PRINTED: 01/04/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING			1	C 20/2020
	ROVIDER OR SUPPLIER	E SERVICES, LLC		52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 IDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 000	INITIAL COMMENTS		G	000			
	re-licensure survey, at (2) complaints. This was a fully extension of Survey began on survey was interrupted suspension of survey survey resumed on O November 2, 5, 9, 10, year 2020. Facility number: 0142 Provider number: 15k Current census: 23 Record review with he Record review without Total records reviewed Apple tree Home Heat precluded from provided training and comfor a period of 2 years 2020 to November 20 of compliance with the 42 CFR 484.50 Paties Comprehensive Assectare planning, coordid 484.65 Quality assessed.	ntiated with findings ntiated with findings March 11, 13, and 16. The d due to COVID-19 and activity per CMS. The ctober 27, 28, 29, 30, 12, 16, 17, 18, 20 of the 207 (164 Ome visits: 3 It home visits: 7 d: 10 Alth Care Services, LLC is ling its own home health petency evaluation program is beginning November 20, 1, 2022 for being found out the Conditions of Participation int Rights, 484.55 ssment of Patients, 484.60 nation, quality of care, sment and performance					
		Infection Prevention and anization and Administration 110 Clinical Records.					

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

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING				20/2020
	ROVIDER OR SUPPLIER	E SERVICES, LLC		5	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220	1 102	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 000		flects State Findings cited in IAC 17. Refer to the State	G	000			
G 374	Accuracy of encoded CFR(s): 484.45(b) Standard: The encod accurately reflect the of assessment. This STANDARD is a Based on record revergistered nurse (RN and assessment inforquestions were answactive records review Findings include: 1. The clinical record on 10/28/20 and indicated a diagnosis orders for skilled nurse medication set up, he to supervise the aides (HHA) 3 hours per dapersonal activities of instrumental activities	ed OASIS data must patient's status at the time not met as evidenced by: iew and interview, the failed to ensure outcome mation set (OASIS) ered accurately for 2 of 5 ed (#2, 3). I of patient #2 was reviewed cated a start of care date of contained a plan of care for d of 8/27/20-10/25/20 which of anoxic brain injury and sing (SN) 1 time per week for ead to toe assessment, and is, and home health aide by for 7 days a week for	G	374			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020	
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP O 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	CODE	11/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 374	During a home visit of spouse of patient #2 in the apartment, that due to his brain injury. A start of care compression completed on 8/27/20 indicated on question lives with other personant with the pers	en 10/29/20 at 11:00 AM, the indicated they lived together the required 24 hour care //. ehensive assessment was 0 by the director of nursing 1 M1100 that the "patient on(s) in the home," with "09" led "occasional," when "06" larked to indicate "around the 1001 indicated "No issues lew," but should have been und during review."	G	374			
	well as multiple mode Drugs.com Major inte "Highly clinically sign the risk of the interact 2. The clinical record on 10/28/20 and indic 5/14/20. The record the certification perior indicated the patient (causes pain, stiffnest tendons and joints), the limited to, tramadol a medication used for esubcutaneous." A recertification completed on 9/15/20 about the patients parts.	erate interactions. The eraction definition stated ificant. Avoid combinations; tion outweighs the benefit." If of patient #3 was reviewed cated a start of care date of contained a plan of care for d of 9/18/20-11/16/20 which had a diagnosis of lupus is, and swelling of muscles, the medications, but not					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 20.25			c
		15K164	B. WING		11/	20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		
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G 374	typically has pain. "Nability to prepare and injectable medication medications prescribed." 3. During an interviet the alternate administ nursing was responsifor accuracy and she Patient rights CFR(s): 484.50 Condition of participate The patient and representations of the patient and representations are presented to be informed to language and manner.	akes tramadol pain y and a diagnosis that //2030 about the patient's take all prescribed as "N/A-No injectable ed." w on 10/26/20 at 1:35 PM, trator stated the director of ible for reviewing the records also reviewed them. tion: Patient rights. esentative (if any), have the of the patient's rights in a or the individual understands.	G 37			
	of these rights. This CONDITION is Based on observation interview the agency were provided privacy rights information, information for the start required, access to a notice, and adequate practices impacted all. The cumulative effect resulted in the agency patients rights were proposed on the control of the start required.	ecord, correct contact ate and funded programs uxiliary aides, discharge discharge notice. These Il patients. t of these systemic problems				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
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(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
G 406	assessment inform notice was given to OASIS assessmen. The agency failed the patient's rights and the patient'caregiver folder, to be review patient/caregiver by 422). The agency failed the notified of their right record and failed to a confidential clinic G 438). The agency failed the advised or ally and thome care service Tag G440). The agency failed the with regulatory required.	o ensure an Outcome and ation set (OASIS) privacy all patients who received an a (See Tag G 416). o ensure a written copy of the responsibilities were given to er and maintained in the home ed periodically with the vagency staff (See Tag G o ensure all patients were at to a confidential clinical ensure that every patient had all record maintained (See Tag o ensure all patients were n writing of the charges for before care is initiated (See	G 40	·	
	correct hours of op-	o advise that patients of the eration for the Indiana Ith (See Tag G444).			
	addresses, and tele following federally-tentities that serve t to include the follow for Independent Liv	o provide the names, ephone numbers of the funded and state-funded the patients' area of residence, ving: Agency on Aging, Centering, Protection and Advocacy Disability Resource Center,			

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G 406	Tag G446). The agency failed to informed of access to	e 5 covernment Organization (See ensure patients were co auxiliary aids and language access them (See Tag	G	406			
G 416	The agency failed to		G	416			
	whom the OASIS da This ELEMENT is no Based on observation interview the agency and assessment info	ot met as evidenced by: on, and record review, and failed to ensure an Outcome rmation set (OASIS) privacy all patients who received an or 3 of 3 home visit					
	Bill of Rights," Policy INSTRUCTIONS C informed of their righ confidentiality related						
	10/26/20 at 2:40 PM, OASIS privacy practi	n packet was reviewed on , and failed to evidence an ice notice.					

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
						С	
		15K164	B. WING _		11.	/20/2020	
NAME OF PROVIDER OR APPLE TREE HOME		E SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
employe 10/29/20 7/11/17). folder wa OASIS p 4. A hon employe with pativisit, the failed to notice. 5. A hon employe 10/29/20 care 5/14 folder wa OASIS p 6. Durin administi an OASI Written r CFR(s): Provide v responsi transfer a paragrap represen evaluatio This ELE Based o interview copy of t	at 8:00 AM, During the vast viewed and vivacy praction of the visit observed and vivacy practice of the visit observed and visit observed and vivacy practice of the visit observed at 12:40 PM (4/20). During as viewed and vivacy practice of the visit observed and vivacy practice of the visit observed and vivacy practice of the visit of the visit of the visit. EMENT is not on observation of the agency the patent's risk viewed and vivacy practice of the visit.	ealth aide (HHA), on with patient #1 (start of care isit, the patient's home defailed to evidence an expension of the visit, the patient's home defailed to evidence and expension was conducted with on 10/29/20 at 11:00 AM, of care 8/27/20). During the ne folder was viewed and OASIS privacy practice expension was conducted with of nursing (DON), on the visit, the patient's home defailed to evidence and the notice.		422			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING				20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		5	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 422	staff, for 2 of 3 home Findings include: 1. An undated agence Bill of Rights," Policy Clients and their reproof their rights as a conservices prior to the selection of their rights as a conservices prior to the selection of the instructions: 1. A desing nurse/therapist shall priority written notice of the hadvance of furnishing the initial evaluation vinitiated" 2. A blank admission 10/26/20 at 2:40 PM, patient right and respection of the patient	exitient/caregiver by agency visit observations (#2, 3). Exy policy titled "Home Care #C-380 stated "Policy: esentatives will be informed insumer of home care start of care Special ignated registered provide the client with a some care bill of rights in a care to the client or during visit before treatment is Expacket was reviewed on and failed to evidence onsibility information. Expacket was conducted with on 10/29/20 at 11:00 AM, for care 8/27/20). During the me folder was viewed and y patient right and tion. Expacket was conducted with of nursing (DON), on l, with patient 1 (start of care visit, the patient's home difficulty information. Expanditure of the care of the patient's home of the patient's home difficulty information. Expanditure of the care of the patient's difficulty of graphs of the patients o	G	422			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	RE SERVICES, LLC		52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220		20/2020
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G 422 G 438	Continued From page responsibilities. Have a confidential c CFR(s): 484.50(c)(6)	linical record		422 438			
	release of patient info is permitted in accord and 164. This ELEMENT is not Based on record rev agency failed to ensu- of their right to a conf failed to ensure that of confidential clinical re- partial or full missing	linical record. Access to or primation and clinical records dance with 45 CFR parts 160 of the met as evidenced by: iew and interview, the gree all patients were notified fidential clinical record and every patient had a ecord maintained for 19 of 19 records (#4, 5, 20, 21, 22, 32, 34, 35, 36, 37, 39, 40,					
	Bill of Rights," Policy The agency will proclient's rights and results INSTRUCTIONS A nurse/therapist shall written notice of the hadvance of furnishing the initial evaluation vinitiated Clients/fartheir right to privacy apersonal health care and transmission (OAA) An undated agency precords/medical recostated "POLICY: A	policy titled "Clinical rd retention," Policy #C-870					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	DDE	20.2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
G 438	as confidential and users" 2. A required state alternate administration unduplicated censurements and a skilled properties of the pr	form was completed by the stor which indicated the s for the last 12 months was aide only, 3 personal service patients). Ince conference on 10/26/20 at late administrator was given a late administrator was given a late to a list included (but not latient census list, and a list of last since the last survey Inve census list revealed the last survey In the list included the last survey In the list revealed the last survey list revealed the last survey In the list revealed the last survey list reve	G 4	138		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		15K164	B. WING		C 11/20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC	5	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220	1.020.2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION
G 438	9. An email that wa administrator and e 7:59 PM, was review review document tit Q.A [quality assurar # 31, 32, 34, 35, 36 listed on the agency had a spot for "Y" fo stated "auditor signs certification period missing needs correhow corrected." 10. During record repatient #4 on 10/30 date of 4/22/20. The section of the hard with a start of care of certification period or record failed to evid the chart for that time. The alternate administrate the administrate whereabouts of at 1:20 PM. The alternate administrate whereabouts of the stated the administrate record prior to the compatient #5 on 10/30 date of 9/20/17 with 9/4/20-11/2/20. The medical record state 9/20/17. The "finance was supplied to the state of the state of the state of 9/20/17 with 9/4/20-11/2/20. The medical record state 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17. The "finance was supplied to the state of 9/20/17.	ses sent by person D to the imployee EE on 11/24/18 at wed and contained a quality led "285/certification review ince] chart," that listed patients and 37, 40, and 41 (none were by's census/discharge lists), for yes and "N" for no and leature: [employee EE] each inceds audited. Each item leated and a note made on eview of the clinical record for 1/20 indicated a start of care least page of the orders chart revealed a plan of care leate of 8/24/18 with a lost 2/16/20-4/14/20. The lence any other documents in leaframe. Inistrator was questioned on the older record on 10/30/20 lernate administrator indicated in the office. Requested she trator to see if he knew the record. Six minutes later she later was looking for it. No urrent start of care was ever	G 438		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
G 438	of the medical record the patient on 6/17/1 beneficiary notice," v patient on 6/17/18. Tresponsibilities," was patient on 2/18/18. I discharge policy," was patient on 6/17/18. I discharge policy," was patient on 6/17/18. I disclosure of protected dated and signed by record failed to evide record from 9/20/17. The alternate adminiserating the missing at 2:00 PM. She standinistrator left the which were shredded office was moved fro Indianapolis some w gaps in services. 12. An interview was 11:17 AM and 11/10/#21. The patient standing the agency from appending the missing at 2:019-August 2019 a services. An email w which contained admicare, and assignment patient #21 while under the documents were which failed to be evon survey. 13. During an intervithe alternate administrecords were present records.	I was dated and signed by 8. The "home health was signed and dated by the The "client rights and dated and signed by the The "revised admission and as dated and signed by the The "consent for the use and ed health information, was the patient on 6/17/18. The ence any documents in the co 2/18/18. Strator was questioned g documentation on 10/30/20 ted when the previous re had been documents d, and indicated when the m Fort Wayne to ere found but there were s completed on 11/2/20 at 20 at 8:35 AM with patient ted they were a patient with	G 4	38	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SU COMPLE							
		15K164	B. WING			1	C 20/2020
	ROVIDER OR SUPPLIER	ı		5257 N TAC	ORESS, CITY, STATE, ZIP CODE OMA DR SUITE 4 OLIS, IN 46220	<u> 11/</u>	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 438	administrator had a secould bring them to the needed. During an interview of administrator was asswere in the office, he asked if there was a (per the alternate administrator was as were in the office, he asked if there was a (per the alternate administrator was then given that I know was then given then 123, 24, 25, 26, 28, 33 and 41 and asked if a had ever been patier none had ever been why the names of the documents retained a previous surveys, or stated patient #20 was that was my auntie." shown to him from the Health database from the chosen sample of the state of the sample of the state of the sample of the samp	storage in Fort Wayne, but he he office if they were on 11/5/20 at 9:19 AM, the ked if all agency records stated "yes." He was then storage facility in Fort Wayne ministrator). He stated the his garage. He was asked if any records there which he ow of." The administrator ames of patients #20, 21, 22, 1, 32, 34, 35, 36, 37, 39, 40, any of those patients were or not so of the agency. He stated patients. When questioned be patients were found on from previous employees, billing the administrator as "never a client because The clinical record was the last survey as a part of for patients reviewed. After	G 4	338			
	that patient #21 was member and had bee indicated he did not I were. Then changed could be records in hoconfident he was that garage he stated "I a could be" due to box he moved. When as and confidential the interest in the state of the st	specific patients he indicated a family member of a board en a previous patient, but know where the records this answer by stating there has garage. When asked how to their were records in the law very confident that there es in the garage from when ked how secure, protected records would be from family, he indicated they would be ected.					

