. Clinical record 3, start of care (SOC) 9-5-13, contained a plan of care (POC) for the certification period 6-17 to 8-15-14. POC orders included low calorie ADA diet, skilled nursing 1 time a month for 2 months and home health aide services (HHA) 4 hours a day, 7 days a week for 9 weeks. The home health aide plan of care dated 6-17-14 for HHA duties included meal set up every visit. The HHA care plan failed to evidence nutritional requirements of the patient. Patient was discharged 7-3-14. 3. Clinical record 6, SOC 1-10-14, contained a POC for the certification period 1-5 to 3-5-15. POC orders included low fat, low cholesterol, low sodium diet, skilled nursing every 2 weeks,and home health aide services (HHA) 8 hours a day, 7 days a week for 9 weeks. The home health aide plan of care dated 1-5-15 for HHA duties included meal set up every visit. The HHA care plan failed to evidence nutritional requirements of the patient.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. Clinical record 9, SOC 1-10-14, contained a POC for the certification period 1-9 to 3-9-15. POC orders included regular diet, physical therapy 1 time a week until 1-25-15, then 2 times a week for 9 weeks, and home health aide services (HHA) 3 hours a visit, 2 days a week for 1 week, then 3 hours a day 7 days a week for 8 weeks. The HHA care plan failed to evidence nutritional requirements of the patient. 5. The administrator indicated on 3-17-15 at 10:45 AM the HHA care plans did not include the required elements per agency policy.			
N 596 Bldg. 00	410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on review of policy, job description review, review of personnel files, and interview, the administrator failed to ensure 3 of 4 Home Health Aides (HHA) (J, M, N) whose files had been reviewed had complete competency skills evaluations in their personnel files. Finding include: 1. Agency policy "Categories/Qualification of Personnel", undated, copyright 2003 The Corridor Group, states under competency, "Home Health Aide: Individuals must demonstrate their competency, within orientation, according to the orientation checklist and the activities delineated in the CMS (Centers for Medicare and Medicaid Services) competency testing." 2. Agency job description for HHA, copyright The Corridor Group, Inc., 2003, states the position qualifications for HHA include "meets the requirements in accordance with state and federal law" ... responsibilities include "baths ... oral hygiene, ... skin care to prevent breakdown ... shampoos ... assisting the patient with toileting activities ... planning and preparing nutritious meals ... taking and recording oral, rectal, and axillary temperatures, pulse respiration	N 596	A contractor will be utilized to conduct Home Health Aide competency evaluations through March 16, 2017. All newly hired Home Health Aides will have a complete competency evaluations before providing care to agency patients. All current staff members have been skills checked and competency tested. A revision to the agency policy has been implemented and states that all patient care employees will be skills checked and competency tested in the required areas prior to being assigned a patient so that the patient will receive the safe, appropriate care. Agency will continue to use the skills check form developed by the Indiana Association of Home and Hospice Care Inc. but will delineate between the required areas & areas that are not mandated. 	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and blood pressure when ordered (with appropriate completed / demonstrated skills competency) ... assisting in ambulation and exercise according to the plan of care ... performing range of motion ... assisting the patient in the self-administration of medication ... doing patient's laundry, as appropriate ... adhering to organizations documentation and care procedures and standards of personal and professional conduct ... " 3. HHA J, has a date of hire (doh) 2-11-15, and date of first patient contact 2-16-15. HHA J's personnel file contained a competency evaluation with Indiana Home and Hospice Care, Inc. in the upper left hand corner, dated 2-16-15. All competencies had been marked as completed 2-16-15. For mobility, the entries under the transfer skill are transfer assist, transfer with wheelchair, and transfer bed-to-chair, these 3 had not been checked as completed. For Personal Care-Oral, entries under dentures and gum care had not been checked as completed. For Bath, the entries under Tub and Sponge had