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	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODI 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	'	20.2020
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G 438	Continued From pag		G 4	138		
G 440	410 IAC 17-12-3 (2) Payment from federa CFR(s): 484.50(c)(7	ally funded programs	G 4	140		
	may be expected from any other federally-fixed known to the HHA, (ii) The charges for some covered by Medicard federally-funded or fixed the HHA, (iii) The charges the before care is initiated (iv) Any changes in accordance with paraccordance in the patient notice 411.408(d)(2) and 42. This ELEMENT is in Based on observation agency failed to ensorally and in writing service before care records reviewed, in 4, 5, 8, 9, 29). Findings include: 1. An undated agent admission process," "SPECIAL INSTRUMAS then financial at	ch payment for HHA services om Medicare, Medicaid, or unded or federal aid program services that may not be e. Medicaid, or any other ederal aid program known to individual may have to pay ed; and the information provided in agraph (c)(7) of this section in the HHA must advise the intative (if any), of these possible, in advance of the sit. The HHA must comply the requirements at 42 CFR				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		1/20/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
G 440	g. Advise the client the charges and billing extent possible, the acoverage, the client/and other methods of concept of assignment for payments received company for the age be informed of any prelated to the care 2. The clinical record on 10/27/20 and indited 7/11/17. The record "Financial responsibility benefits for insurance dated and signed by of nursing on 6/13/18"Please check the rates as they apply check which services and space to write in The document had may going to receive skill aide services, but fait for services. During a home visit of 10/29/20 at 8:00 AM evidenced in the patt group home. 3. The clinical record "Apple tree home he stated"Apple tree	admission professional will: t/caregiver/representative of ang procedures and, to the anticipated insurance caregiver financial liability, if payment. h. Explain the ant of benefits and the liability and from the insurance incy's services. Clients will cossible financial obligations	G 4					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		15K164	B. WING			C 1/20/2020		
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	•	172072020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE		
G 440	4. The clinical reco on 10/30/20 and ind 4/22/20. The recon "Apple tree home h stated "Apple tree supplies benefit cov" The document from patient/caregiv 5. The clinical reco on 10/30/20 and ind 9/20/17. The recon "Financial responsii benefits for insuran dated and signed b document stated " services and enter space on the form t patient was going to cost for the service "NA[not applicable] words on the docur 6. The clinical reco on 11/2/20 and indi 7/18/19. The recon "Financial responsii benefits for insuran that failed to be signagency staff. The concect the following they apply" an "health aide with a reconstruction."	was signed on the bottom by ing only. ord of patient #4 was reviewed dicated a start of care date of d contained a document titled ealth care charges," which e Home Hewalth [sic] care verage will begin on 4/24/20 failed to evidence a signature ver or agency staff. ord of patient #5 was reviewed dicated a start of care date of d contained a document titled bility and assignment of ce and private pay clients," y the patient on 6/17/18. ThePlease check the following rates as they apply" then to check which services the o get and space to write in the after, which was blank and "written over some of the	G 44					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K164	B. WING				20/2020
	ROVIDER OR SUPPLIER	E SERVICES, LLC		5	STREET ADDRESS, CITY, STATE, ZIP CODE 1257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220	1102	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 440	"Financial responsibil benefits for insurance that was completely be "NA" written in the mifailed to be signed by staff. 8. The clinical record reviewed on 11/2/20 and date of 7/18/19. The manner of the signed by staff.	ontained a document titled ity and assignment of and private pay clients," blank with the exception of ddle of the document, it also the patient/family or agency	G	440			
G 442	CFR(s): 484.50(c)(8) Receive proper writte specific service being believes that the servicare; or in advance of terminating on-going comply with the requita 405.1200 through 4	n notice, in advance of a furnished, if the HHA ice may be non-covered if the HHA reducing or care. The HHA must also rements of 42 CFR 5.1204. It met as evidenced by: ew and interview, the re their policy correlated ements for discharge notice patients received a 15 day or 3 of 3 discharged records ample of 10 (# 8, 9, 29). Packet was reviewed on An agency policy revised insfer and discharge policy, above or other	G	442			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) IND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		, ,	(3) DATE SURVEY COMPLETED		
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	1	11720/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 442	transfer/discharge, I will keep me and or process and I will be as soon as applicable calendar days befor Apple tree will continue to provide services of 2. The agency discharged patients 17, 29, 30, 33, and 3 dates of discharge. 3. The entire clinical agency for patient # which indicated a stand unknown discharge record. The record on 11/2/20. The record care and discharge record. The record discharge notice was the periods extended the findings are as An agency safety ex 8/11/17 with referral care was completed outcome and assess (OASIS) was complored for the discharge record. The discharge record for the discharge record outcome and assess (OASIS) was complored for the discharge record.	understand that the agency my caregiver involved in the a provided with proper notice le, being at least (10) et the services are stopped nue, in good faith, to attempt during the (10) day period" narge list revealed the were # 8, 9, 13, 14, 15, 16, 38, but failed to evidence the laws reviewed on 11/2/20 eart of care date of 7/18/19, arge date. The record failed to egarding discharge (order, essment, notice to	G 4	42		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	l(X	(3) DATE SURVEY COMPLETED
		15K164	B. WING			C 11/20/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 442	Admission consents a completed with a star order was written on patient. A discharge completed on 12/6/19. 5. The clinical record reviewed on 11/2/20, care date of 7/18/19, date. The record faile regarding discharge (assessment, notice to 6. During an interview the alternate administ days notice of dischastated "At least 10." During an interview of alternate administrated discharged patients. listed. When queried didn't know when all discharged, but would information was submistate toll free HH tele CFR(s): 484.50(c)(9) Be advised of the statelephone hot line, its hours of operation, an receive complaints on	and plan of care was to for care date of 3/21/18. An 9/29/19 to discharge the OASIS assessment was 3. I of patient #29 was which indicated a start of and unknown discharge of to evidence anything forder, comprehensive or patient/caregiver). W on 10/26/20 at 1:35 PM, trator was asked how many rige patients receive. She In 10/30/20 at 9:15 AM, the for submitted the list of the No discharge dates were about this, she stated she the patients were ditry to find out. No further nitted for review.	G 4			
	Based on record rev agency failed to advis	ot met as evidenced by: iew and interview, the se that patients of the correct the Indiana Department of d all patients.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		15K164	B. WING _				C 20/2020
	ROVIDER OR SUPPLIER REE HOME HEALTH CAR	RE SERVICES, LLC	•	STREET ADDRESS, C 5257 N TACOMA DR INDIANAPOLIS, IN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 444	Continued From page	÷ 19	G 4	.44			
G 446	10/26/20 at 2:40 PM. the admission packet start of care by an agand the patient or aut stated "Home health 1-800-227-6334 24 hr. The hours of operation represented for the line (8:15 AM-4:45 PM). During an interview of alternate administrate that the hours of oper would get it updated. IAC 410 17-12-13(b)(Contact info Federal/SCFR(s): 484.50(c)(10) Be advised of the nartelephone numbers of Federally-funded and serve the area where (i) Agency on Aging (ii) Center for Indeper (iii) Protection and Ad (iv) Aging and Disabil (v) Quality Improvement This ELEMENT is no Based on record reviagency failed to proviand telephone number federally-funded and sederally-funded and s	cours day, 7 days a week" In failed to be accurately adiana Department of Health In 10/26/20 at 2:40 PM, the constated she was not aware ration were incorrect and she In (2)(c) State-funded entities In (i,ii,iii,iv,v) In mes, addresses, and of the following distate-funded entities that the patient resides: Indent Living divocacy Agency, lity Resource Center; and ent Organization. In the total met as evidenced by: In item as evidenced by: Item as evidenced by: Item and interview, the ide the names, addresses,	G	.46			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15K164	B. WING _			l	20/ 2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		525	REET ADDRESS, CITY, STATE, ZIP CODE 57 N TACOMA DR SUITE 4 DIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·			(X5) COMPLETION DATE
G 446	Continued From pag		G 4	146			
	Independent Living, I Agency, Aging and D	ey on Aging, Center for Protection and Advocacy Disability Resource Center, ovement Organization. This patients.					
	Findings include:						
	alternate administrate provided services to counties in Indiana: A Hancock, Marion, He A blank admission pa 10/26/20 at 2:40 PM. admission folder, corphone numbers (no a fire department, polichospitals. Communit were the Indiana Hor Indiana, the Indiana County Adult Protect Department of Child evidence the phone of the Center for Independications of County Resource Resource Resource Resource Resource Resource R	ty resource numbers listed me and Aging for northeast Department of Health, Allen ive Services, and Indiana Services. The list failed to numbers or addresses for endent Living, Aging and Center, and the Quality zation as well as addresses					
	alternate administrate one admission packet areas they serve. St Indianapolis (where the and a Fort Wayne ad patients are located).	on 10/26/20 at 3:52 PM, the or was asked if there was et or more than one for the ne indicated there was an the agency is now located) lmit packet (where the . She stated the only folders was a list of local					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
							0
		15K164	B. WING _			11/2	20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
G 446 G 450	During that time, she entities contact inform Access to auxiliary ai	ncy numbers that are ng else was the same. was notified of the missing nation. ds and language service		446 450			
	and language services (f) of this section, and services. This ELEMENT is not Based on observation interview, the agency were informed of accolanguage services, at This practice impacted. A blank admission particle impacted in the practice impacted in the practice impacted in the practice impacted. A blank admission particle impacted in the practice	ght to access auxiliary aids es as described in paragraph d how to access these of met as evidenced by: on, record review and of failed to ensure patients ess to auxiliary aids and not how to access them. Ed all patients. Cacket was reviewed on The admission packet formation for patients auxiliary aids and language Cons were completed on with patient #1 and 19/20 at 11:00 AM with patient #0, and on 10/29/20 at 12:40 and employee C. During the land they failed to evidence and they failed to evidence and they failed to evidence and consistency at 3:34 PM, the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15K164	B. WING				20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220		20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 450	Continued From page regarding auxiliary air admission paperwork available to the patier admission at no cost Document complaint	des was added to the and would be made nt within 24 hours of to the patient.		450 484			
	CFR(s): 484.50(e)(1) (ii) Document both th and the resolution of This ELEMENT is not Based on record revagency failed to ensure	e existence of the complaint the complaint; and of met as evidenced by: iew and interview, the ire all complaints with umented. This practice had					
	An undated agency promplaint/grievance promplaints will be docomplaint form and firm an administrative file. Review of the agency 10:32 AM, revealed a #30 dated 2/24/20, an administrator on 2/25 alternate administrator complaint log. She in complaints since she	cumented on a client led with the complaint log in" / complaint log on 3/12/20 at a complaint regarding patient and signed by the alternate					
	disappeared with ma Review of the agency at 10:40 AM, revealed	ne previous log was as it had nagement changes. y complaint log on 10/27/20 d an empty complaint log. At ed where the previously					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3) DATE SUR' COMPLETE	
		15K164	B. WING _		C 11/20/2	2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/20/2	1020
APPLE TR	REE HOME HEALTH CAR	RE SERVICES. LLC		5257 N TACOMA DR SUITE 4		
				INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CC	(X5) DMPLETION DATE
G 484	viewed complaint was indicated "we did log since the agency move that time she was not complaints, grievance and staff must be loggethoroughly. She ackreinformation by stating indicated she found it. During an interview of administrator was ask or investigated any conever have." Then in that he had received father of patient #30. stated that was the copy of in March. The was responsible for complete must be employed with the again log with several complete must be employed with the again log with several complete must be employed. Comprehensive Assecting Condition of participal assessment of patient Each patient must reconstruction. For Medium the must reconstruct werify the patient home health benefit in both at the time of the	s, the alternate administrator it, I have to find it" and that wed she could not find it. At iffed of the concern that all es from patients, families ged and investigated nowledged receipt of the low." Prior to exit she on her laptop. In 11/5/20 at 3:00 PM, the ked if he had ever received omplaints, he stated "No, dicated that was incorrect a call one time from the The alternate administrator omplaint that she made a e administrator stated he omplaints. In 11/9/20 at 4:56 PM, stated when they were ency, there was a complaint olaints logged in it. It is series of Patients Series of the concern that all each in the		510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _		C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	,	1723/2320
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 510	Based on observation interview, the register ensure all compone comprehensive assorting the comprehensive assorting the cumulative efferesulted in the home ensure the provision safe environment for Participation 42 CFI Assessment of Patie Findings include: The RN failed to ensusessment reflected psychosocial, function (See Tag G 528). The RN failed to ensusessment contain care preferences, and demonstrate progregoals identified by the outcomes identified 530). The RN failed to ensusessment contain patient's medical, not and discharge plant. The RN failed to ensusessment contain patient's primary care their willingness and thei	s not met as evidenced by: on, record review, and ered nurse (RN) failed to nts were present on the essment. ct of these systemic problems e health agency's inability to n of quality health care in a r the Condition of R 484.55 Comprehensive	G 5	10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7 50.25			С	
		15K164	B. WING _			11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	ΣΕ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
G 510	assessment with upd (See Tag G 544). The RN failed to ensu	ate the comprehensive ated and revised information	G s	510			
G 528		period (See Tag G 546).	G s	528			
	Based on observation interview, the register ensure the comprehent the patient's current had functional, and cognitional the patient's current had been supported by the patient had been supported by the p	tive status; of met as evidenced by: n, record review and red nurse (RN) failed to ensive assessment reflected nealth psychosocial, tive status for 8 of 8 iewed, in a sample of 10					
	C-145 stated "POLIC visit must be held eith or within 48 hours of The assessment iden possible barriers to cl goals including prese PURPOSE: To deterr treatment, and service needs and his/her che data about the client's functional and psycholand their needs as appropriate the state of the control of the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand their needs as appropriate the client's functional and psycholand the client's functional an	nt assessment," Policy# Y: The initial assessment her within 48 hours of referral the client's return home tifies facilitating factors and lient reaching his or her					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		15K164	B. WING		C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11120/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
G 528	needs SPECIAL II comprehensive assereflect the client's staminimum, the following current health status status" 2. The clinical record on 10/27/20 and indited 7/11/17. The record the certification period which indicated orded time per week for meassessment, and to home health aide (H days a week for personal (IADL), around the comprehension, set up a light housekeeping. diagnoses of benign lower urinary tract sy type 2 diabetes, and paralysis (failed to esummary indicated to see the status of the comprehension of the c	and discharge planning NSTRUCTIONS The essment must accurately atus, and must include at a ing information: The client's a assess the functional d of patient #1 was reviewed feated a start of care date of contained a plan of care for od of 10/23/20-12/21/20 ers for skilled nursing (SN) 1 edication set up, head to toe supervise the aides, and HA) 12 hours per day for 7 conal activities of daily living activities of daily living lock supervision, meal assist, bathing, dressing, and Furthermore, it indicated prostatic hyperplasia with comptoms, hyperlipidemia, and a functional limitation of vidence to what area). The the patient had a previous continued.	G 5	,		
	limited to, calcium w divalproex (common mental illness disord constipation), fluticas allergies), levothyrox dysfunction), loratad quetiapine (used for bipolar and schizoph depression), and acc	ere medications, but not ith vitamin D (supplement), ly used for seizures or ers), docusate (for sone nasal spray (used for				

AND BLAN OF CORRECTION INDESTRUCTION NUMBERS		` ′	PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	1 1	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
G 528	by the end of the ca [neurological] status and free from S&S [complications or furt will be free from falls client will be free from falls client will be free from S&S [s.00 AM, patient #1 paralysis of upper a lived in a group hom available, and the ust the bathroom. An agency aide care "encourage to wear A recertification com completed on 10/22 The assessment stat traumatic brain injur headaches." The ast traumatic brain injur headaches. The ast traumatic brain injur headaches and the cardiac section weights," stated the processional headach sounds, stated the processional headach sounds are processional headach sounds.	client will verbalize oper use of pain medication re period. Neuro will be within normal limits signs and symptoms] of ther deterioration. The client of during the care period. The minjury during care period." completed on 10/29/20 at was observed having left side and lower extremities, patient the with staff there and see of a toilet riser when using	G 5	28		

PRINTED: 01/04/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K164	B. WING				20/2020
	ROVIDER OR SUPPLIER	E SERVICES, LLC	1	52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220	1 102	20/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 528	section regarding the needed from the hom and for what), and de information about oxy 3. The clinical record on 10/28/20 and indic 8/27/20. The record of the certification period indicated orders for signer week for medicatic assessment, and to shome health aide (Hidays a week for perso (ADL), instrumental a (IADL), meal preparated dressing, and light how the consent form on indicated "the anticipal care services and free skilled nursing 1 hour hours a day, and waits A office visit encounted physician dated 8/14/diagnoses of COPD (pulmonary disease), I hypercholesterolemia infarction, history of riarthritis, arthritis, and During an interview of spouse of patient #2 spacemaker/defibrillated.	ne date was listed on n), and an incomplete care and/or teaching e health agency (SN or HHA tailed no lung sounds or gen use. of patient #2 was reviewed cated a start of care date of contained a plan of care for d of 8/27/20-10/25/20 which killed nursing (SN) 1 time on set up, head to toe upervise the aides, and liA) 3 hours per day for 7 conal activities of daily living ctivities of daily living ctivities of daily living tion, set up assist, bathing, usekeeping. admission, dated 8/27/20 ated apple tree home health quency to be provided," was weekly, home health aide 2 yer 3 times a week. For from the patient's 20 indicated the patient had chronic obstructive mypertension, history of history of myocardial ght hand fracture, gouty compression fractures.	G	528			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K164	B. WING		C 11/20/2020	
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
G 528	completed on 10/25. The assessment state "skilled intervention evidence what was "community resourceare," was marked what was needed. patient's pacemake patient had no teeth nutritional assessment as a high nutrition diet order (left blank assess client filling client is preparing compatient had "anoxic" 4. The clinical recordent on 10/28/20 and incompleted on 9/15/20 and incompleted on 9/15/20. The recordent recordent indicated the medical "toujeo [injectable in 300/10 units daily some severy other wassessment, and ai supervision as well week for personal cambulation, meal proposed in the completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to, iron doubypass status for other completed on 9/15/20 and indicated not limited to iron doubypass status for other completed on 9/15/20 and iron doubypass	is/20 by the director of nursing. ated, "conclusions" were needed," but failed to needed for the patient also be info needed to manage "yes" but failed to evidence It failed to evidence the r/defibrillator, stated the n, but then failed to complete a ent (to determine if the patient all risk) and failed to identify a k), and indicated the "SN to medication box to determine if orrectly," but stated the brain damage." It dof patient #3 was reviewed dicated a start of care date of d contained a plan of care for od of 9/18/20-11/16/20 which ation, but not limited to, nedication used for diabetes] ubcutaneous," a diet order of et," diagnoses of lupus, type II sion, orders for a registered week for med set up, de and skilled nurse as HHA 3 hours, 5 days per are, range of motion,	G 52	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		,	C 11/20/2020	
	ROVIDER OR SUPPLIER	CARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP C 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	•	11/23/2023	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
G 528	(she lives by herse and takes 3 or mo counter medication an additional 5 por assessment was in patient has diabet surgery, all which. The assessment at taken, respiratory limits," but failed to documenting shore 20 feet or climbing system is "WNL" to with diet, but listed to injectable diabet the plan of care) and There was no bloof from the last week determine if the paradminister the injectable diabet to take a randuring the recertificardiovascular and documented as ""findings the presefrequency, urgence pain (just as an exassessed). The normal "WNL" but the pat surgery (listed on assessed nutrition eats alone most of and would give the nutritional assistates the patient."	eats alone most of the time elf and would give her 5 points), re prescribed or over the ins daily which would give her ints), thus the nutritional incorrect. Furthermore, the es, and had a gastric bypass would affect nutritional status. Also failed to have vital signs stated "WNL(within normal to have lung sounds despite thess of breath "when walking gratins," stated endocrine but was a diabetic managed did diet as "regular" (incorrect due interned was able to use glucometer. And sugar ranges documented to or other time period, failed to entient was able to prep and entable diabetic medication and indom or fasting blood sugar cation assessment. The did urinary systems were work work as were work was a history of bariatric start of care assessment), all risk as a "0" but the patient of the time (she lives by herself or 5 points), and takes 3 or more of the counter medications daily ther an additional 5 points), thus the patient was on a regular diet, but in pated diabetes was managed.	G	528			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K164	B. WING			C		
	ROVIDER OR SUPPLIER	1	B. WING	STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	I	11/20/2020		
(X4) ID PREFIX TAG	(ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
G 528	with diet (diabetic pa and modified diet). strengths were left b 5. The clinical record on 10/30/20 and indi 4/22/20. The record the certification period indicated SN orders supervisory visits an and HHA orders for sweek to assist with Adisease process." A comprehensive readocumented on 10/2 nursing (DON). The evidence any vital significance and the patient palsy," Und the pt has dysphasial listed as an area of contained no assess stated "WNL," in the intervention listed for daily/weekly weights evidence if it was to where it was document the patient had bowel movement was assessment). It indicates the patient had bowel movement was assessment). It indicates the patient had bowel movement was assessment). It indicates the patient had bowel movement was assessment). It indicates the patient had bowel movement was assessment). It indicates the patient had bowel movement was assessment). It indicates the patient had bowel movement was assessment). It indicates the patient had bowel movement was assessment). It indicates the patient had bowel movement was assessment). It indicates the patient had bowel movement was assessment). It indicates the patient had been added to the patient had bowel movement was assessment). It indicates the patient had been added to the patient had be	tients have to eat a balanced The psychosocial and client lank (not assessed). d of patient #4 was reviewed cated a start of care date of contained a plan of care for od of 8/24/20-10/22/20 which once per month for aide d head to toe assessment, hours per day, 5 days per LDL's, IADL's and "monitoring certification assessment was 2/20 by the director of assessment failed to gns were taken, no weight, osis of "spastic quadriplegic er the mouth section states hours per day, 5 days per certification assessment was 2/20 by the director of assessment failed to gns were taken, no weight, osis of "spastic quadriplegic er the mouth section states hours per day, only cardiac section there was an	G	528				
	last changed, who cl to be changed, flush take in food/fluids by	pe, or when the peg tube was nanged it, or when it was due orders, water bolus, ability to mouth even with peg tube. ed to evidence the patient						