not been checked as completed. For Shampoo-the entries under bed; sink; and bathtub had not been marked as completed. For Bodily functions, the the entries under toileting bathroom, bedpan, urinal, bedside commode, ex-dwelling catheter, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	catheter had not been checked. Employee J had not signed and dated the form. 5. HHA M, has a date of hire (doh) 10-17-14, and date of first patient contact 10-18-14. HHA M's personnel file contained a competency evaluation with Indiana Home and Hospice Care, Inc. in the upper left hand corner, dated 10-18-14. For mobility, the entries cane, walker, crutches had not been checked. For Bodily functions, the the entries under toileting bedpan, urinal, bedside commode, ex-dwelling catheter, and catheter had not been checked. For Fluid balance, intake or output, measurement, was marked as N/A. For medication assistance, competent client, mentally incompetent client, both had been marked N/A. 6. HHA N, has a date of hire (doh) 11-18-14, date of first patient contact 11-19-14. HHA N's personnel file contained a competency evaluation with Indiana Home and Hospice Care, Inc. in the upper left hand corner, dated 11-21-14. For mobility, the entry crutches had not been checked. For Personal care, bed bath had not been marked as completed. For Bodily functions, the entries under			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	toileting-ex-dwelling catheter and catheter had not been checked. 7. The Administrator, Employee A, indicated on 3-4-15 at 2:00 PM, the agency procedure is to have an RN competency HHA's during one patient care visit and that one patient would not present the opportunity to competency all the skills on the agency skills competency checklist.			
N 606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on policy review and clinical record review, the agency failed to ensure the clinician performing supervisory visits of the home health aide (HHA) reviewed and took corrective action indicated for the home health aide duties not performed for 1 of 4 (9) active clinical records reviewed of patients receiving skilled services and home	N 606	All Case Managers were in-serviced on the requirements of supervising home health aides. All active patients have been reviewed for scheduled home health aide supervisory visits. Upcoming supervisory visits will be reported during the daily morning meeting. Monitoring will be ongoing. The Director	05/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	health aide services and failed to ensure supervisory visits were made at least each 14 days for 1 of 6 patients receiving skilled services and home health aide services (4). Findings include: 1. Agency policy "Home Health Aide Supervisory Visits", undated, copyright 2003 The Corridor Group, states "The registered nurse and/or appropriate therapist will be responsible for: A. Supervision of all services provided for in the plan of care... C. Regular consultations with the HHA .. the frequency of supervisory visits will be based upon the needs of the patient after the plan of care is established. They must be conducted at least every two (2) weeks on skilled patients and at least every 30 days on patients only receiving Home Health Aide Services." 2. Clinical record 2, start of care (SOC) 2-5-15, on 3-9-15 contained a plan of care (POC) for certification period 2-5 to 4-5-15. The POC included orders for skilled nursing visits and home health aide services. A supervisory visit was made on 2-19-15. The clinical record failed to evidence another supervisory visit on or before 3-5-15 (14 days).		of Nursing will be responsible for compliance with this standard. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. Clinical record 9, SOC 11-10-14, contained a POC for the certification period 1-9 to 3-9-15. Orders included physical therapy (PT) 2 times a week starting 1-11-15 and home health aide (HHA) services. a. HHA care plan by the physical therapist (PT) dated 1-8-15 included assist with bathing (shower, partial bed bath, or assist with bath-chair), ambulation-assist with walker, assist with dressing, hair care, skin care, and medication reminders. b. HHA visit notes 1-9, 1-10, 1-13, 1-14, 1-20, 1-21, 1-22, 1-23, 1-26, 1-27, 1-28, 1-29, 1-30, 2-2, 2-3, 2-4, 2-5, and 2-6-15 failed to evidence skin care and medication reminder had been performed. c. PT supervisory visit notes on 1-14, 1-27, and 2-7-15 evaluated the HHA services under item 8 "follows client care plan" as "meets requirements."			