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, Z 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	IP CODE	11/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICII	ACTION SHOULD BE TO THE APPROPRIA	DATE	
G 528	interview), stated in that the patient was to evidence any inforscoliosis, or other dia During an interview of mother of patient #4 stayed with grandmore every other weekend gastrostomy tube (G things by mouth such snacks and the aide taking things in orally the mother, a call was at 1:03 PM. She indigetube which all med through and that the managed it during the and aides were not from Getube had to be in gweight up to 70 lbs. surgery for Scoliosis the physicians would patient's weight had 70 pounds. A physician's "final redated 6/21/20 indicated 6/21/20 indicated for maling the feeding that state pump over 1 hour 4 required AFO's (ankled an outpatient vendor Additionally, it stated water needs but may with free water. [patient was discovered by the water. [patient was discovered by the water needs but may with free water. [patient was discovered by the water. [patient was discovered by the water needs but may with free water. [patient was discovered by the water. [patient was discovered by the water needs but may with free water. [patient was discovered by the water water. [patient was discovered by the water was di	cional risk (see family the diet recommendations on a "regular" diet, and failed rmation about the patient's agnoses per the physician. In 11/2/20 at 12:53 PM, the stated the patient currently other and came to her house of that the patient can has a stube), but can have small assists the patient when of the patient when of the patient had a lications and feeding go patient's grandfather e day due to being off work nelping with that. Stated the place to get the patient's The patient required a (curvature of the spine), but I not do the surgery until the reached and maintained at eport," from the hospital ted the patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been nutrition and failure to thrive. The patient had been not patient had been nutrition and failure to thrive. The patient had been not patient had been nutrition and failure to thrive.	G	528			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K164		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		15K164	B. WING		C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11720/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION	
G 528	affecting the brain w speech, language, s brain/spinal cord] hy to thrive, tetraplegic GER [gastroesophage 6. The clinical record on 10/30/20 and indig 9/20/17. The record the certification period indicated HHA order per week for personal light housekeeping, and indigen the period indicated past multimited to, arterioven stomach, bursitis of artery disease, COP vitamin D deficiency hyperlipidemia, microobesity, and unstable the comprehensive dated 9/3/20 failed to the comprehensive dated 9/3/20 failed	developmental birth defect hich causes delays in eizures, and problems with drocephalus, scoliosis, failure cerebral palsy, constipation, geal reflux] with vomiting." d of patient #5 was reviewed cated a start of care date of contained a plan of care for od of 9/4/20-11/2/20 which is for 2 hours per day, 4 days al care, meal preparation, and weight log at each visit. It deted 9/12/17 stated the edical history of, but not ous malformation of the the left shoulder, coronary D with asthma, deafness, hypertension, ocytic anemia, morbid	G 52	28		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP C 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	ODE	11720/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BI	DATE	
G 528	11/13/19, completed evidence the patient tones, edema, nutritirisk for skin breakdo functional status. 8. The clinical record on 11/2/20 and indictional and a discharge record contained a proceeding certification period of indicated orders for certification period for preparations, and light The comprehensive dated 11/14/19 failed current health psychologinitive status, as in the complete of th	d of patient #9 was reviewed ated a start of care date of 12/6/19. The olan of care for the f 11/14/19-1/12/20 which HHA 12 hours per day for the present date of personal care, meal	G	528			
	date of 7/18/19. The care for the certifical 11/16/19-1/14/20 wh 2 hours per day duri personal care, DME medications, but not constipation), polyet constipation), simvalevothyroxine (for the (for seizures of anxion insomnia or mental icomprehensive assecompleted by emplo	and indicated a start of care e record contained a plan of tion period of hich indicated orders for HHA and the certification period for of a left leg brace and limited to, docusate (for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
			7 50.25			С	
		15K164	B. WING			11/	20/2020
	ROVIDER OR SUPPLIER	E SERVICES, LLC		5257	EET ADDRESS, CITY, STATE, ZIP CODE N TACOMA DR SUITE 4 ANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 528	risk, risk for skin brearisk, diagnoses for the rationale for leg brace. 10. During an interviet the director of nursing comprehensive assess current health, psychologicognitive status, she	tional risk, hospitalization kdown, psychosocial, fall e above medications, e, and functional status. ew on 10/29/20 at 12:50 PM, g was asked if the patient's esment should contain the osocial, functional, and stated "yes."	G	528			
G 530	used to demonstrate toward achievement of patient and the measing by the HHA; This ELEMENT is not assed on record reviregistered nurse (RN) comprehensive assess patient's goals, and conformation to demon achievement of goals measurable outcome 8 of 8 complete record for 10 (1, 2, 3, 4, 5, 8, Findings include: 1. An undated agence "Comprehensive clier C-145 stated" PUF	as, goals, and care g information that may be the patient's progress of the goals identified by the urable outcomes identified at met as evidenced by: ew and interview, the large preferences, as well as strate progress toward identified by the patient and is identified by the agency for d reviews, in a total sample 9, 29).	G	530			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
		15K164	B. WING _			C 11/20/2020	
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COI 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
G 530	needs. To collect dhistory, physical, fur cognitive status and the home care setting medical, nursing, redischarge planning INSTRUCTIONS assessment must a status, and must independent of the care preferences 2. The clinical recoon 10/27/20 and independent of the certification period which indicated a prostatic hyperplasis symptoms and order time per week for massessment, and to home health aide (Hodays a week for per (ADL), instrumental (IADL), around the preparation, set up; light housekeeping. The recertification of dated on 10/22/20 figoals, and care predemonstrate progress.	ds and his/her changing ata about the client's health inctional and psychosocial and it their needs as appropriate to ing To identify clients shabilitative, social and needs SPECIAL. The comprehensive ccurately reflect the client's clude at a minimum, the inc The client's goals, and" In of patient #1 was reviewed dicated a start of care date of identificated a plan of care for iod of 10/23/20-12/21/20 frimary diagnosis of Benign a with lower urinary tract ers for skilled nursing (SN) 1 inedication set up, head to toe is supervise the aides, and indicated all plants of daily living activities of daily living activities of daily living activities of daily living activities of daily living clock supervision, meal assist, bathing, dressing, and semprehensive assessment failed to evidence the patient's ferences, information to its stoward achievement of the patient, or measurable	G	530			
	on 10/28/20 and inc	rd of patient #2 was reviewed dicated a start of care date of d contained a plan of care for					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMPLETED			
		15K164	B. WING		C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
G 530	which indicated order time per week for massessment, and to home health aide (H days a week for pers (ADL), instrumental (IADL), meal preparadressing, and light has a recertification common completed on 10/25, patient's goals, and to demonstrate proggoals identified by the outcomes identified 4. The clinical record on 10/28/20 and ind 5/14/20. The record the certification perior indicated orders for other week for mediand skilled nurse surbours, 5 days per week for mediand skilled nurse surbours, 6 days per week for mediand skilled nurse surbours, 6 days per week for mediand skilled nurse surbours, 6 days per week for mediand skilled	od of 10/26/20-12/24/20 ers for skilled nursing (SN) 1 edication set up, head to toe supervise the aides, and IHA) 3 hours per day for 7 sonal activities of daily living activities of daily living ation, set up assist, bathing, ousekeeping. The prehensive assessment was I/20 failed to evidence the care preferences, information ress toward achievement of the patient, or measurable by the agency. If of patient #3 was reviewed ficated a start of care date of I contained a plan of care for a registered nurse every set up, assessment, and aide pervision as well as HHA 3 eek for personal care, range	G 53	30	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	COMPLETED	
		15K164	B. WING			C 44/20/2020	
	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		I	11/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 530	indicated SN orders supervisory visits an and HHA orders for week to assist with A disease process." A comprehensive redocumented on 10/2 nursing (DON) failed goals, and care prefedemonstrate progres goals identified by thoutcomes identified outcomes identified of the certification periodicated HHA order per week for personal light housekeeping, and care prefedemonstrate progres goals identified by thoutcomes identif	once per month for aide d head to toe assessment, 9 hours per day, 5 days per ADL's, IADL's and "monitoring certification assessment was 12/20 by the director of 1 to evidence the patient's erences, information to 1 to evidence the patient of 1 to evidence, information to 1 to evidence, information to 1 to evidence, or measurable oby the agency. In or of 9/4/20-11/2/20 which is for 2 hours per day, 4 days 1 to 2 hours per day wist. In or of 9/4/20-11/2/20 which is for 2 hours per day each visit. In or of 9/4/20-11/2/20 which is for 2 hours per day during 2 to 3 hours per day during 2 to 4 for personal care, check 1 light housekeeping.	G 5	30			
		omprehensive assessment ed to evidence the patient's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		15K164	B. WING _			C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
G 530	Continued From pag	ge 39	G 5	30			
	achievement of goal measurable outcome. 8. The clinical record on 11/2/20 and indicated orders for certification period of indicated orders for certification period of preparations, and light of the comprehensive dated 11/14/19 faile strengths, goals, an information to demonstrate and the comprehensive dated 11/14/19 faile strengths, goals, an information to demonstrate outcome. 9. The clinical record reviewed on 11/2/20 date of 7/18/19. The care for the certification of the certification of the certification of dated 11/13/19, conto evidence the paticare preferences, in progress toward activities.	Instrate progress toward It is identified by the patient, or les identified by the agency. It dof patient #9 was reviewed lated a start of care date of large date of 12/6/19. The lolan of care for the lif 11/14/19-1/12/20 which HHA 12 hours per day for the lor personal care, meal light housekeeping. It is tart of care assessment lid evidence the patient's lid care preferences, linstrate progress toward lis identified by the patient, or les identified by the agency. It dof patient #29 was light and indicated a start of care les record contained a plan of					
		riew on 10/29/20 at 12:50 PM, ng was asked if the patient's					

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 01/04/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		15K164	B. WING _			11/2	20/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD)E		
APPLE TR	REE HOME HEALTH CAR	RE SERVICES, LLC		5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
G 530	information that may patient's progress tow goals identified by the outcomes identified b	care preferences, including be used to demonstrate the vard achievement of the e patient and the measurable	G 5				
	social, and discharge This ELEMENT is no Based on record rev registered nurse (RN comprehensive assess information regarding nursing, rehabilitative planning needs for 8 reviews, in a total sar 9, 29).	of met as evidenced by: iew and interview, the) failed to ensure the essment contained the patient's medical, e, social, and discharge					
	C-145 stated " PUF appropriate care, treathe client initial needs needs. To collect dathistory, physical, function of the home care setting medical, nursing, rehadischarge planning needs. The clinical records	ant assessment," Policy# RPOSE: To determine the atment, and services to meet and his/her changing a about the client's health ctional and psychosocial and their needs as appropriate to g To identify clients abilitative, social and					

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		' '	TE SURVEY MPLETED		
		15K164	B. WING _		1	C 1/ 20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 534	the certification period which indicated a priprostatic hyperplasia symptoms and order time per week for meassessment, and to home health aide (H days a week for pers (ADL), instrumental (IADL), around the correparation, set up; light housekeeping. The comprehensive 10/22/20 failed to evithe patient's medical social, and discharge 3. The clinical record on 10/28/20 and india 8/27/20. The record the certification period which indicated order time per week for meassessment, and to home health aide (H days a week for pers (ADL), instrumental (IADL), meal prepara dressing, and light him A recertification common completed on 10/25/information regarding nursing, rehabilitative planning needs.	contained a plan of care for od of 10/23/20-12/21/20 mary diagnosis of Benign with lower urinary tract is for skilled nursing (SN) 1 edication set up, head to toe supervise the aides, and HA) 12 hours per day for 7 sonal activities of daily living activities of daily living lock supervision, meal assist, bathing, dressing, and assessment dated on idence information regarding l, nursing, rehabilitative, e planning needs. In of patient #2 was reviewed a start of care date of contained a plan of care for od of 10/26/20-12/24/20 pers for skilled nursing (SN) 1 edication set up, head to toe supervise the aides, and HA) 3 hours per day for 7 sonal activities of daily living activities of dail	G 5	34		

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, 5257 N TACOMA DR SUI INDIANAPOLIS, IN 46	ITE 4	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	
G 534	5/14/20. The record the certification perior indicated orders for a other week for med and skilled nurse suphours, 5 days per we of motion, ambulation. A recertification common completed on 9/15/2 information regarding nursing, rehabilitative planning needs. 5. The clinical record the certification perior indicated SN orders supervisory visits an and HHA orders for week to assist with A disease process." A comprehensive redocumented on 10/2 information regarding nursing, rehabilitative planning needs. 6. The clinical record on 10/30/20 and indicated HHA order planning perior indicated HHA order per week for personal indicated HHA order per week for personal indicated personal indicated HHA order per week for personal indicated indicated indicated personal indicated indicat	cated a start of care date of contained a plan of care for od of 9/18/20-11/16/20 which a registered nurse every set up, assessment, and aide pervision as well as HHA 3 eek for personal care, range n, meal prep.	G	534		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
G 534	dated 9/3/20 failed to regarding the patien rehabilitative, social, needs. 7. The clinical record on 11/2/20 and indica 7/18/19. The record the certification period indicated orders for the certification period pressure areas, and The recertification period pressure areas, and The recertification condated 11/13/19, failed regarding the patien rehabilitative, social, needs. 8. The clinical record on 11/2/20 and indica 11/14/19 and a dischard record contained a precertification period of indicated orders for certification period of preparations, and light The comprehensive dated 11/14/19 failed regarding the patien rehabilitative, social, needs. 9. The clinical record reviewed on 11/2/20	recertification assessment of evidence information the evidence information the medical, nursing, and discharge planning. It is medical, nursing, and discharge planning of of patient #8 was reviewed ated a start of care date of contained a plan of care for od of 11/16/19-1/14/20 that HHA, 2 hours per day during od for personal care, check light housekeeping. It is medical, nursing, and discharge planning of of patient #9 was reviewed ated a start of care date of harge date of 12/6/19. The olan of care for the formation the formation of the personal care, meal with thousekeeping. It is medical, nursing, and discharge planning of the evidence information the evi	G 53			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	' '	E SURVEY PLETED
		15K164	B. WING		1	C / 20/2020
NAME OF PR	ROVIDER OR SUPPLIER	1011101		STREET ADDRESS, CITY, STATE, ZIP CODE	11	120/2020
4 DDI E TD	NEE 110ME 11E 41 TH 0 A B	NE 0550//050 110		5257 N TACOMA DR SUITE 4		
APPLE IR	REE HOME HEALTH CAR	E SERVICES, LLC		INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
G 534	2 hours per day durin personal care. The recertification condated 11/13/19, compto evidence information medical, nursing, rehadischarge planning network the director of nursing comprehensive assess patient's medical, nur and discharge planning that the director of nursing comprehensive assess patient's medical, nur and discharge planning that the director of nursing comprehensive assess patient's medical, nur and discharge planning that the director of nursing comprehensive assess patient's medical, nur and discharge planning that the director of nursing the director of nursing that the director of nursing the director of	ch indicated orders for HHA g the certification period for mprehensive assessment pleted by employee G, failed on regarding the patient's abilitative, social, and peeds. Sew on 10/29/20 at 12:50 PM, g was asked if the essment should contain the sing, rehabilitative, social, and needs, she stated "yes."		534		
G 536	using in order to identice effects and drug react drug therapy, significating interactions, dup noncompliance with a This ELEMENT is not Based on record reviregistered nurse (RN) comprehensive assess complete review of m were identified, and naccurately maintained.	ations the patient is currently tify any potential adverse tions, including ineffective ant side effects, significant blicate drug therapy, and drug therapy. It met as evidenced by: ew and interview, the pailed to ensure the essment contained a edications, drug interactions	G:	536		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		15K164	B. WING		11/20/2020	
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
G 536	1. An undated ager "Comprehensive cli C-145 stated " SI A review of all medi using in order to ide effects and drug readrug therapy, signifidrug interactions, dinoncompliance with An undated agency profile," Policy# C-7 medication profile documentation of the assessment of all micurrently taking and SPECIAL INSTRUC professional shall climay be taking to ide therapy or adverse effects, drug allergie mediation. The clinidentified problems 2. The clinical reco on 10/27/20 and inc 7/11/17. The record the certification peri which indicated mediacetaminophen, nassmooth, guaifenesir ibuprofen, milk of micured aspirin. The pla failed to evidence ir needed (PRN) med were to be applied,	ent assessment," Policy# PECIAL INSTRUCTIONS f. cations the client is currently entify any potential adverse actions, including ineffective icant side effects, significant uplicate drug therapy, and indrug therapy" policy titled "medication oo stated " complete a PURPOSE: To provide the comprehensive the dications the client is indentify discrepancies CTIONS:the admission theck all medications a client entify possible ineffective drug reactions, significant side tes, and contraindicated ician shall promptly report any	G 53	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	15K164	B. WING _		C 11/20/2020
NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE	SERVICES, LLC	•	STREET ADDRESS, CITY, STATE, ZIP CO 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
of care were checked of interactions. The interactions with ibupro multiple moderate inter Major interaction definition significant. Avoid combinate action outweighs the second of the certification period indicated medications, atorvastatin, bacitracing of care and medication indications for the use of where topical agents with failed to evidence a thou which identified major of the second of care were checked of care were checked of care were checked of interactions. The interactions with atorvative well as multiple moderations. The interactions of the interactions with interactions with atorvative well as multiple moderations. The interactions with atorvative well as multiple moderations.	actions and duplicate ations from the agency plan on Drugs.com for actions showed major ofen and aspirin as well as ractions. The Drugs.com tion stated "Highly clinically binations; the risk of the he benefit." of patient #2 was reviewed ted a start of care date of ontained a plan of care for of 8/27/20-10/25/20 which but not limited to, , and ranolazine. The plan illist failed to evidence of PRN medications, were to be applied, and brough medication review medication interactions. cument titled "drug-drug o interactions found during ations from the agency plan on Drugs.com for actions showed major astatin and ranolazine as ate interactions. The	G	536	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC	STREET ADDRESS, CITY, STATE, ZIP CC 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
G 536	the certification pericindicated orders for other week for med and skilled nurse suphours, 5 days per we of motion, ambulation care and medication moderate medication moderate medication moderate medication. On 11/20/20 all med of care were checke interactions. The intinteractions with transcyclobenzaprine with tramadol, hydroxych buspirone with tramadovitamin D3, hydroxych buspirone with save cyclobenzaprine, hydromansetron, ondan buspirone with onda milnacipran, cyclobe cyclobenzaprine with milnacipran, and mir well as multiple mod Drugs.com Major into "Highly clinically sign the risk of the interaction on 10/30/20 and individual to	contained a plan of care for od of 9/18/20-11/16/20 which a registered nurse every set up, assessment, and aide pervision as well as HHA 3 eek for personal care, range n, meal prep. The plan of list failed to evidence a review which identified n interactions. ications from the agency plan d on Drugs.com for eractions showed major nadol with mirtazapine, on tramadol, ondansetron with loroquine with tramadol, adol, buspirone with ol with lyrica, calcium with chloroquine with mirtazapine,	G 5:	36		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	E	11120/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 536	disease process." medication list failed the use of as needed agents were to be a a thorough medicate moderate medication. On 11/20/20 all medicate of care were checked interactions. The ininteractions with diatriamcinolone with a senna, triamcinolone with a senna, triamcinolone with lactulose, senne with esome prazole, ondansetron with mand lactulose with moderate interaction clinically significant use it only under specification per indicated HHA order per week for person light housekeeping, The plan of care an evidence a thorougidentified moderate. On 11/20/20 all medicate of care were checked interactions. The ininteractions with popotassium with cyclinication potassium with cyclinication in the popotassium with cyclinication in the popotassium with cyclinication.	ADL's, IADL's and "monitoring The plan of care and d to evidence indications for d PRN tylenol, where topical applied, and failed to evidence ion review which identified	G 5	536		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 1/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		1/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 536	Avoid combinations; outweighs the benefit 7. The clinical record on 11/2/20 and indica 7/18/19. The record the certification period indicated medication lidocaine ointment at The recertification codated 11/13/19, who and salonpas) were evidence a thorough identified moderate interactions. The intrinteractions with divavenlafaxine with lacotopiramate, venlafaxine venlafaxine with divalproex, lorazepam with backmoderate interaction clinically significant. Use it only under specification period of certification period of certificat	the risk of the interaction t." d of patient #8 was reviewed ated a start of care date of contained a plan of care for d of 11/16/19-1/14/20 that orders, but not limited to, and salonpas pain patch. Imprehensive assessment are topical agents (lidocaine to be applied, and failed to medication review which medication interactions. Cations from the agency plan of the orders of the agency plan of the orders of the agency plan of	G 5	36		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	, ,	DATE SURVEY COMPLETED
		15K164	B. WING_			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	ı	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 536	indicated the followicentrum, colace, los multivitamin, omepro On 11/20/20 all medication list were interactions. The in interactions adderal Drugs.com Major into "Highly clinically signed the risk of the interactions adderal Drugs.com Major into "Highly clinically signed the risk of the interactions of the interaction of the certification of	tion list dated 11/14/19 which any medication: clorazepate, artan, cymbalta, adderal, azole. ications from the agency checked on Drugs.com for teractions showed major with cymbalta. The teraction definition stated inficant. Avoid combinations; ction outweighs the benefit." In d of patient #29 was and indicated a start of care the record contained a plan of the period of the indicated medication and to, bacitracin ointment, the or PRN." In the or PRN." In the order for each), where the pleted by employee G, failed attention for the use diazepam of either PRN or at bedtime that order for each), where the pleted to medication review which medication interactions.	G 5	36		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO IDENTIFICATION NUMBER: A. BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		15K164	B. WING		11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
G 536	the director of nursing comprehensive assess review of all medicati using in order to iden effects and drug read drug therapy, signific drug interactions, dup	the benefit." ew on 10/29/20 at 12:50 PM,	G 53	6	
G 538	other available suppor (i) Willingness and als (ii) Availability and so This ELEMENT is not Based on observation interview, the register ensure the comprehe information regarding caregiver, or lack of of and ability to provide schedule for 8 of 8 co total sample of 10 (#7 Findings include: 1. An undated agency "Comprehensive client C-145 stated" The facilitating factors and	if any (i,ii) caregiver(s), if any, and orts, including their: oility to provide care, and hedules; ot met as evidenced by: on, record review and red nurse (RN) failed to ensive assessment contained of the patient's primary one, and their willingness care, availability, and omplete record reviews, in a 1, 2, 3, 4, 5, 8, 9, 29).	G 53	8	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		15K164	B. WING		C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11120/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
G 538	appropriate care, tre the client initial need needs SPECIAL primary caregiver (s ability to provide car schedules" 2. The clinical record on 10/27/20 and ind 7/11/17. The record the certification peri which indicated a pr prostatic hyperplasis symptoms and orde time per week for m assessment, and to home health aide (H days a week for per (ADL), instrumental (IADL), around the of preparation, set up; light housekeeping. During a home visit 8:00 AM, the patient group home and a se home was present i The comprehensive 10/22/20 failed to ev the patient's primary information, their wi care, availability and 3. The clinical record	DSE: To determine the eatment, and services to meet as and his/her changing. INSTRUCTIONS The), if any, willingness and re, and their availability and re, and their availability and re as the first of care date of a contained a plan of care for red of 10/23/20-12/21/20 regionary diagnosis of Benign as with lower urinary tract res for skilled nursing (SN) 1 redication set up, head to toe supervise the aides, and althay 12 hours per day for 7 resonal activities of daily living activities of daily li	G 53		
	on 10/28/20 and ind 8/27/20. The record	icated a start of care date of I contained a plan of care for od of 10/26/20-12/24/20			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		20.2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 538	time per week for massessment, and to home health aide (I days a week for per (ADL), instrumental (IADL), meal prepadressing, and light I During a home visit 11:00 AM, the patie apartment with the A recertification cor completed on 10/28 information regarding caregiver, their willing care, availability and 4. The clinical recon 10/28/20 and inc 5/14/20. The recon the certification per indicated orders for other week for med and skilled nurse surports, 5 days per work of motion, ambulation A start of care completed on 5/14/assessment stated primary caregiver, assessment identification per indicated orders for other week for med and skilled nurse surports, assessment stated primary caregiver, assessment identification primary caregivers, willingness and abiliand schedules.	res for skilled nursing (SN) 1 nedication set up, head to toe of supervise the aides, and HHA) 3 hours per day for 7 resonal activities of daily living activities of daily living ration, set up assist, bathing, nousekeeping. completed on 10/29/20 at nt was observed living in an aspouse. Inprehensive assessment was 6/20 failed to evidence righthe patient's primary ngness and ability to provide dicated a start of care date of dicated a start of care date of dicated a plan of care for iod of 9/18/20-11/16/20 which a registered nurse every set up, assessment, and aide upervision as well as HHA 3 reek for personal care, range on, meal prep. orehensive assessment was 20 in one area of the the patient did not have a	G 5	38		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
G 538	on 10/30/20 and inc 4/22/20. The record the certification peri indicated SN orders supervisory visits ar and HHA orders for week to assist with disease process." A comprehensive re documented on 10/2 information regardir caregiver, their willin care, availability and 6. The clinical reco on 10/30/20 and inc 9/20/17. The record the certification peri indicated HHA orde per week for person light housekeeping, The comprehensive dated 9/3/20 failed to regarding the patier willingness and abil and schedules. 7. The clinical reco on 11/2/20 and indic 7/18/19. The record the certification peri indicated orders for the certification peri pressure areas, and The recertification of	icated a start of care date of d contained a plan of care for od of 8/24/20-10/22/20 which once per month for aide and head to toe assessment, 9 hours per day, 5 days per ADL's, IADL's and "monitoring accertification assessment was 22/20 failed to evidence g the patient's primary agness and ability to provide	G 538		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		OMPLETED
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP C 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		11720/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 538	Continued From pag	ge 55	G 5	538		
		t's primary caregiver, their ty to provide care, availability				
	on 11/2/20 and indic 11/14/19 and a disch record contained a p certification period o indicated orders for	f 11/14/19-1/12/20 which HHA 12 hours per day for the or personal care, meal				
	dated 11/14/19 failed regarding the patien	start of care assessment d to evidence information t's primary caregiver, their ty to provide care, availability				
	date of 7/18/19. The care for the certificat 11/16/19-1/14/20 wh	and indicated a start of care e record contained a plan of				
	dated 11/13/19, com to evidence informat	omprehensive assessment apleted by employee G, failed cion regarding the patient's neir willingness and ability to boility and schedules.				
	the director of nursir comprehensive asse information about th caregiver(s), if any,	essment should contain				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
			71. 50125			(c
		15K164	B. WING			11/	20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 538 G 540	Continued From page care, and availability "yes." The patient's represe	and schedules, she stated		538 540			
	CFR(s): 484.55(c)(7) The patient's represer This ELEMENT is not Based on observation interview, the register ensure the comprehensive the patient's represer reviewed with needed in a total sample of 1 Findings include: 1. An undated agency "Comprehensive client C-145 stated" The facilitating factors and reaching his or her groblems PURPO appropriate care, treather client initial needs needs SPECIAL client's representative 2. The clinical record on 10/27/20 and indicated order time per week for me assessment, and to shome health aide (Hidays a week for persistence).	entative (if any); of met as evidenced by: on, record review and red nurse (RN) failed to ensive assessment reflected intative for 3 of 3 records d representatives (#1, 4, 9), o. cy policy titled int assessment," Policy# e assessment identifies d possible barriers to client oals including presenting insert To determine the atment, and services to meet and his/her changing instructions The					

NAME OF PROVIDER OR SUPPLIER 15K164 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE	0/2020
	0/2020
APPLE TREE HOME HEALTH CARE SERVICES, LLC 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Preparation, set up; assist, bathing, dressing, and light housekeeping. During a home visit completed on 10/29/20 at 8:00 AM, the patient was observed living in an group home and a staff person from the group home was present in the home. A recertification comprehensive assessment was completed on 10/22/20 by the director of nursing failed to evidence who the patient's representative was. An undated document from the medical record titled "kardex," stated "Guardian [person H]." 3. The clinical record of patient #4 was reviewed on 10/30/20 and indicated a start of care date of 4/22/20. The record contained a plan of care for the certification period of 8/24/20-10/22/20 which indicated SN orders once per month for aide supervisory visits and head to loe assessment, and HHA orders for 9 hours per day, 5 days per week to assist with ADL's, IADL's and "monitoring disease process." During an interview on 11/2/20 at 1:03 PM, the grandmother of the patient stated the patient was staying at her house currently, but did go to the patient's mother and father's houses. A comprehensive recertification assessment was documented on 10/22/20 by the director of nursing (DON) failed to evidence who the patient's representative was, who had custody of patient. 4. The clinical record of patient #9 was reviewed	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		AFIVAÇA	B. WING	_			0
NAME OF DE	ROVIDER OR SUPPLIER	15K164	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	11/2	20/2020
	EE HOME HEALTH CAR	E SERVICES, LLC		52	257 N TACOMA DR SUITE 4 IDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 540	record contained a placertification period of indicated orders for H certification period for preparations, and light. The comprehensive stated 11/14/19 failed patient's representative During an interview of person D indicated the guardian. 5. During an interview of person D indicated the guardian. 5. During an interview of person D indicated the guardian. 5. During an interview of person D indicated the guardian. 5. During an interview of person D indicated the guardian. 5. During an interview of person D indicated the guardian. 5. During an interview of person D indicated the guardian. 5. During an interview of person D indicated the guardian. The director of nursing comprehensive assessment. Update of the comprehensive assessment. The comprehensive assessment.	arge date of 12/6/19. The an of care for the 11/14/19-1/12/20 which HA 12 hours per day for the personal care, meal at housekeeping. Start of care assessment to evidence who the ve was. In 10/28/20 at 9:22 AM, ey were patient #9's W on 10/29/20 at 12:50 PM, as asked if the esment should contain patient's representative, whensive assessment The comprehensive assessment must be (including the administration uently as the patient's e to a major decline or atient's health status, but not not met as evidenced by: ew, the registered nurse		540			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 1/20/2020
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 544	C-145 stated "POLIC visit must be held eit or within 48 hours of The assessment ide possible barriers to goals including pres PURPOSE: To deter treatment, and servi needs and his/her cl data about the client functional and psych and their needs as a setting To identif rehabilitative, social needs SPECIAL comprehensive assereflect the client's staconducted based on orders and for an will be sent to the phase sessment/updat assessment," Policy comprehensive asserevised as often as the due to major decline status Reassess within last five (5) 48 hours of client rei	acy policy titled ent assessment," Policy# CY: The initial assessment ther within 48 hours of referral if the client's return home ntifies facilitating factors and client reaching his or her enting problems mine the appropriate care, ces to meet the client initial hanging needs. To collect t's health history, physical, hosocial and cognitive status happropriate to the home care by clients medical, nursing, and discharge planning INSTRUCTIONS The essment must accurately atusReassessments are or client needs, physician by changes in the plan of care hysician.	G 5	44		
	on 10/27/20 and ind	d of patient #1 was reviewed icated a start of care date of contained a plan of care for				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K164	B. WING			C 11/20/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		11/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G 544	the certification per 10/23/20-12/21/20 skilled nursing (SN medication set up, to supervise the aid (HHA) 12 hours per personal activities of instrumental a	iod of 8/24/20-10/22/20 and both which indicated orders for 1 time per week for head to toe assessment, and les, and home health aide r day for 7 days a week for of daily living (ADL), les of daily living (IADL), upervision, meal preparation, ling, dressing, and light in mprehensive assessment was 20 and 10/22/20 by the light the assessments mirrored led to be updated as evidenced lince a weight, but stated in the light to identify the person for light to identify the person for light to identify the person for light to identify a pain led (left blank) but stated "Client light brait brain injury and gets light to identify and gets light light light to identify and gets light	G 5	44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
						С	
		15K164	B. WING _			11/	20/2020
NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC		E SERVICES, LLC		52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 IDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 544	week to assist with Al disease process." The update the comprehe evidenced by: A comprehensive recodocumented on 10/22 nursing (DON), stated	hours per day, 5 days per DL's, IADL's and "monitoring are registered nurse failed to nsive assessment as ertification assessment was 2/20 by the director of the patient's last bowel /20" (2 months prior to	G s	5544			
G 546	CFR(s): 484.55(d)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	ery 60 days beginning with unless there is all transfer; in condition; or turn to the same HHA during at met as evidenced by: we and interview, the failed to ensure the chensive assessment was days of the 60 day period for eviews, in a total sample of a start of care date of eation period was	G	546			
	(i) Beneficiary elected (ii) Significant change (iii) Discharge and ret the 60-day episode. This ELEMENT is not Based on record reviregistered nurse (RN) recertification comprecompleted the last 5 of 2 of 5 active record ret 10 (#3, 4). Findings include: 1. The clinical record on 10/28/20 and indict 5/14/20.	I transfer; in condition; or turn to the same HHA during of met as evidenced by: ew and interview, the of failed to ensure the whensive assessment was days of the 60 day period for eviews, in a total sample of of patient #3 was reviewed eated a start of care date of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	1112012020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION	
G 546	5/14/20-7/12/20). A between 7/8/20-7-/12 comprehensive asset the agency director of (late). A home health certifith 7/20/20-9/17/20 (but 7/13/20-9/10/20). A between 9/6/20-9/10 AM, the electronic mand no recertification was completed betweregular nurse visit was DON on 9/8/20 and 9/18/20-11/16/20 (but 9/11/20-11/9/20). During an interview of alternate administration missing recertification assessment in Septem would look into it. Si company and asked and completed. The stated the visit was administrator on 9/18 does when a visit is administrator of nursin 2. The clinical record on 10/30/20. The "coof care date of 4/22/20 for care date of 4/22/20 for contact and complete of the cord of care date of 4/22/20 for	recertification was due 2/20. The recertification ssment was completed by of nursing (DON) on 7/15/20 cation period was should have been recertification was due /20. On 10/28/20 at 7:30 edical record was viewed a comprehensive assessment een these dates, but a as documented from the 2/15/20. cation period was at should have been on 10/30/20 at 11:23 AM, the or was queried about the nomprehensive ember. She indicated she he called the software when the visit was created electronic record company completed by the alternate 6/20 (which she stated she due) and then completed by g on 10/30/20. d of patient #4 was reviewed ient profile" indicated a start 20. ed 6/25/20-current stated the	G 54	6		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	COMPLE	COMPLETED	
		15K164	B. WING _		C 11/20	0/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11/20	<i>3</i> 12020
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
G 546	Continued From page	e 63	G 5	46		
	nursing assessment,	t titled "Comprehensive adult " M0030 Start of care date of dated by employee G on				
	The first home health 4/24/20-6/23/20 (which	certification period was ch was accurate).				
		health certification period /23/20 (but should have been				
		health certification period 0/22/20 (but should have 20).				
	was dated 10/23/20-been 10/22/20-12/20 due between 10/17/2 nursing completed th	health certification period 12/21/20 (but should have /20). A recertification was 0-10/21/20. The director of e recertification ssment on 10/22/20 (late).				
G 570	IAC 410 17-14-1(a)(1 Care planning, coord CFR(s): 484.60)(b) ination, quality of care	G 5	70		
	Patients are accepted reasonable expectation patient's medical, nursocial needs in his or Each patient must rewritten plan of care, in additions. The individual specify the care and	ation: Care planning, ces, and quality of care. d for treatment on the on that an HHA can meet the rsing, rehabilitative, and ther place of residence. ceive an individualized ncluding any revisions or lualized plan of care must services necessary to meet eeds as identified in the				