N 608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on policy review, clinical record review and interview, the agency failed to ensure the patient's clinical record contained a complete plan of care for 1 of 10 clinical records reviewed (2); failed to ensure the plan of care (POC) was timely signed by the attending physician for 3 of 10 plans of care reviewed (2, 4, and 5); failed to ensure the plan of care was transmitted to the attending physician for 3 of 10 plans of care reviewed (2, 4, and 5); failed to ensure a discharge summary was in the clinical record for 2 of 3 discharged patients (4 and 5) whose clinical records were reviewed; failed to ensure the clinical record contained all home health aide (HHA) visit notes for 2 of 8 records reviewed of patients receiving HHA services (8 and 9); and failed to ensure the clinical record contained a written order based on a verbal order received for 1 of 10 clinical	N 608	Each patient shall have a completed, current written Plan of Care that covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. All services rendered must be according to the written Plan of Care unless there has been verbal orders obtained. All verbal orders will be documented and sent to the physician for signature. New medications both prescribed and OTC including herbal remedies and specific nursing, therapy and home health aide orders for frequency and care to be	04/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	records reviewed (5). Findings include: 1. Agency policy "Care Planning Process", undated, copyright 2003 The Corridor Group, states, "A written plan of care will be initiated within five (5) days of start of care and updated every 60 days or as patient's condition warrants ... The clinical plan of care includes: pertinent primary and secondary diagnoses, food or drug allergies, homebound status, goals/outcomes to be achieved, patient's mental status, functional limitations, activities permitted, safety measures, nutritional requirements, medications and treatments, specific procedures to be performed by therapies, including amount, frequency, and duration, supplies and equipment required, discharge or referral plans, discharge teaching, frequency and duration of visits, prognosis, rehabilitation potential, other appropriate items such as precautions and contraindications." 2. Agency policy "Discharge Criteria and Process", undated, copyright 2003 The Corridor Group, states, "A discharge summary will be completed and filed in the clinical record ... "		provided. Should a sudden need arise for altering the present Plan of Care a Verbal Order will be obtained from the patient's physician and dually noted in the patient's chart and documented on an order to be signed by the physician. The RN Case Managers will be responsible for assuring all Care Plans are updated as needed. Missed visits will be documented in the clinical chart with physician notification in a timely manner. An order will be obtained for visits outside the stated frequency on the Plan of Care, including PRN visits. The Director of Nursing will be responsible for ongoing monitoring and maintaining compliance with this standard through daily Quality Assurance reviews. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3. Agency policy "Verification of Physician Orders", undated, copyright 2003 The Corridor Group, states, "A copy of the physician's ... order will be kept in the clinical record ... the original of the order form will be delivered to the physician ... for signature ... signed orders will be in the clinical record within 30 days of initiation of care or interim order, unless otherwise specified by applicable state law and regulation." 4. On 3-4-15 at 3:00 PM, clinical record 2, start of care (SOC) 2-5-15, contained a document in the electronic clinical record, Kantime, titled "Home Health Certification and Plan of Care" for the certification period 2-5 to 4-5-15. Field identifier 23 "Nurse's signature and date of verbal SOC, where applicable" was signed and dated 2-5-15 by registered nurse, Employee D. A nebulizer was identified as durable medical equipment. The plan of care (POC) failed to evidence pertinent secondary diagnoses of incontinence and asthma, nutritional requirements, allergies, mental state, treatments and orders for disciplines, and goals/rehabilitation potential/discharge plan." Field identifier 10"Medications" included albuterol-ipratropium 2.5 mg-0.5 mg/3 mL inhalation solution twice a day (asthma medication).			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5. On 3-4-15 at 3:00 PM, clinical record 2, start of care (SOC) 2-5-15, contained a comprehensive assessment dated 2-5-15 at 2:30 PM, completed by Employee D, registered nurse, that identified the patient had daily urinary incontinence both day and night. The medication profile dated 2-5-15 included albuterol-ipratropium 2.5 mg-0.5 mg/3 mL inhalation solution twice a day (asthma medication). A. On 3-4-15 at 3:00 PM, Employee F, client experience advocate, reviewed the electronic plan of care for clinical record 2 with the surveyor and indicated he could not locate a complete POC in the electronic clinical record. Employee F stated, "there isn't another plan of care in Kantime (electronic clinical record)." B. On 3-4-15 at 3:00 PM, clinical record 2 document ""Home Health Certification and Plan of Care" in field identifier 25 "Date HHA Received Signed POT" was entered the date 2-27-15. 