PRINTED: 01/04/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _				20/2020
	NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC			52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 570	the measurable outcome and coordinating the individualized plan of patient and caregiver Services must be furraccepted standards of This CONDITION is Based on observation interview the agency and complete plan of coordination of care we patients were provided. The cumulative effect resulted in the agency with the Condition of Care planning, coordination of Care planning include: The agency failed to contained all pertinent measurable goals and the agency and patient visits, the patient's rist and hospitalization withe underlying risk face education to facilitate specific interventions directive information. The agency failed to oprovided absent of a start of care (See Tagent Service).	espensible discipline(s), and omes that the HHA as a result of implementing plan of care. The care must also specify the education and training. hished in accordance with of practice. In the most as evidenced by: In, record review, and failed to ensure an accurate care was completed, and that ad with required documents. It of this systemic problem by being out of compliance Participation 42 CFR 484.60 ination, quality of care. The ensure the plan of care at diagnoses, allergies, doutcomes established by and, frequency and duration of the for emergency room visits ith interventions to address cotors, patient and caregiver timely discharge, patient and education, advance (See Tag G 574).	G	570			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED
		15K164	B. WING	B. WING		C 11/20/2020	
	ROVIDER OR SUPPLIER	E SERVICES, LLC		52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 IDIANAPOLIS, IN 46220	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 570	appropriate amount of The director of nursing physician was notified 590). The agency failed to was completed with the patients resided (See The agency failed to received a copy of the health staff (See Tag The agency failed to received a written coporder to have knowled administered, including set up (See Tag G 61). The agency failed to received a written coporder to have knowled administered, including set up (See Tag G 61). The agency failed to contact information of given to the patients in Plan of care must incomplete (See Tag G 61). The individualized platfollowing: (i) All pertinent diagnor (ii) The patient's mencognitive status; (iii) The types of serve equipment required;	ed who the order was ders were signed in an of time (See Tag G 584). If time (See Tag G 584). If time (See Tag G 584). If g failed to ensure the dof changes (See Tag G 606) densure coordination of care the group homes where the Tag G 608). It is the patient/family the visit schedule for home G 614). If the patient/family the patient of care in dege of any treatments to be the greathing or medication (See Tag G 622). If the director of nursing was in writing (See Tag G 622). If the director of care must include the coses; Ital, psychosocial, and		570			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING				20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 IDIANAPOLIS, IN 46220		20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 574	(xii) A description of emergency departm re-admission, and a address the underly (xiii) Patient and car to facilitate timely di (xiv) Patient-specific measurable outcom HHA and the patient (xv) Information reladirectives; and (xvi) Any additional may choose to inclu This ELEMENT is r Based on observati interview, the agency care contained all processor and pativisits, the patient's r and hospitalization with the underlying risk feeducation to facilitat specific intervention directive information reviews in a total sa 4, 5, 8, 9, 29). Findings include: 1. An undated ager Policy #C-580 states.	betential; ations; ations; ations; ations; and treatments; and treatments; and treatment's risk for ant visits and hospital all necessary interventions to an risk factors. aregiver education and training ascharge; a interventions and education; and goals identified by the ation of the training sectors and goals identified by the ation of the training sectors and goals identified by the ation of the training sectors and goals identified by the ation of the training sectors and goals identified by the ation of the training sectors and goals identified by the ation of the training sectors and goals identified by the ation of the training sectors and goals identified by the ation of the training sectors are at the training sectors and goals identified by the ation of the training sectors are at the training sectors and goals identified by the ation of the training sectors are at the training sectors and goals identified by the ation of the training sectors are at the training sectors and goals identified by the ation of the training sectors are at the training sectors at the training sectors are at the training sectors at the training sectors are at the training sectors a	G	574			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _		C 11/20/2020
NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11120/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
G 574	medications, treatme equipment required 2. The clinical record on 10/27/20 and indition 7/11/17. The record the certification period which indicated diagous hyperplasia with low hyperlipidemia, and functional limitation of evidence to what are the patient had a preheadaches, left side memory loss. Addition medications, but not vitamin D (supplementations) (supplementatio	ents medical supplies and" d of patient #1 was reviewed cated a start of care date of contained a plan of care for od of 10/23/20-12/21/20 noses of benign prostatic er urinary tract symptoms, type 2 diabetes, and a of paralysis (failed to ea). The summary indicated evious traumatic brain injury, d weakness, and short term onally there were limited to, calcium with ent), divalproex (commonly mental illness disorders), pation), fluticasone nasal gies), levothyroxine (used for loratadine (used for e (used for mental illness, schizophrenia), sertraline of, and acetaminophen, ofen (all pain medication).	G 5	74	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		(X3) DATE SURVEY COMPLETED	
	15K164	B. WING		C 11/20/2020	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11/20/2020	
(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) BE COMPLETION	
available, and the use the bathroom. A recertification cor completed on 10/22. The assessment st traumatic brain injust headaches." Patient #1's plan of diagnoses, but not injury, headaches, (paralysis), short te disorder that cause mental illness (which used for), allergies, dysfunction), and dalso failed to evide or drug allergies, arelated to all the meabove, patient's rist and hospitalization the underlying risk education to facilitate specific intervention medical equipment advance directive in regarding the group with contact informs. 3. The clinical record on 10/28/20 and incomplete the certification per indicated orders for per week for medical.	mprehensive assessment was 2/20 by the director of nursing. ated "Client has history of ry and gets occasional care failed to evidence limited to, traumatic brain left sided hemiplegia rm memory loss, pain (or spain), seizures and/or chever divalproex was being hypothyroidism (thyroid epression. The plan of care note if the patient had any food my goals and interventions edications and diagnoses k for emergency room visits with interventions to address factors, patient and caregiver the timely discharge, patient and education, durable (DME) of a toilet riser, information, and information of home living and guardian ation. and of patient #2 was reviewed dicated a start of care date of d contained a plan of care for iod of 8/27/20-10/25/20 which skilled nursing (SN) 1 time ation set up, head to toe	G 57	74		
	ROVIDER OR SUPPLIER SUMMARY (EACH DEFICIEI REGULATORY OF Continued From paravailable, and the underlying risk education to facilitate specific intervention medical equipment advance directive in regarding the group with contact informs 3. The clinical record on 10/28/20 and ind 8/27/20. The record the certification per indicated or drug alter in the group with contact informs.	TORRECTION IDENTIFICATION NUMBER: 15K164 ROVIDER OR SUPPLIER REE HOME HEALTH CARE SERVICES, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 68 available, and the use of a toilet riser when using the bathroom. A recertification comprehensive assessment was completed on 10/22/20 by the director of nursing. The assessment stated "Client has history of traumatic brain injury and gets occasional	ROVIDER OR SUPPLIER REE HOME HEALTH CARE SERVICES, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 68 available, and the use of a toilet riser when using the bathroom. A recertification comprehensive assessment was completed on 10/22/20 by the director of nursing. The assessment stated "Client has history of traumatic brain injury and gets occasional headaches." Patient #1's plan of care failed to evidence diagnoses, but not limited to, traumatic brain injury, headaches, left sided hemiplegia (paralysis), short term memory loss, pain (or disorder that causes pain), seizures and/or mental illness (whichever divalproex was being used for), allergies, hypothyroidism (thyroid dysfunction), and depression. The plan of care also failed to evidence if the patient had any food or drug allergies, any goals and interventions related to all the medications and diagnoses above, patient's risk for emergency room visits and hospitalization with interventions to address the underlying risk factors, patient and caregiver education to facilitate timely discharge, patient specific interventions and education, durable medical equipment (DME) of a toilet riser, advance directive information, and information regarding the group home living and guardian with contact information. 3. The clinical record of patient #2 was reviewed on 10/28/20 and indicated a start of care date of 8/27/20. The record contained a plan of care for the certification period of 8/27/20-10/25/20 which indicated orders for skilled nursing (SN) 1 time per week for medications set up, head to toe assessment, and to supervise the aides, and home health aide (HHA) 3 hours per day for 7	TOURISECTION IDENTIFICATION NUMBER: 15K164 15K164 15K164 15K164 15K164 15K1664 15K1664 15K1664 15K1664 15K1664 15K1664 15K1664 15K1666 15K1666	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		C 11/20/2020
	NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
G 574	(IADL), meal prepadressing, and light of the consent form of indicated "the anticicare services and fiskilled nursing 1 however hours a day, and with the complete of the court of the cour	activities of daily living ration, set up assist, bathing, nousekeeping. In admission, dated 8/27/20 pated apple tree home health requency to be provided," was ur weekly, home health aide 2 aiver 3 times a week. Inter from the patient's 4/20 indicated the patient had 0 (chronic obstructive 0, hypertension, history of nia, history of myocardial fright hand fracture, gouty nd compression fractures. Inprehensive assessment was 5/20 by the director of nursing ent "conclusions" were needed," but failed to needed for the patient.	G 57	74	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	•	1172072020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 574	directive information 4. The clinical record on 10/28/20 and incompleted on 9/15/20. The record the certification perimidicated the medical "toujeo [injectable medical	ducation, and advance and of patient #3 was reviewed icated a start of care date of dicontained a plan of care for ad of 9/18/20-11/16/20 which ation, but not limited to, nedication used for ts daily subcutaneous "	G	-		
	points), and takes 3 the counter medical her an additional 5 passessment was incepatient has diabetes surgery, all which we Patient #3's plan of diagnoses, but not I anemia, gastric byposteopenia. The platevidence a diet order	or more prescribed or over ions daily which would give points), thus the nutritional correct. Furthermore, the s, and had a gastric bypass ould affect nutritional status. Care failed to evidence imited to, iron deficiency ass status for obesity, and an of care also failed to er which matched the discipline, frequency and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	COMPLETED	
		15K164	B. WING		C 11/20/2020
	NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
G 574	duration with tasks in measurable goals a the diagnoses above room visits and hos to address the under education to facilitate specific intervention advance directive in 5. The clinical record on 10/30/20 and independent of the certification perimidicated SN orders supervisory visits are and HHA orders for week to assist with a disease process." A comprehensive redocumented on 10/3 nursing (DON). The has dysphasia, orded aily/weekly weights had nausea/vomitin. During an interview mother of patient #4 stayed with grandmevery other weeken gastrostomy tube (Othings by mouth such sancks and the aided taking things in oral the mother, a call wat 1:03 PM. She incompeted that the patient's grant the patient's grant wat the patient wat the patient wat the patient wat th	to be completed, any nd interventions related to all e, patient's risk for emergency pitalization with interventions erlying risk factors, patient te timely discharge, patient s and education, and	G 57	4	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER	101(10-7	1	STREET ADDRESS, CITY, STATE, ZIP COD	•	11/20/2020
				5257 N TACOMA DR SUITE 4		
APPLE TR	REE HOME HEALTH CAR	RE SERVICES, LLC		INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 574	Continued From page	e 72	G 5	574		
	place to get the patie patient required a sur of the spine), but the	ated the G-tube had to be in nt's weight up to 70 lbs. The rgery for Scoliosis (curvature physicians would not do the ent's weight had reached and nds.				
	dated 6/21/20 indicated hospitalized for malnow The patient was discontinuous the feeding that state pump over 1 hour 4 to required AFO's to be vendor to be readjusted the patient had "No fifflush meds with free pureed foods and hou Lastly, the physician "schizencephaly, hydrothrive, tetraplegic of the position of the position of the pureed foods and hou be a supplementation of the pureed foods and hours of the pure foods and hours of the	eport," from the hospital ed the patient had been utrition and failure to thrive. harged with a new pump for d "Pediasure 1.0 420 ml via imes per day,"the patient taken to an outpatient ted. Additionally, it stated ree water needs but may water. [patient] may eat ney thick liquids by mouth." had diagnoses listed as procephalus, scoliosis, failure berebral palsy, constipation, eal reflux] with vomiting."				
	hospitalization in Jun diagnoses, but not lir hydrocephalus, scolid tetraplegic cerebral p The plan of care also diet with thickened lid (whether bolus or colfor G-tubes, the DME pump and specific susafety measures of a dysphasia), daily wei parameters to notify measurable goals an the diagnoses above	alsy, constipation, and GER. failed to evidence a pureed quid order, orders for feeding ntinuous), water/flush orders of a carseat, AFO's, type of applies for g-tube feedings, spiration precautions (due to ght orders or vital sign				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTR			X3) DATE SURVEY COMPLETED			
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	•	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 574	Continued From pag	ge 73	G 5	574		
	to address the under education to facilitate specific intervention advance directive in 6. The clinical record on 10/30/20 and incomplete for the certification perimedicated HHA order per week for person light housekeeping, that the patient had pulmonary disease and goals stated "clumderstanding of prother end of the care free of S&S [signs as	erlying risk factors, patient the timely discharge, patient as and education, and aformation. The dof patient #5 was reviewed dicated a start of care date of the contained a plan of care for a contained a				
	be free from falls du will remain safe in his present." A physician office no patient had a past in limited to, arteriover stomach, bursitis of artery disease, COF vitamin D deficiency hyperlipidemia, microbesity, and unstab	rocytic anemia, morbid le angina. care failed to evidence				
	stomach, bursitis of artery disease, COF vitamin D deficiency hyperlipidemia, mici	venous malformation of the the left shoulder, coronary D with asthma, deafness, N, hypertension, rocytic anemia, morbid legina, daily weight parameters				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		15K164	B. WING		C 11/20/2020	
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	1.120/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION	
G 574	Continued From pa	ge 74	G 574	1		
	interventions related patient's risk for em hospitalization with underlying risk factor facilitate timely discrinterventions and edirective information. 7. The clinical reco	an, any measurable goals and do all the diagnoses above, ergency room visits and interventions to address the ors, patient education to harge, patient specific ducation, and advance hard of patient #8 was reviewed cated a start of care date of				
	the certification peri indicated medication acetaminophen, sal failed to evidence a assist with mitigatio emergency room vis interventions to add factors, patient educ discharge, patient s	d contained a plan of care for od of 11/16/19-1/14/20 which in orders, but not limited to, onpas (both for pain), but my interventions or goals to in of pain, patient's risk for sits and hospitalization with ress the underlying risk cation to facilitate timely pecific interventions and ance directive information.				
	on 11/2/20 and indic 11/14/19 and a disc record contained a certification period of	of 11/14/19-1/12/20 which n orders for clorazepate,				
	indicated the followi	tion list dated 11/14/19 which ng medication: clorazepate, sartan, cymbalta, adderal, azole.				
	diagnoses all medic	care failed to evidence ations, any measurable goals lated to all medications,				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		15K164	B. WING				20/2020
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	117.	20/2020
APPLE TR	REE HOME HEALTH CAR	E SERVICES. LLC		5	257 N TACOMA DR SUITE 4		
				II	NDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 574	hospitalization with in underlying risk factors facilitate timely discharations and educative information. 9. The clinical record reviewed on 11/2/20 adate of 7/18/19. The care for the certification 11/16/19-1/14/20 white patient's risk for emer hospitalization with in underlying risk factors facilitate timely discharationistic interventions and educative information. An agency document completion of plan of empty/incomplete box "Homebound status diet functional lir permitted mental serequired for physician rehabilitation potential was signed and dated	gency room visits and terventions to address the s, patient education to arge, patient specific location, and advance of patient #29 was and indicated a start of care record contained a plan of on period of ch failed to evidence the gency room visits and terventions to address the s, patient education to arge, patient specific location, and advance titled "Items required for care," contained less for choices for DMESafety measures mitations activities status prognosis ordersgoals I disaster codes" and diby the person listed in the aking lead responsibility for (C) (C) (D)(iii) (D)(viii) (D)(viii)	G	574			
G 580	IAC 410 17-13-1(a)(1 Only as ordered by a		G	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING			l	20/2020
	ROVIDER OR SUPPLIER	EE SERVICES, LLC	•	5	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CROSS-REFERENCED TO T			(X5) COMPLETION DATE
G 580	only as ordered by a This ELEMENT is not Based on record reviensure care was not physician's order for tactive records (#3), in Findings include: The clinical record of 10/28/20 and indicate 5/14/20. The record of the certification period faxed order was sent stated "admit & treat management." On the stated "person l/person the physician. The rephysician's order priod agency. IAC 410 17-13-1(a) Verbal orders CFR(s): 484.60(b)(3)(3) Verbal orders must personnel authorized.	treatments are administered physician. In met as evidenced by: It we the agency failed to provided absent of a she start of care for 1 of 5 in a total sample of 10. In a to		580			
	policies. (4) When services are physician's verbal ord accordance with state other qualified practiti	e licensure requirements, or					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING ———————————————————————————————————		` '	COMPLETED			
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 584	must document the crecord, and sign, dat Verbal orders must be the physician in accollaws and regulations internal policies. This ELEMENT is not assed on record revergistered nurse failed orders indicated who from, and orders we amount of time for 5 in a sample of 10 (#Findings include: 1. An undated agent orders," Policy #C-6: INSTRUCTIONS: and then read the orverifying that the perit correctly verbal authorized, licensed accordance with approximate the certification period the certification period An agency physician director of nursing stated "Order read be failed to evidence if the certification in the certification of the certification is serviced. The certification bear of the certification is serviced. The certification is serviced to evidence if the certification of the certification is serviced. The certification is serviced to evidence if the certification is serviced. The certification is serviced to evidence if the certification is serviced to evidence if the certification is serviced.	te law and the HHA's policies, orders in the patient's clinical te, and time the orders. The authenticated and dated by ordance with applicable state is, as well as the HHA's not met as evidenced by: View and interview, the red to ensure physician verbal or the order was received are signed in an appropriate of 5 active records reviewed, 1, 2, 3, 4, 5). The cy policy titled "Physician as stated" SPECIAL shall write the order as given der back to the physician are orders are accepted by agency personnel in	G 5	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	<u> </u>	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 584	Continued From pa	ge 78	G 5	84		
	alternate administrate verbal order. The at order and indicate that the director of order wrong because more than 12 hours her." Later, at 1:30 shown from the director alternate administratincorrect and shoul The alternate administration and the certification per documented) the order and incomplete the certification per day 7 days a week if the order was obtain a nurse at the physical director of nursing sorder] the certification per An agency physicial director of nursing sorder] for home carthe next certification	on 10/30/20 at 1:00 PM, the ator was queried about the alternate administrator looked ed the order was incorrect, nursing must have wrote the se the patient could not have and stated "I will have to call PM, a text message was ector of nursing to the ator that the order was d have read 12 hours, not 16. Inistrator was notified of the d back and verified (like reder should have been correct. And of patient #2 was reviewed dicated a start of care date of d contained a plan of care for iod of 8/27/20-12/24/20. An order dated 8/28/20 by the stated "verbal order contained SN [skilled nurse] weekly and HHA services 3 hours a "The order failed to evidence ained by the physician or from ician's office. And of patient #3 was reviewed dicated a start of care date of d contained a plan of care for iod of 9/18/20-11/16/20. An order dated 9/17/20 by the stated "Received VO [verbal e services to continue through in period. HHA 2 hrs [hours] a for grooming, bathing, light				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	I	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
G 584	housekeeping." The the document that it v on 10/29/20 at 1:13 P agency signed by the 11:58 AM. The order order was obtained from the director of 10/30/20 and indicated the certification period. 5. The clinical record on 10/30/20 and indicated the certification period. An agency physician the director of nursing 176 mg/5 ml daily by failed to identify it was the order was received buring an interview of grandmother of patien had a g-tube which all through. 6. The clinical record on 10/30/20 and indicated a g-tube which all through. 6. The clinical record on 10/30/20 and indicated a g-tube which all through. An agency physician 9/8/20 by the director "Verbal order for SN rand HHA 2 hours a day order failed to identify where the order was a grant	order indicated at the top of vas faxed to the physician M and re-faxed back to the physician on 11/5/20 at or failed to indicate who the om or if it was read back of patient #4 was reviewed ated a start of care date of contained a plan of care for d of 8/24/20-10/22/20. order dated and signed by 1 on 8/20/20 stated "senna mouth (PO)." The order is a verbal order, or where d from. In 11/2/20 at 1:03 PM, the not #4 indicated the patient I meds and feeding went of patient #5 was reviewed ated a start of care date of contained a plan of care for d of 9/4/20-11/2/20. order dated and signed of nursing which stated medication set up weekly ay 4 days a week." The it was a verbal order, or received from.	G	584		
G 588	IAC 410 17-14-1 (a)(F Reviewed, revised by	-) physician every 60 days	G 5	588		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		15K164	B. WING				20/2020
NAME OF PR	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	117.	20/2020
			5257 N TACOMA DR SUITE 4		257 N TACOMA DR SUITE 4		
APPLE TR	REE HOME HEALTH CAR	E SERVICES, LLC		IN	IDIANAPOLIS, IN 46220		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	OVIDER'S PLAN OF CORRECTION	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 588	Continued From page	280	6.1	500			
0 300	CFR(s): 484.60(c)(1)	5 00	G ;	588			
	The individualized pla and revised by the ph for the home health p frequently as the patic require, but no less fr days, beginning with the This ELEMENT is not Based on record revi- ensure the plan of car to ensure accurate in 1 of 5 active records of Findings include:	at met as evidenced by: If we the agency failed to If was reviewed and revised If the formation was recorded for If the fail the					
	10/27/20 and indicate 7/11/17. The record of the certification period indicated diagnoses of hyperplasia with lower hyperlipidemia, and ty the plan of care stated injuries or hospital vis [certification] period	r urinary tract symptoms, ype 2 diabetes. Additionally d "[patient] has not had any its during this cert ." A recertification esment was completed on					
	home health aide not patient was not feelin the aide to send the patient department. The patient emergency department constipation with a net (medication to treat net plan of care failed to leave the patient of the p	ated 8/10/20 indicated the ified the nurse that the g well and the RN instructed patient to the emergency tent did have a visit to the ent that day for vomiting and the worder for promethazine ausea and vomiting). The one updated to show that the he hospital during the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(>	(3) DATE SURVEY COMPLETED
						С
		15K164	B. WING _			11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 588	identical and failed to	od.	G 5	88		
G 590	CFR(s): 484.60(c)(1) The HHA must promp physician(s) to any clean condition or needs the are not being achieved care should be altered. This ELEMENT is not a Based on observation director of nursing fair was notified of changes skilled nurse visits observed. Findings include:	otly alert the relevant hanges in the patient's at suggest that outcomes ed and/or that the plan of d. ot met as evidenced by: on and record review the led to ensure the physician les in condition for 1 of 1 oserved (#3).	G 5	90		
	5/14/20. The record the certification perio indicated orders for a other week for med s and skilled nurse sup hours, 5 days per we of motion, ambulation A home visit observa 10/29/20 at 12:40 PM	tion was completed on				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
							С
		15K164	B. WING			11/	20/2020
	ROVIDER OR SUPPLIER	E SERVICES, LLC		52	REET ADDRESS, CITY, STATE, ZIP CODE 57 N TACOMA DR SUITE 4 DIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 590	complained about "fer having pain in the bac "electric" feeling in he to document the visit		G	590			
G 608	needs, and involve the any), and caregiver(secoordination of care at This ELEMENT is not Based on record reviagency failed to ensure completed with the grapatients resided for 1 lived in a group home 10. Findings include: The clinical record of 10/27/20 and indicate 7/11/17. The record of the certification period which indicated home 12 hours per day for activities of daily living activities activiti	ery to meet the patient's e patient, representative (if), as appropriate, in the activities. It met as evidenced by: I ew and interview, the re coordination of care was roup homes where the of 1 active patients who e (#1), in a total sample of the contained a plan of care for d of 10/23/20-12/21/20 e health aide (HHA) orders of d days a week for personal g (ADL), instrumental g (IADL), around the clock paration, bathing, dressing,	G	608			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(
		15K164	B. WING _			11/	20/2020
	ROVIDER OR SUPPLIER	E SERVICES, LLC		52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 608	8:00 AM, the patient of group home and a state home was present in staff failed to communduring the visit. The comprehensive at 10/22/20 failed to evice the patient living in at the patient living in a the patient living	completed on 10/29/20 at was observed living in an aff person from the group the home, but the agency nicate with group home staff assessment dated on dence information regarding group home. Vidence documentation of with the group home staff. In the group home staff are the patient/family the visit schedule for home home visit observations (#1, patient #1 was reviewed on a start of care date of contained a plan of care for d of 8/24/20-10/22/20, bservation on 10/29/20 at older for patient #1 was		608	DELIGITY		
	from April 2020. The	isit schedule observed was folder failed to have an up from the current certification					

	DF DEFICIENCIES CORRECTION			(X3) DATE COMP	SURVEY		
		15K164	B. WING				C 20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		5257 N TAC	DRESS, CITY, STATE, ZIP CODE COMA DR SUITE 4 POLIS, IN 46220		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 614	10/28/20 and indicate 8/27/20. The record the certification period 11:00 AM, the home visit of 11:00 AM, the home viewed and failed to shome health staff. The clinical record of 10/28/20 and indicate 5/14/20. The record the certification period a home visit observat AM, the home folder and failed to evidence health staff. During an interview of director of nursing was a schedule of visits, so treatments and there CFR(s): 484.60(e)(3) Any treatments to be personnel and person HHA, including thereof the person of	patient #2 was reviewed on ed a start of care date of contained a plan of care for d of 8/27/20-10/25/20. bservation on 10/29/20 at folder for patient #2 was evidence a visit schedule of patient #3 was reviewed on ed a start of care date of contained a plan of care for d of 7/20/20-9/17/20. During cion on 10/29/20 at 12:40 for patient #3 was viewed e a visit schedule of home on 10/29/20 at 12:50 PM, the est asked if patients received the stated "I'm not sure." apy services administered by HHA annel acting on behalf of the easy services. The patient family on the plan of care in dige of any treatments to be and teaching, or medication	G		DETICIENCY		
	Findings include:						

AND DUAN OF CORDECTION		1 ' '	PLE CONSTRUCTION G	l ^{(X}	3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	I	11/20/2020
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
G 618	18 Continued From page 85		G 6	18		
	10/27/20 and indicate 7/11/17. The record of the certification period 8:00 AM, the home for viewed and it failed to from the current certification period 10/28/20 and indicate 8/27/20. The record the certification period During a home visit of 11:00 AM, the home six viewed and it failed to from the current certification period 11:00 AM, the home six viewed and it failed to from the current certification period the current certification the current	patient #2 was reviewed on ed a start of care date of contained a plan of care for d of 8/27/20-10/25/20. bservation on 10/29/20 at folder for patient #2 was o evidence a plan of care				
G 622	5/14/20. The record the certification period a home visit observat AM, the home folder and it failed to eviden current certification puring an interview of director of nursing was a copy of their plan of all have been mailed.	n 10/29/20 at 12:50 PM, the as asked if patients received f care, she stated "yes, not	G 6	22		
3 022	CFR(s): 484.60(e)(5) Name and contact intermanager.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		C 11/20/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
G 640	Based on record revifailed to ensure the nof the director of nursin writing for 3 of 3 hocompleted (#1, 2, 3). Findings include: 1. A home visit observemployee H, home hotology at 8:00 AM, 7/11/17). The home for to identify the name at the director of nursing. 2. A home visit observemployee OO, HHA, with patient #2 (start of folder was viewed an and contact information. 3. A home visit observemployee C, director 10/29/20 at 12:40 PM care 5/14/20). The hotological folder was viewed an and contact information. 4. During an interview the director of nursing and contact information home visits. Quality assessment/pCFR(s): 484.65	ew and interview the agency ame and contact information ing was given to the patients me visit observations vation was conducted with ealth aide (HHA), on with patient #1 (start of care older was viewed and failed and contact information of l. vation was conducted with on 10/29/20 at 11:00 AM, of care 8/27/20). The home of failed to identify the name on of the director of nursing. vation was conducted with of nursing (DON), on , with patient #3 (start of me folder was viewed and ame and contact information ing. v on 10/29/20 at 12:50 PM, I stated she gave her name on verbally to patients at erformance improvement	G 62		

OLIVILIV	O T OIT WILDIO, ITTE G	WEDIO/ ND GET WIGEG					7. 0000 000 I
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				-		، ا	C
		15K164	B. WING			1	20/2020
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 117.	20/2020
					257 N TACOMA DR SUITE 4		
APPLE TR	REE HOME HEALTH CAR	RE SERVICES, LLC			NDIANAPOLIS, IN 46220		
(V4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREF	Χ	(EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
					DEFICIENCY)		
G 640	Continued From page	a 87		640			
0010				040			
	maintain an effective	op, implement, evaluate, and					
		gram. The HHA's governing					
		at the program reflects the					
		inization and services;					
	involves all HHA serv						
	services provided und						
	-	es on indicators related to					
	improved outcomes,	including the use of					
		es, hospital admissions and					
		akes actions that address the					
	-	across the spectrum of care,					
		ion and reduction of medical					
		t maintain documentary					
		program and be able to					
	demonstrate its opera	not met as evidenced by:					
	Based on observatio	_					
	interview, the agency						
		and maintain an effective,					
	ongoing, agency wide						
		ice improvement program					
	•	cate the frequency and					
	method in which qual	lity indicators were to be					
	measured, analyzed,	and tracked, failed to show					
	measurable improver						
		health, safety, and quality of					
		the frequency and detail of					
	the data collection wa						
	governing body, and						
		ement projects all with an					
		n control due to the public ated to COVID-19. These					
	, ,	ential to affect all patients.					
	F. Source had the pot	to anote an patiente.					
	The cumulative effect	t of this systemic problem					
		y being out of compliance					
		Participation 484.65 Quality					
	assessment and perf	ormance improvement.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		15K164	B. WING _			C 1/20/2020	
	NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
G 640	Continued From pag	e 88	G 6	40			
	(QAPI)," Policy #B-20 develop, implement, effective, ongoing ag program SPECI/ agency's governing be program reflects the and services SCO program will be capa improvement in indic outcomes, client safe agency will identify, r quality indicators that events, and other releprocesses of care, se frequency and detail be approved by the gency's performance focus on high risk, his areas that are specific events will be tracked document the implemactions PERFORM PROJECTS: Beginnimust conduct perform" The entire QAPI bind at 11:05 AM. The bir and undated "QAPI sedocuments titled "seriors agency is performent to the implemactions PERFORM PROJECTS: Beginnimust conduct perform"	formance Improvement 50 stated "Policy: Agency will evaluate, and maintain an ency wide, data driven QAPI AL INSTRUCTIONS: The body must ensure that the complexity of its organization PE OF PROGRAM: The ble of showing measurable ators that will improve health ety, and quality for care. The measure, analyze, and track t include client adverse evant data to assess ervices, and operations. The of the data collection must poverning body BRAM ACTIVITIES: The e improvement activities will gh volume, or problem prone to this agency Adverse d and analyzed for cause and mentation of prevention MANCE IMPROVEMENT ng July 13, 2018, agencies mance improvement projects ler was reviewed on 10/27/20 meder evidenced an unsigned summary report, ten rvice/care documentation					
	16, and 17 and 5 dat	1/18 for patients #10, 14, 15, ed 1/28/19 for patients #1, 5, ument asked a series of 10					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 1/20/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 640	services are provide [sic] If no, what days provided match the cassigned task not condocumentation why task completed that sheet? If yes, what sassignment? Is the verification legible? Is there any documentation sheet assignment sheet? (initials same as previously signature and client/ there any document provided? (example refused bath but would lend to evidence with being monitored (not measurable improved alternate administrative responsible for the cand she indicated he nursing was. She with had an infection condition control programs with the QAPI programs believe so, I don't know the cassing an interview of the QAPI programs an interview of the QAPI programs and the QAPI pro	followed: "Do the day d match the assigned days? are missing? Does services client assignment sheet? If ompleted, is there (refused, ect?) Is there any is not on the assignment service was provided but not weekly documentation form indications that the t was a copy of a previous form has marks, signatures, rious sheets) IS staff time, family signature present? Is ation needed to clarify care. PRN [as needed] care, client ald allow face to be washed, to visit)" The documents inch quality indicators were ne related to COVID-19), any ment. Son 10/26/20 at 1:35 PM, the for was asked who was oversight of the QAPI program erself and the director of as also asked if the agency trol program and she stated, es," and the director of sible for the oversight of the gram. Son 10/29/20 at 12:50 PM, the as asked if she was involved arm. She stated "I don't	G 6	40			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		C 11/20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
G 640	to." During an interview administrator stated responsible for the data had been applied of a months. During an interview alternate administrate mployee D typed of previous employee audits they had con She also indicated QAPI meeting some wasn't able to be the	e all that they are supposed on 10/30/20 at 5:25 PM, the distriction of nursing was QAPI program, and no QAPI roved by the governing body on 11/5/20 at 10:28 AM the ator stated that previous up the last QAPI report after E, and herself submitted chart inpleted for human resources. the administrator completed a etime after March 2020, but "I ere." When queried if she port was, she stated "He might	G 64		
	administrator was a meeting was, he ind completed in late A they did not have a [employee EE], and there were no QAP agency had an infestated "I don't have what the agency did COVID-19, the admishould ask that patibefore having hand stated patient and staken and should b home, and the direct rounds to the patier Lastly he stated "to	on 11/5/20 at 3:00 PM, the asked when the last QAPI dicated he thought it was pril 2020. He also indicated committee it was "myself, at the clinical supervisor], and I minutes. When asked if the ction control program he a program." When queried do to screen and prevent ministrator indicated each staff tent about COVID symptoms is on contact. Furthermore, he staff temperatures should be de documented in the patient's ctor of nursing should make not's home to pick them up. my knowledge these leing done as they should be."			

AND DEAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	E	11/20/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 640	Home visit observations were completed on 10/29/20 at 8:00 AM with patient #1 and employee H, on 10/29/20 at 11:00 AM with patient #2 and employee OO. During the home visit observations, the patient's home folders were viewed and they failed to evidence temperature logs from patients and staff, aides failed to ask the patient's about COVID 19 symptoms or take the patient's temperature. During a home visit observation on 10/29/20 at 12:40 PM with patient #3 and employee C the patient's home folder was viewed and they failed to evidence temperature logs from patients and staff. Employee C failed to ask the patient about COVID-19 symptoms. Employee C took the temperature of patient # 3 and it revealed low grade temperature of 99.7. Furthermore, the patient complained about "feeling shaky" on the inside, having pain in the back and chest, and feeling an "electric" feeling in her head.		G	540		
G 680	CFR(s): 484.70 Condition of Participal and control. The HHA must maint infection control progue the prevention and communicable disease. This CONDITION is	and control ation: Infection prevention ain and document an ram which has as its goal ontrol of infections and	G	580		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3	3) DATE SURVEY COMPLETED		
		15K164	B. WING	B. WING		C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	'	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
G 680	followed infection corprecautions, and that program was created practices affected all. The cumulative effect resulted in the agency with the Condition of Infection Prevention at Findings include: The agency failed to standard precautions policies (See Tag G 6 The agency failed entinfection control prog surveillance, identification and investigation of pwith the addition of dealth emergency rel G 684). Infection Prevention CFR(s): 484.70(a) Standard: Infection P The HHA must follow practice, including the precautions, to preveinfections and common This STANDARD is a Based on observation interview, the agency followed standard present the standard p	refailed to ensure all staff and policies, standard an effective infection control and utilized. These patients. It of this systemic problem by being out of compliance Participation 42 CFR 484.70 and Control. The ensure all staff followed and infection control (882) Sure an agency-wide aram was maintained for the patient, prevention, control, patient and staff infections at a regarding the public atted to COVID-19 (See Tag) The revention accepted standards of the push of the public accepted standard and the transmission of		682		

1 '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		X3) DATE SURVEY COMPLETED	
		15K164	B. WING		1	C 1/20/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		11/20/2020	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
G 682	Continued From pag	e 93	G 6	82			
	stated "PURPOSE practices of agency sof pathogenic microsopersonnel in the hom HYGIENE TECHNIQ with soap and water. apply an amount of pranufacturer to hand vigorously for at least surfaces of hand and 2. A home visit obset 10/29/20 at 8:00 AM 7/11/17) and employed who provided personemployee H complet times. For 7 out of 7 washed hands between at least in part under failed to wash hands of time per CDC requored for 20 seconds, and fascrub was not complemated to the second of the seco	Hygiene," Policy # D-330 To improve hand hygiene staff and reduce transmission organisms to clients and the care setting HAND tuE: When washing hands wet hands first with water, product recommended by the sand rub hands together to 20 seconds, covering all					
	patient was in showe 7 second hand wash	while wearing gloves. After ed patient #2 (after shower),					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	11/20/2020
ADDLE TO	EE HOME HEALTH CAR	E SERVICES LLC		5257 N TACOMA DR SUITE 4		
APPLE IK	EE HOME HEALTH CAR	E SERVICES, LLC		INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	OTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
G 682	gloves were removed was completed. Ther patient's beard, hair a gloves were removed (without providing har failed to wash hands of time per CDC requipation of 20 seconds, failed hands being washed, hygiene prior to donning. 4. A home visit obsert 10/29/20 at 12:40 PM care 5/14/20) and emnursing) who provided Prior to care hands withen gloves were don temperature was take back into nursing bag. Employee C then tool saturation and pulse wiped it off with an alc in the nursing bag. The wastaken, then the calcohol pad and place assessment was then removed, and a 22 secompleted. Employed and complete hand higher the clean bag (to put inside), thus contaming.	, and 15 second hand wash a employee OO trimmed and mustache. Lastly, and new gloves donned and hygiene). Employee H for the appropriate amount irements and agency policy to remove gloves prior to and failed to complete hand and new gloves. Vation was completed on with patient #3 (start of ployee C, (director of d a nurses assessment. Here washed for 27 seconds, and thermometer placed (without being cleaned). As the patient's oxygen with the pulse oximeter, cohol pad and placed it back the patient's blood pressure and back in bag. Nursing a completed, gloves accord handwash was a C failed to remove gloves, wigiene prior to re-entering each alcohol equipment anating nursing bag. W on 10/30/20 at 3:53 PM, rator stated staff should	Ge	582		
G 684	IAC 410 17-12-1(m) Infection control		G 6	684		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		15K164	B. WING _		C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC	•	STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11120/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPLICATION OF THE PROPERTY OF THE APPLICATION	OULD BE COMPLETION	
G 684	identification, prevent investigation of infect diseases that is an ir quality assessment a improvement (QAPI) control program must (1) A method for ider communicable diseases (2) A plan for the appropriate of the prevention. This STANDARD is Based on observation interview, the agency agency-wide infection maintained for the suprevention, control, and staff infections we regarding the public COVID-19. These paffect all patients. Findings include: An undated agency particular agency in a undated agency is surveillance," Policy Apple Tree Home He establish a continuous collecting system to changes in infection	tain a coordinated in for the surveillance, ition, control, and itious and communicable integral part of the HHA's and performance in program. The infection it include: Intifying infectious and see problems; and improvement and disease in the tast evidenced by: Intifying infectious and see problems; and investigation of patient in control program was inveillance, identification, and investigation of patient investigation of data inves	Gé	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED			
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	ı	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
G 684	Prevention/Control," tree home health ser recommended preca identified by the Cer Prevention (CDC) An article published	Policy #B-403 stated "Apple rvices, LLC will observe the autions for home care as aters for Disease Control and ." by the CDC on 11/4/2020	G 6	84		
	recommendations for during he coronaviru Pandemic," stated ". symptoms will not id pre-symptomatic ind infection, symptom s important strategy to	on prevention and control or healthcare personnel as disease 2019 (COVID-19)Although screening for entify asymptomatic or ividuals with SARS-CoV-2 screening remains an oridentify those who could appropriate precautions can				
	on 10/27/20 at 11:05 infection control police B-406, and a blank "Additionally, there we screening," tools one administrator dated employee PP dated asked 5 questions re-					
	alternate administrat anyone with "any inf logged." During an interview alternate administrat	on 10/27/20 at 11:22 AM, the tor indicated they had not had ections that required to be on 10/26/20 at 1:35 PM, the tor was asked if the agency trol program and she stated,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		' '	(X3) DATE SURVEY COMPLETED			
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	<u> </u>	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
G 684	infection control production in the visit observations, the production in the program in the view administrator was a infection control program." When observations in the director of product. Furthermore temperatures should ocumented in the director of nursing patient's home to produce in the director of nursing patient's home to produce in the director of nursing patient's home to produce in the director of nursing patient's home to produce in the director of nursing patient's home to produce in the director of nursing patient's home to produce in the production of the production in the production	nsible for the oversight of the ogram. If on 11/5/20 at 3:00 PM, the asked if the agency had an ogram he stated "I don't have a useried what the agency did to t COVID-19, the administrator of should ask that patient about before having hands on ore, he stated patient and staff lid be taken and should be patient's home, and the should make rounds to the should make rounds to the sick them up. Lastly he stated these procedures aren't being lid be." ations were completed on M with patient #1 and 1/29/20 at 11:00 AM with patient DO. During the home visit opatient's home folders were and staff, aides failed to ask COVID 19 symptoms or take	G 6	· ·		
	12:40 PM with pati patient's home fold to evidence tempe staff. Employee C COVID-19 symptor temperature of pat grade temperature patient complained inside, having pain	t observation on 10/29/20 at ent #3 and employee C the ler was viewed and they failed rature logs from patients and failed to ask the patient about ms. Employee C took the lient # 3 and it revealed low of 99.7. Furthermore, the labout "feeling shaky" on the in the back and chest, and 'feeling in her head.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	COMPLETED			
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP (5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
G 684	symptoms the patier physician of the sym	o document the visit and the not that was having, or notify the uptoms.		684		
G 706	CFR(s): 484.75(b)(1 Ongoing interdiscipling patient; This ELEMENT is in Based on record refailed to complete a assessment of the pinursing visits for 2 on nursing (#3, 5), in a Findings include: 1. The clinical record on 10/28/20 and ind 5/14/20. The record the certification period indicated orders for other week for mediand skilled nurse surbours, 5 days per well of motion, ambulation Skilled nursing visits certification period bing/22/20-10/20/20. Althe cardiovascular significant in period bing/22/20-10/20/20. Althe cardiovascular significant in period bing/22/20-10/20/20. Althe cardiovascular significant in period bing/22/20-10/20/20, althe cardiovascular significant in period bing/22/20-10/20/20. Althe cardiovascular significant in period bing/22/20-10/20/20, althe cardiovascular significant in period bing/22/20-10/20/20. Althe cardiovascular significant in period bing/22/20-10/20/20, althe cardiovascular significant in period bing/22/20-10/20/20. Althe cardiovascular significant in period bing/22/20-10/20/20/20/20/20/20/20/20/20/20/20/20/20	inary assessment of the ot met as evidenced by: view, the skilled nurse (SN) thorough and complete atient during subsequent f 4 patients with skilled sample of 10. d of patient #3 was reviewed icated a start of care date of contained a plan of care for od of 9/18/20-11/16/20 which a registered nurse every set up, assessment, and aide pervision as well as HHA 3 eek for personal care, range	G	706		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K164	B. WING				20/2020
	ROVIDER OR SUPPLIER	EE SERVICES, LLC	•	52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 706	the certification period indicated orders for s week for medication s well as HHA 2 hours personal care, meal p housekeeping, and w Skilled nurse visits we director of nursing on visits were marked as was "WNL (within nor (AM) blood sugar rea	contained a plan of care for d of 9/4/20-11/2/20 which killed nursing (SN) once per set up and assessment as per day, 4 days per week for preparation, light reight log at each visit. ere completed by the 9/10/20-10/22/20. All the set the cardiovascular system and limits)," the morning ding was 150 every visit, the movement was 9/8/20 on	G	706			
G 710	Based on record revifailed to follow the wractive records review services, in a total of 3, 5). Findings include: 1. An undated agency documentation," Policy Agency will documentation." PURPOSE: accurate record of the	at are ordered by the	G	710			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		15K164	B. WING			C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		1112012020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
G 710	7/11/17. The record the certification period indicated orders for per week for medical assessment, and to summary of the plandlent to take pain more becomes severe to a SN to assess skin for to perform weekly we neurological assess instruct client to use when ambulating The skilled nurse fair orders as evidence all completed by the 9/8/20-10/27/20 all for was obtained, teach medication, or instruct was completed during the certification period indicated orders for per week for medical assessment, and to home health aide (Hodays a week for period (ADL), instrumental (IADL), meal prepar dressing, and light holds.	icated a start of care date of contained a plan of care for od of 8/24/20-10/22/20 which skilled nursing (SN) 1 time attion set up, head to toe supervise the aides. The of care stated "SN to instruct edication before pain achieve better pain control. For breakdown every visit. SN eights. SN to performs a ment each visit. SN to prescribed assistive device a weight ing regarding pain acting on assistive devices and the visit. In d of patient #2 was reviewed icated a start of care date of a contained a plan of care for od of 8/27/20-10/25/20 which skilled nursing (SN) 1 time attion set up, head to toe supervise the aides, and activities of daily living activities of daily living activities of daily living attion, set up assist, bathing,	G7	10		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		15K164	B. WING		11/2	0/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
G 710	Continued From pa	ge 101	G 7 ²	10		
	The alternate admir 10/30/20 after receiclinical record if the was everything from indicated it was. The record failed to visits had been comfor the start of care (10/25/20) thus the 4. The clinical record indicated orders for other week for medicated orders for other week for medicated nurse surprised to date (9/22 evidence completion patient was compliant was	inistrator was asked on ving copies at 1:09 PM of the copies received for patient #2 in "8/27/20 to current" and she evidence any skilled nurse inpleted/documented, except (8/27/20) and recertification SN frequency was not met. In the provided in the start of care date of indicated a start of care date of indicated a start of care date of indicated a plan of care for indicated in the previous of the previous as well as HHA 3 in the previous and preparent in the provided in the previous interest interest in the previous interest				
		were completed by the n 9/10/20-10/22/20. All the				