6. Clinical record 4, SOC 11-18-14, contained a POC for certification period 11-18-14 to 1-16-15. By physician order services were placed on hold on 1-11-15. The clinical record failed to evidence the plan of care had been transmitted to the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attending physician for signature. The clinical record failed to evidence a discharge summary. 7. Clinical record 5, start of care 11-18-14, contained a POC for the certification period 11-18-14 to 1-16-15. The verbal order dated 11-18-14 in identifier field 23 of the POC was not signed by the registered nurse, Employee U. The clinical record failed to evidence a written order signed and dated by the clinician taking the verbal order and the attending physician. The clinical record failed to evidence the plan of care had been transmitted to the attending physician. The POC failed to evidence notification to the attending physician regarding expiration of the certification period on 1-17-15. The clinical record failed to evidence the attending physician's signature on the POC. 8. On 3-10-15, 9:30 AM, a request was made to the administrator for any documentation notifying the attending physician of expiration of certification period and discharge of patient in clinical record 5. The administrator presented a "Care Coordination" document with the date 2-3-15 and "Foster Healthcare" in the upper left hand corner. The content was "Dear Dr. (name of attending physician): We are providing Home			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Healthcare services to (patient in clinical record 5) date of birth 2-28-1972. During a recent review of our records we discovered that she had a missed recertification on 1-15-2015 for SN (sic skilled nursing) every 2 weeks for medication set up and home health aide 7 hours daily. Due to the missed recertification we will conduct a paper discharge and readmission. You will be notified of the assessment findings and asked to collaborate on the development of the Plan of Care. The new Plan of Care will be sent to you for review and signature. If you have questions regarding this request please contact us at (agency phone number). Thank you, Foster Clinical Team (no signature)." On 3-10-15 at 9:32 AM, a request was made to the administrator for documentation of transmission to the attending physician of the "Care Coordination" memo dated 2-3-15 regarding patient in clinical record 5. At 9:40 AM, the administrator provided a document "Fax Transmission Results" with 2 entries. Both entries were dated 3-10-15. The first at 9:36 AM and second at 9:38 AM, result "success". He stated the document was generated in his computer and then sent by fax. 9. Clinical record 8, SOC 12-11-14,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	contained a POC in the electronic clinical record for the certification period 2-9- to 4-9-15 including orders for HHA services 4 hours a day, 6 days a week, for 8 weeks, then 4 hours a day for 5 days a week, for 1 week. The clinical record failed to evidence HHA visit notes from 2-9 to 2-28-15. After request for a copy of the POC and access to any HHA visit notes not yet in the clinical record, no further documentation was provided prior to exit. 10. Clinical record 9, SOC 11-10-14, contained a POC for the certification period 1-9 to 3-9-15 including HHA visits 3 hours a visit, 2 days a week for 1 week, then 3 hours a visit, 7 days a week for 8 weeks. The clinical record failed to evidence HHA visit notes from 2-7 to 2-23-15 (14 days prior to exit of survey). After request, no further documentation was provided prior to exit. 11. On 3-4-15 at 5:00 PM, the administrator indicated the agency considered patients in clinical records 4 and 5 as discharged on 1-17-15, at the end of their certification periods. On 3-16-15 at 2:30 PM, the administrator indicated most HHA visit notes were recorded by "telephony." He indicated telephony is a system where the HHA calls in care codes which are then			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157638	A. BUILDING 00 B. WING	03/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOSTER HEALTHCARE	445 GRADLE DRIVE CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	converted to a PDF document for the electronic or paper clinical record. The administrator indicated the new electronic clinical record system has been labor intensive to implement and there is a backlog of HHA visit notes in telephony (including clinical records 8 and 9) waiting to be converted to PDF format for the electronic clinical record. The administrator stated he would provide the HHA visit notes prior to exit. The administrator could not explain the discrepancy in the communication note dated 2-3-15 for clinical record 5, which was transmitted on 3-10-15.			