I i i		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K164	B. WING				C 20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		5257	ET ADDRESS, CITY, STATE, ZIP CODE N TACOMA DR SUITE 4 ANAPOLIS, IN 46220	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 710	were "diabetic monito sugar] daily diet te SN failed to evidence	nd interventions completed oring care check bs [blood aching reg [regular]." The completion of med box set as compliant with taking the	G	710			
G 798	Home health aide ass CFR(s): 484.80(g)(1) Standard: Home headuties. Home health aides as patient by a registere skilled professional, vinstructions for a hom that registered nurse professional (that is, speech-language pat therapist). This STANDARD is a Based on record rev registered nurse (RN health aides to specifiensure the aide care specific/individualized health aide (HHA) to an RN for 5 of 5 active home health aide ser sample of 10 records Findings include: 1. An undated agence manager," Policy#B-	alth aide assignments and re assigned to a specific d nurse or other appropriate with written patient care ne health aide prepared by or other appropriate skilled physical therapist, thologist, or occupational not met as evidenced by: iew and interview, the) failed to assign home fic patients and failed to plan contained patient d directions for the home follow that was created by re records reviewed with vices (#1, 2, 3, 4, 5), in a cy policy titled "clinical 105 stated ""POLICY This ical oversight over all client	G	798			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	((X3) DATE SURVEY COMPLETED
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	I DDE	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCE	ON SHOULD BE HE APPROPRIAT	
G 798	the clinical manager includes a. making coassignments" An undated agency paide care plan," Polic complete and appropries appropries and appropries and adentification and appropries and appropries and adentification and appropries and appropries and appropries and appropries and appropries and alternate by a series and particular client by a series and appropries and approp	The oversight provided by (s) [director of nursing] lient and personnel colicy titled "Home health by# C-751 stated " A coriate care plan shall be stered nurse All home follow the identified plan e shall be assigned to a registered nurse" Ew on 10/29/20 at 12:50 PM, g was asked who made the nts, she stated "[employee B] on 11/2/20 at 12:39 PM, d practical nurse) stated inployment, employee B (as expersonnel assignments.	G 7	98		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OATE SURVEY OMPLETED
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	'	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
G 798	dated 10/23/20 and nursing (DON) evid standard precautior oxygen (O2) precautomplete, but failed equipment were new 4. The clinical record on 10/28/20 and incomplete and the certification perimidicated orders for per week for medical assessment, and to home health aide (Hadys a week for per (ADL), instrumental (IADL), meal preparatesing, and light had An Agency documed dated 10/26/20 and nursing (DON) evid standard precaution ADLs as tasks for the to evidence what skeeded for those propersonal 9/23/20 at 10:45 AM administrator (a hor	nt titled "HHA Care Plan" signed by the director of enced fall precautions, as/Infection Control, and ations as tasks for the HHA to to evidence what skills or eded for those precautions. and of patient #2 was reviewed dicated a start of care date of ad contained a plan of care for od of 8/27/20-10/25/20 which skilled nursing (SN) 1 time ation set up, head to toe supervise the aides, and altha) 3 hours per day for 7 asonal activities of daily living	G 7			
	complete, but failed equipment were ne	DLs as tasks for the HHA to to evidence what skills or eded for those precautions. ernate administrator assigned				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTR A. BUILDING				OATE SURVEY OMPLETED		
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	COMPLIANCE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
G 798	Continued From pa	ge 105	G 7	98		
	"shower, hair care/o assist with transfer, ambulation, light ho "every visit."	e assistants to complete comb hair, oral care, skin care, range of motion, assist with busekeeping," to be completed				
	on 10/28/20 and inc 5/14/20. The recor the certification per indicated HHA orde	rd of patient #3 was reviewed dicated a start of care date of d contained a plan of care for iod of 9/18/20-11/16/20 which ers for 3 hours, 5 days per eare, range of motion, rep.				
	dated 9/18/20 and s nursing (DON) evid precautions, standa Control, safety in Al during meals as tas	nt titled "HHA Care Plan" signed by the director of enced fall precautions, seizure and precautions/Infection DLs, and proper position lks for the HHA to complete, ce what skills or equipment ose precautions.				
	on 10/30/20 and inc 4/22/20. The record the certification per	rd of patient #4 was reviewed dicated a start of care date of d contained a plan of care for iod of 8/24/20-10/22/20 which rs for 9 hours per day, 5 days				
	dated 8/24/20 and s nursing (DON) evid standard precautior in ADLs as tasks fo	ont titled "HHA Care Plan" signed by the director of enced fall precautions, as/Infection Control, and safety or the HHA to complete, but what skills or equipment were recautions.				
	7. The clinical reco	rd of patient #5 was reviewed				

	DF DEFICIENCIES CORRECTION			(X	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING			C 11/20/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		11/20/2020
ΔPPI F TR	EEE HOME HEALTH CAR	E SERVICES LLC		5257 N TACOMA DR SUITE 4		
ALLELIN	CE HOME HEALTH OAK	LE GERVIGEO, LEG		INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
G 798	9/20/17. The record of the certification period indicated HHA orders per week for personal light housekeeping, at An Agency document dated 9/6/20 and sign (DON) evidenced fall precautions/Infection precautions, and safe HHA to complete, but skills or equipment we precautions.	cated a start of care date of contained a plan of care for d of 9/4/20-11/2/20 which for 2 hours per day, 4 days I care, meal preparation, and weight log at each visit. Ititled "HHA Care Plan" are deed by the director of nursing precautions, standard Control, oxygen by in ADLs as tasks for the failed to evidence what	G.	798		
G 800	CFR(s): 484.80(g)(2) A home health aide p (i) Ordered by the phy (ii) Included in the pla (iii) Permitted to be per (iii) Permitted to be per (iv) Consistent with the consistent with the consistent with the complete clinical results aide failed to fer the complete clinical results ample of 10 records Findings include: 1. An undated agency aide care plan," Policy complete and appropriate in the physical properties of the complete and appropriate in the physical properties and properties are plan, and the physical plan plan plan plan plan plan plan pl	rovides services that are: /sician; n of care; erformed under state law; le home health aide training. It met as evidenced by: lew and interview, the home follow the plan of care for 8 of cords reviewed, in a total (#1, 2, 3, 4, 5, 8, 9, 29).	G	800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C I1/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	•	11/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 800	health aide staff will for The home health aide particular client by a second on 10/27/20 and indicated orders for second per week for medicate assessment, and to second home health aide (Health aide (Health aide)), instrumental at (IADL), around the clarge preparation, set up as light housekeeping. Viewed in the electron documentation was not hours, the HHA fair frequency as evidence. On 8/29/20, 10/4/20, made to the patient. On 9/12/20, 9/13/20, hour visits were completed on 8/28/20, 9/6/20, 9/14/20-9/18/20, 9/21 visits were completed. On 8/30/20, a six hour on 8/24/20-8/27/20, 9/12/20, and hour visits were completed.	collow the identified plan e shall be assigned to a registered nurse" If of patient #1 was reviewed cated a start of care date of contained a plan of care for d of 8/24/20-10/22/20 which killed nursing (SN) 1 time ion set up, head to toe supervise the aides, and HA) 12 hours per day for 7 conal activities of daily living lock supervision, meal esist, bathing, dressing, and The patient's calendar was nic record, but visit led to follow the ordered led by: and 10/14/20, no visits were 9/20/20, and 9/26/20, two pleted each day. d 10/2/20, and 10/12/20, four pleted each day. //9/20, 9/10/20, 9/11/20, //20, and 9/22/20, five hour	G 8				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			1	C 20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		11720/2020	
(X4) ID PREFIX TAG			ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE
G 800	Continued From pag	e 108	G 8	300			
	were completed eac	h day.					
		9/29/20, 10/3/20, 10/6/20, 0/18/20, eight hour shifts h day.					
	On 9/23/20, a ten ho	ur shift was completed.					
	On 9/25/20 and 10/1 completed each day	/20, eleven hour shifts were					
	alternate administrat patient #1 record wh notes from 8/24/20-1 administrator indicat "saved" not "comple documentation was visualized. She indict to have her complete printed. No docume	viewed, it was not able to be cated she would contact her e them so they could be ntation was ever submitted.					
	on 10/28/20 and indi 8/27/20. The record the certification period indicated orders for seper week for medical assessment, and to home health aide (H days a week for personal (ADL), instrumental separations.	d of patient #2 was reviewed cated a start of care date of contained a plan of care for od of 8/27/20-10/25/20 which skilled nursing (SN) 1 time tion set up, head to toe supervise the aides, and HA) 3 hours per day for 7 conal activities of daily living activities of daily living ation, set up assist, bathing, ousekeeping.					
		ol record document copies 0//30/20 at 11:39 AM.					
	The alternate admin	strator was asked on					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020	
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		11/20/2020	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G 800	clinical record if the was everything from indicated it was. The record failed to aide visits had been the HHA frequency 4. The clinical record on 10/28/20 and indicated HHA order week for personal composition ambulation, meal properties the ordered frequent. The record evidence 10/20/20, one to five 1-4 hours each being per day ranged from 5. The clinical record on 10/30/20 and indicated HHA order per day ranged from the certification per indicated HHA order per week. The HHA frequency the entire evidenced by: On 9/12/20-9/13/20 9/26/20-9/27/20, 10/9/20-10/11/20, 10/9/20-10/11/20, 10/9/20-10/11/20, 10/9/20-10/11/20, 10/9/20-10/11/20, 10/9/20, 9/24/	wing copies at 1:09 PM of the copies received for patient #2 in "8/27/20 to current" and she evidence any home health a completed/documented, thus was not met. Ind of patient #3 was reviewed dicated a start of care date of id contained a plan of care for iod of 9/18/20-11/16/20 which iters for 3 hours, 5 days per iters, range of motion, rep. The HHA failed to follow here as evidenced by: Indeed every day fro 9/18/20 to evisits per day ranging from any completed daily. Total hours in 1 hour to 13 hours. Ind of patient #4 was reviewed dicated a start of care date of id contained a plan of care for iod of 8/24/20-10/22/20 which is for 9 hours per day, 5 days in A failed to follow the ordered in exercision period as 1, 9/15/20-9/23/20, 0/1/20-10/7/20, 0/17/20 and 10/18/20, no	G 8				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		11	C / 20/2020	
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	<u>'</u>	120/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G 800	Continued From pa	ge 110 completed each day.	G 80	00			
		16/20, a 4 hour shift was					
		nour shift was completed, and nour shift was completed.					
	on 10/30/20 and ind 9/20/17. The record the certification per indicated HHA orded per week for persor	ord of patient #5 was reviewed dicated a start of care date of d contained a plan of care for iod of 9/4/20-11/2/20 which ers for 2 hours per day, 4 days hal care, meal preparation, and weight log at each visit.					
	On 9/13/20-9/19/20	, no visits were documented.					
	HHA documented to signed, but they fail hours/what times th	ed from 9/27/20-10/17/20, the asks completed, visits were led to evidence how many le visit was conducted which HHA met the ordered					
		his certification period, failed to ogged on the documentation.					
	on 11/2/20 and indi- 7/18/19. The recorn the certification per indicated orders for the certification per pressure areas, and On 11/17/19, 11/22, 12/7/19, 12/8/19, 12	ord of patient #8 was reviewed cated a start of care date of d contained a plan of care for iod of 11/16/19-1/14/20 that HHA 2 hours per day during iod for personal care, check d light housekeeping. 19, 11/24/19, 12/1/19, 2/14/19, 12/15/19 only a 1 coleted (not 2 hours per order).					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _				20/2020
NAME OF PR	ROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4	117.	20/2020
APPLE TR	EE HOME HEALTH CAR	E SERVICES, LLC			NDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 800	Continued From page	÷ 111	G	800			
	On 12/21/19, 1/6/20, completed.	and 1/14/20 no visit was					
	on 11/2/20 and indica 11/14/19 and a discha record contained a pla certification period of	11/14/19-1/12/20 which HA 12 hours per day for the personal care, meal					
		vidence any home health completed/documented, thus as not met.					
	date of 7/18/19. The care for the certification 11/16/19-1/14/20 which	and indicated a start of care record contained a plan of					
	On 11/16/19-12/15/19 12/28/19-12/29/19, 1/ 1/11/20-1/14/20, no vi completed/documente	4/20-1/6/20, isits were					
G 804	the director of nursing follow the plan of care aide care plan. Aides are members o	ew on 10/29/20 at 12:50 PM, g indicated staff should e and HHA should follow the f interdisciplinary team	G	804			
	CFR(s): 484.80(g)(4) Home health aides m	ust be members of the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '			(X3) DATE SURVEY COMPLETED	
						С	
		15K164	B. WING _			11/2	20/2020
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
APPLE TR	REE HOME HEALTH CAR	E SERVICES, LLC			257 N TACOMA DR SUITE 4		
		<u> </u>		IN	IDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 804	patient's condition to appropriate skilled procomplete appropriate the HHA's policies and This ELEMENT is not Based on record revibealth aides (HHA) fachanges in patient's caregistered nurse for (employees H and OCF Findings include: An undated agency phealth Aide," Policy#any observed or report condition and for need nurse"	must report changes in the a registered nurse or other ofessional, and must records in compliance with d procedures. It met as evidenced by: ew and interview, the home illed have knowledge that all condition must be reported to 2 of 2 interviewed HHA's D). colicy titled "Position: Home C-140 stated"Reports rted changes in the client's	G	804			
G 940	employee H was aske about a patient's cond it to. She stated "[em hours, would call the During an interview o employee OO was as about a patient's cond it to. She stated "[em Organization and adn CFR(s): 484.105 Condition of participal administration of serve The HHA must organists resources to attain	ed if they had a concern dition, who they would report ployee B] if it was after on call number. In 10/29/20 at 11:00 AM, ked if they had a concern dition, who they would report ployee B] or [employee C]" ninistration of services	G	940			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING			C 11/20/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	IP CODE	11/20/2020	
(X4) ID PREFIX TAG			ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
G 940	optimal care to achie identified in the patie patient's medical, nu needs. The HHA must and supervisory fund another agency or or not furnished directly controlled. The HHA organizational struction authority, and services. This CONDITION is Based on observation interview, the agency who the administrator were for 1 of 2 home interviewed during he the governing body, nursing fulfilled all repractices impacted a The cumulative effect has resulted in the he to ensure the provision environment for the CFR 484.105 Organis Services. In regards to G 940, During an interview of employee H was ask administrator was. Sine then was asked administrator was.	eve the goals and outcomes int's plan of care, for each rising, and rehabilitative st assure that administrative stions are not delegated to reganization, and all services are monitored and must set forth, in writing, its are, including lines of ses furnished. In the metias evidenced by: on, record review, and affect administrator in health aide's (HHA) one visits (employee H), the administrator, and director of sponsible duties. These affects affects affects are health agency's inability on of quality of care in a safe condition of Participation 42 dization and Administration of findings include: On 10/29/20 at 8:00 AM, and who the agency's who the alternate of the stated "[employee B]." Who the alternate of the stated "[person H], I employee by that name on the stated "[person H], I employee by that name on the stated "[employee by the stated "	G	940			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	120,2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
G 940	information regardin approvals, fiscal operation quality assessment (QAPI) approvals (Some aday to day functions 948). The administrator fare director of nursing wooperating hours (see The administrator was augoverning body (See The administrator fare operating hours (See The director of nursing personnel and patient patient care (See Tathe director of nursing hours). The director of nursing personnel and patient personnel personnel and patient personnel	minutes failed to evidence g policy review updates, and eration approvals, budget lal plans and approvals, and performance improvement ee Tag G 942). Illed to be responsible for the of the agency (See Tag G erag erag erag erag erag erag erag erag	G 94		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING			C 11/20/2020	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	CODE	11/20/2020	
(X4) ID PREFIX TAG			ID PREFII TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
G 942	CFR(s): 484.105(a) Standard: Governing A governing body (or functioning) must assure responsibility for the management and ophome health services the agency's budget and its quality assess improvement program. This STANDARD is Based on record revigoverning body minuinformation regarding approvals, fiscal operapprovals, operation quality assessment program. (QAPI) approvals. Findings include: An undated agency prolicy B-100 stated in INSTRUCTIONS: The governing bodd direction and leaders in the agency's quality performance improved Adopt and periodical administrative and prolicies and procedus state licensure regulations are governed to the survey was concontrolled. The survey was concontrolled.	designated persons so sume full legal authority and agency's overall eration, the provision of all s, fiscal operations, review of and its operational plans, sment and performance m. not met as evidenced by: riew and interview, the stes failed to evidence g policy review updates, and ration approvals, budget all plans and approvals, and performance improvement colicy titled "Governing body," cSPECIAL e duties and responsibilities y shall include 4. provide thip and be directly involved the ament program(QAPI). 5. ly review and approve the ersonnel policies, client care res, bylaws as required by ations, the annual operating	G	942			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COMPLETED	
		15K164	B. WING		C 11/20/2020
	NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	1 11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
G 942	in Fort Wayne on 10 Governing body shountil 11/5/20 (when it present). During the entrance copy of the governin requested. At 1:18 members was received board members as: Person D, and patie of board members wadministrator with the Employee S, EE, AA Review of the agence was completed on 1 were requested since The meeting dates if followed: The governing body failed to have any in budgets, operational plans, Comparational pl	of/29/20. No members of the level presence in the survey the administrator was conference on 10/26/20 a leg body members was PM, a copy of the board wed with the names of the Employee's A, EE, U, AA, nt#5. At 1:44 PM, another list was submitted by the alternate lee names of the board as: A, Person D, and patient #5. by governing body minutes 0/30/20 at 3:10 PM, which lee inception of the company. From 2018 to current were as meeting minutes for 4/26/18 formation regarding policies, I plans, QAPI, or PIPS. meeting minutes for 8/2/18 manged and modified some of lee health policies] but failed to in regarding budgets,	G 94	12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020
	NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	•	11/20/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 942	Continued From pag		G S	142		
	[human resources], t failed to have any in budgets, operational	ting and report on (QA. HR financials" The meeting formation regarding policies, plans, QAPI, or PIPS. meeting minutes for 12/12/18				
	was blank under the new business, PSA	categories: old business, (personal service agency) rt, QA report, supervisor d failed to have any g policies, budgets,				
	A singular document Heath Care Services Board approval date signatures of employ failed to evidence a was held and it failed about the agencies by	titled "Apple Tree Home s, LLC BUDGET 2019 & 2020				
	stated "[patient 2] is failed to have any in	meeting minutes for 2/19/19 waiting to get serviced" and formation regarding policies, plans, QAPI, or PIPS.				
	stated "Vote [employ administrator," but fa	meeting minutes for 5/21/19 yee A] as the new alled to have any information udgets, operational plans,				
	stated "New busines approval" but failed t	meeting minutes for 8/12/19 as: prepare a new budget for to have any information udgets, operational plans,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	E	11/20/2020	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
G 942	The governing body r (last documented me categories: approval the health services application, report, and failed to health services application, report, and failed to he regarding policies, but QAPI, PIPS, or the application was listed as 12/10/1. A copy of the agency received on 11/5/20 a failed to be dated as at the governing body. During an interview of alternate administrate met one time per year. During an interview of alternate administrate administrate binder "probably don' supposed to." During an interview of administrator was ast reviewed and approve bylaws, budgets, QAF it was completed, to was used if the board approved asked if the board approved and approved asked if the board approved asked if the boar	meeting minutes for 11/5/19 eting) was blank under the of budget, new hires, home cation, VA[veteran affairs] new clients, administrator's ave any information idgets, operational plans, opointment of the alternate vee B) whose date of hire 9 on the employee list. Is bylaws was requested and at 3:35 PM. The bylaws adopted or last reviewed by in 10/26/20 at 1:35 PM, the or stated the governing body	GS	042			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING		C 11/20/2020	
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11120/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
G 948 G 948	CFR(s): 484.105(b) (ii) Be responsible for the HHA; This ELEMENT is represented to day functions of the day functions of the second readministrator failed to day functions of the second regulation, accreditation, ac	day-to-day operations (1)(ii) or all day-to-day operations of not met as evidenced by: eview and interview, the to be responsible for the day he agency. policy titled "Governing body," "SPECIAL he duties and responsibilities dy shall include 1. Appoint a tor. Delegate to that individual sponsibility for the operations lude provision of home care nce with state and federal ation standards, and agency	G 94 G 94			
	and 11/5/20. Home in Fort Wayne on 10 showed presence ir The alternate admir	visits were conducted all day 0/29/20. The administrator in the survey only on 11/5/20. histrator provided copies, questions, obtained access to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING				C 20/2020
NAME OF P	ROVIDER OR SUPPLIER	ionio:		STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 11/	20/2020
10 101 11	to vibert of tool i eleft				57 N TACOMA DR SUITE 4		
APPLE TR	REE HOME HEALTH CAR	RE SERVICES, LLC			DIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 948	Continued From page	e 120	G 9	948			
	surveyor, made calls	I record system for the to families and patients to d was the active face of the					
		he administrator on 10/30/20 s no answer and a voicemail					
	administrator on 10/3 asked who was in chafunctions of the agenasked what her day to she indicated she did to making sure aides supposed to be doing director of nursing with made sure orders we incoming calls, return especially scheduling she made sure the di	ducted with the alternate 0/20 at 3:05 PM. She was arge of the day to day cy. She stated "me." When o day functions looked like everything from scheduling, were doing what they were g, chart audits, helped the th quality assurance duties, re faxed out, answered all led calls, took patient calls i, if patient care issues arose rector of nursing knew about					
	with personnel files, he consulted with the director complaint was clinical nursing to approve reshe did nothing with and stated "I am an alternate administrator reported to the administrator office about once per initially moved to Indinow and she had not weeks. Furthermore, available 24 hours a worked at the agency	of nursing, completed audits nandled complaints and sector of nursing if the I, worked with the director of offerrals/admission, but stated governing body or the budget office manager with an or title." She indicated she histrator and he was in the week when the office anapolis, but not as often					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COL 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	DE	11/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
G 948	Continued From pag	ne 121	G	048		
	queried on the role of "he is the administral patient's family to ge refused, he handled the field, he overseed dealt with the budge	the weekends. When of the administrator she stated tor by title." He has called a of the avisit when they some concerns with aides in s payroll and billing, and t. Inducted when a returned call				
	10/30/20 at 5:25 PM charge of the day to He stated "Me and [asked what his day the administrator. Hon-call for phone cal	by the administrator on . He was asked who was in day functions of the agency? employee B] is." He was to day functions look like as e indicated he was always ls from the alternate byee B), sometimes he had to				
	"calls me about to ta was asked how ofter indicated that he we once per week. Who full-time job elsewher Lastly, when asked we	or anything (employee B) ke care of on this end." He he came to the office. He ht to the office a minimum of en queried if he had a hre he stated "Yes ma'am." hwhat his availability was, he				
	him flexibility and sta to readjust the admin myself." At that time were several concer	ary not hourly so that gave ated "we are currently looking nistrative staff, and removing e, he was notified that there ns noted with the agency and viewed with the alternate				
	administrator indicat and the office was in on reasoning for mo when all patients we he indicated it was the	on 11/5/20 at 3:00 PM, the ed he lived in Fort Wayne Indianapolis. When queried ving office to Indianapolis re currently in Fort Wayne, the intention for the agency to the start, and since				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		451/404				
		15K164	B. WING _		11/2	20/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
APPLE TR	REE HOME HEALTH CAR	E SERVICES, LLC		5257 N TACOMA DR SUITE 4		
				INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 948	office to Indianapolis He was asked if he ki care documents had Indianapolis office, bu Wayne, Indiana. He s that." The alternate ac hasn't been updated i record as it is pre-pop asked if he was awar alternate administrate the capacity of the ad administrator is unava or vacation. He state now," then indicated if	d he wanted to move the since "she lives down here." new the patient's plan of the street address of the at the city and state was Fort stated "no I didn't know dministrator then indicated it in the electronic medical culated. Lastly, he was the purpose of an or should only be to to act in ministrator only when the callable due to acute illness d "OK, I am aware of it the would be submitting the or's name to the board to inistrator.	GS	148		
G 950	Ensure clinical manage CFR(s): 484.105(b)(1) (iii) Ensure that a clinic paragraph (c) of this soperating hours; This ELEMENT is not Based on record reviadministrator failed to nursing was available Findings include: An undated agency period Policy B-100 stated "INSTRUCTIONS: The of the governing body	ger is available)(iii) ical manager as described in section is available during all of the met as evidenced by: lew and interview, the length end in the director of length end all operating hours.	G 9	950		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		15K164	B. WING _			C 11/20/2020	
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	E	29.2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
G 950	The agency phone 10/26/20 at 10:10 A answered. Employer moved to 5257 N Ta about a month ago, in Fort Wayne, there to drop off paperwo available 24 hours puring an interview family of patient #2 a nurse was available. During an interview director of nursing with days/times that she role as director of nursing with days/times that she role as director of nursing with would be ablest clinical set of the clinical need came a stated there would be she possibly would a phone call but if significant would not be reported the alternamost of the time after used to take the on moved to Indianapo call. If a clinical need would call her, she emergent or if it could	number was called on M, and employee B Be B reported the agency acoma Ave, Indianapolis, there was no longer an office Be's only a "virtual site" for staff rk, and there's a nurse	G	950			
	10/29/2020 7:41 PN voicemail, and indic	The call went straight to ated to call 911 if emergency, be returned by the end of the					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			DATE SURVEY COMPLETED
	15K164	B. WING			C 11/20/2020
	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	•	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
day. Left voicemail w from a nurse was req number for the agenc patient name was left Employee B (alternaticall on 10/30/2020 at there was a voicemai with a nurse, apologiz they had trouble with everything was okay, particular patient, and nurse. She was instruprevious night and the needed. During an interview of alternate administration with the phone lines a rolled over to the cell not obtained until the before. She stated it times, but she had be company. During an interview of alternate administration and interview of alternate administration that the director of nurse.	hich indicated a call back uested, with a phone by to call back. No name or a search of the call back. No name or a search of the call was about a difference of the call was about a difference of the phones. She asked if if the call was about a difference of the call was about a difference of the phones with a cated the need was the at a nurse call was no longer on 10/30/20 at 9:00 AM, the or stated there was issues and the phones were not phone so the voicemail was morning from the night had happened a couple the in contact with the or stated she was unaware ursing was not available on	G	950		
CFR(s): 484.105(b)(2 When the administrated qualified, pre-designated authorized in writing leadings.	or is not available, a ated person, who is by the administrator and the	G s	954		
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR IN THE PROPERTY OR INTERPRETATION O	TORRECTION IDENTIFICATION NUMBER: 15K164 ROVIDER OR SUPPLIER REE HOME HEALTH CARE SERVICES, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 124 day. Left voicemail which indicated a call back from a nurse was requested, with a phone number for the agency to call back. No name or patient name was left. Employee B (alternate administrator) returned a call on 10/30/2020 at 8:11 AM. She indicated there was a voicemail left about needing to speak with a nurse, apologized for the delay, and stated they had trouble with the phones. She asked if everything was okay, if the call was about a particular patient, and if needed to speak with a nurse. She was instructed the need was the previous night and that a nurse call was no longer needed. During an interview on 10/30/20 at 9:00 AM, the alternate administrator stated there was issues with the phone lines and the phones were not rolled over to the cell phone so the voicemail was not obtained until the morning from the night before. She stated it had happened a couple times, but she had been in contact with the company. During an interview on 10/30/20 at 3:05 PM, the alternate administrator stated she was unaware that the director of nursing was not available on Monday and Fridays for patient needs.	TOURISH TOUR NUMBER: A BUILDI B. WING ROVIDER OR SUPPLIER REE HOME HEALTH CARE SERVICES, LLC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 124 day. Left voicemail which indicated a call back from a nurse was requested, with a phone number for the agency to call back. No name or patient name was left. Employee B (alternate administrator) returned a call on 10/30/2020 at 8:11 AM. She indicated there was a voicemail left about needing to speak with a nurse, apologized for the delay, and stated they had trouble with the phones. She asked if everything was okay, if the call was about a particular patient, and if needed to speak with a nurse. She was instructed the need was the previous night and that a nurse call was no longer needed. During an interview on 10/30/20 at 9:00 AM, the alternate administrator stated there was issues with the phone lines and the phones were not rolled over to the cell phone so the voicemail was not obtained until the morning from the night before. She stated it had happened a couple times, but she had been in contact with the company. During an interview on 10/30/20 at 3:05 PM, the alternate administrator stated she was unaware that the director of nursing was not available on Monday and Fridays for patient needs. IAC 410 17-12-1(d) Ensures qualified pre-designated person CFR(s): 484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the	RECORRECTION IDENTIFICATION NUMBER: 15K164 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 124 day, Left voicemail which indicated a call back from a nurse was requested, with a phone number for the agency to call back. No name or patient name was left. Employee B (alternate administrator) returned a call on 10/30/2020 at 8:11 AM. She indicated they had trouble with the phones. She asked if everything was okay, if the call was about a particular patient, and if needed to speak with a nurse, apologized for the delay, and stated they had trouble with the phones were not rolled over to the cell phone so the voicemail was not obtained until the morning from the night before. She stated it had happened a couple times, but she had been in contact with the company. During an interview on 10/30/20 at 3:05 PM, the alternate administrator stated she was unaware that the director of nursing was not available on Monday and Fridays for patient needs. IAC 410 17-12-1(d) Ensures qualified pre-designated person CFR(s): 484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the	TISK164 ROWIDER OR SUPPLIER REF HOME HEALTH CARE SERVICES, LLC SUMMARY STATEMENT OF DEFICIENCES PROVIDERS RUM OF CORRECTION PREFIX TAGO PROVIDERS RUM OF CORRECTION PROVIDERS THAN OF CORRECTION PREFIX TAGO PROVIDERS RUM OF CORRECTION PROVIDERS TAGO PROVIDERS RUM OF CORRECTION PROVIDERS TAGO PROVIDER

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _				20/2020
	ROVIDER OR SUPPLIER REE HOME HEALTH CAR	E SERVICES, LLC		52	REET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 IDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
G 954	the clinical manager a (c) of this section. This ELEMENT is not Based on record reviagency failed to ensure administrator was aut governing body. Findings include: An undated agency peolicy B-100 stated "INSTRUCTIONS: The of the governing body qualified administrator the authority and responsation, accreditation, accr	bligations as the e-designated person may be as described in paragraph of the met as evidenced by: sew and interview, the re the alternate thorized in writing by the colicy titled "Governing body," SPECIAL eduties and responsibilities of shall include 1. Appoint a r. Delegate to that individual consibility for the operations de provision of home care see with state and federal ion standards, and agency	G	954			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
G 954	alternate administrate appointed her to the place IAC 410 17-12-1(d)(8	n 10/26/20 at 1:35 PM, the or stated the administrator position.		954		
G 956	available during all of This ELEMENT is not Based on record reviadministrator failed to operating hours. Findings include: An undated agency per Policy B-100 stated "INSTRUCTIONS: The of the governing body qualified administrator the authority and responsible of the agency to incluservices in accordance regulation, accreditate mission. 2. The administrator's rewhen acting in that reapproved by the governmeans physically prebe contacted by telepimeans"	a pre-designated person is perating hours. In the as evidenced by: it is and interview, the probabilities and responsibilities and responsibilities are consibility for the operations are provision of home care be with state and federal it is available during all as a sample of the person assumes are personabilities and obligations between the personabilities and obligations of the personable of the personable to the or other electronic	G	956		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		15K164	B. WING				20/2020
	ROVIDER OR SUPPLIER	l		5257 N	TADDRESS, CITY, STATE, ZIP CODE TACOMA DR SUITE 4 NAPOLIS, IN 46220	1 117.	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
G 956	in Indianapolis) on 10 and 11/5/20. Home vin Fort Wayne on 10/showed presence in The alternate adminisanswered interview of the electronic medica surveyor, made calls set up home visits an agency in the office. A call was placed to the at 2:51 PM, there was left. An interview was considered who was in chefunctions of the agent asked who was in chefunctions of the agent asked what her day the she indicated she did to making sure aides supposed to be doing director of nursing with made sure orders we incoming calls, return especially scheduling she made sure the did it, hired all staff except through the director of with personnel files, I consulted with the director of with personnel files, I consulted with the director of the agent and stated "I am an of alternate administrator reported to the administrator reported reporte	20/27/20, 10/28/20, 10/30/20, visits were conducted all day 29/20. The administrator the survey only on 11/5/20. Strator provided copies, puestions, obtained access to all record system for the to families and patients to ad was the active face of the the administrator on 10/30/20 as no answer and a voicemail adducted with the alternate 20/20 at 3:05 PM. She was arge of the day to day cy. She stated "me." When to day functions looked like a everything from scheduling, were doing what they were cy, chart audits, helped the the quality assurance duties, are faxed out, answered all led calls, took patient calls go, if patient care issues arose rector of nursing knew about	G	956			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING			C 1 1/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COL 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		1720,2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 956	now and she had no weeks. Furthermore available 24 hours a worked at the agence worked at the agence even sometimes on queried on the role of the is the administration patient's family to ge refused, he handled the field, he oversee dealt with the budger. An interview was conwas finally received 10/30/20 at 5:25 PM charge of the day to He stated "Me and [a asked what his day to the administrator. Hon-call for phone cal administrator (emplorun out for supplies, "calls me about to tawas asked how ofter indicated that he were noce per week. Whe full-time job elsewhe Lastly, when asked vindicated he was salhim flexibility and stato readjust the admir myself." At that time were several concert that they were all revadministrator.	ianapolis, but not as often to seen in him a couple of she indicated she was day/7 days per week, only by with no other job and by (in the office) every day, the weekends. When of the administrator she stated tor by title." He has called a to me a visit when they some concerns with aides in spayroll and billing, and the same and	G 9	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		15K164	B. WING				20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC	•	52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 IDIANAPOLIS, IN 46220			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
G 956	and the office was in on reasoning for mo when all patients we he indicated it was to be in Indianapolis from employee B was himoffice to Indianapolis. He was asked if he care documents had Indianapolis office, k Wayne, Indiana. He that." The alternate shasn't been updated record as it is pre-possible asked if he was awas alternate administratine capacity of the administrator is unawor vacation. He stat now," then indicated alternate administratake over as the administratake over as the administratinate over as the administratinate administrati	red he lived in Fort Wayne In Indianapolis. When queried ving office to Indianapolis are currently in Fort Wayne, the intention for the agency to toom the start, and since the ded he wanted to move the since "she lives down here." And the street address of the tout the city and state was Fort the stated "no I didn't know administrator then indicated it the in the electronic medical copulated. Lastly, he was the purpose of an tor should only be to to act in administrator only when the vailable due to acute illness the "OK, I am aware of it the would be submitting the tor's name to the board to ministrator. The sersonnel assignments, the met as evidenced by: view and interview, the DON) failed to make all and assignments. policy titled "clinical -105 stated ""POLICY This mical oversight over all client		956				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	' '	SURVEY PLETED
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		15K164	B. WING _		11/	/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
G 960	the clinical manager(sincludes a. making clincludes a. making cliassignments" During an interview of director of nursing was personnel assignment does that." During an interview of employee E (licensed during her time of emwell as herself) made of the material of	The oversight provided by s) [director of nursing] ient and personnel n 10/29/20 at 12:50 PM, the as asked who made the ats, she stated "[employee B] n 11/2/20 at 12:39 PM, dispractical nurse) stated aployment, employee B (as a personnel assignments. n 10/30/20 at 3:05 PM, the or indicated she made the adules.	G			
G 964	Based on record rev director of nursing (D agency referrals. Findings include: An undated agency p manager," Policy#B-2 position provides clin care services and statinsTRUCTIONS:4.	s, ot met as evidenced by: iew and interview, the ON) failed to coordinate colicy titled "clinical 105 stated "POLICY This ical oversight over all client ff SPECIAL The oversight provided by s) [director of nursing]	GS	964		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 501251			(
		15K164	B. WING _			11/	20/2020
	ROVIDER OR SUPPLIER	E SERVICES, LLC		52	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 IDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 964	Continued From page	÷ 131	G	964			
	_	n 10/29/20 at 12:50 PM, the is asked once a referral was ed it. She stated					
G 968	Assure implementation CFR(s): 484.105(c)(5		G	968			
	updates of the individ	ment, implementation, and ualized plan of care. It met as evidenced by: 0968, Regulation D101					
	of care were develope updated per the indiv	ON) failed to ensure plans					
	Findings include:						
	position provides clini care services and sta INSTRUCTIONS:4. T clinical manager(s) [d e. assuring the de	05 stated ""POLICY This cal oversight over all client					
	on 10/27/20 and indic 7/11/17. The record of the certification period which indicated diagr	of patient #1 was reviewed cated a start of care date of contained a plan of care for d of 10/23/20-12/21/20 coses of benign prostatic r urinary tract symptoms,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K164 B. WING			C 11/20/2020		
NAME OF P	ROVIDER OR SUPPLIER	101104		S	TREET ADDRESS, CITY, STATE, ZIP CODE	117.	20/2020
	REE HOME HEALTH CAF	RE SERVICES, LLC		5	257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G 968	functional limitation of evidence to what are the patient had a presheadaches, left sided memory loss. Addition medications, but not vitamin D (supplementated for seizures or adocusate (for constipus spray (used for allergithyroid dysfunction), allergies), quetiapine typically bipolar and substitute (used for depression), naproxen, and ibuport Lastly, it identified gounderstanding of proby the end of the care [neurological] status and free from S&S [scomplications or furthwill be free from falls client will be free from During a home visit substitute of the care from the complex of the care from the complex of the care from	ype 2 diabetes, and a if paralysis (failed to a). The summary indicated vious traumatic brain injury, d weakness, and short-term conally there were limited to, calcium with int), divalproex (commonly mental illness disorders), ation), fluticasone nasal jies), levothyroxine (used for loratadine (used for (used for mental illness, schizophrenia), sertraline), and acetaminophen, ofen (all pain medications), rals as "client will verbalize per use of pain medication e period. Neuro will be within normal limits igns and symptoms] of her deterioration. The client during the care period. The in injury during care period." completed on 10/29/20 at was observed having left side d lower extremities, patient e with staff there and e of a toilet riser when using orehensive assessment was 20 by the director of nursing, ed, "Client has history of	G	968			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 1/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		11/20/2020	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 968	Patient #1's plan of odiagnoses, but not lininjury, headaches, led (paralysis), short terridisorder that causes mental illness (which used for), allergies, indysfunction), and de also failed to evidence as no concentrated shaving diabetes and medications (metform patient had any food and interventions reland diagnoses above emergency room visinterventions to addressed factors, patient and of facilitate timely dischinterventions and ed equipment (DME) of directive information the group home livin information. 3. The clinical record the certification periodicated orders for sper week for medical assessment, and to shome health aide (H days a week for person (ADL), instrumental addressing, and light health aide (H days and light health aide).	care failed to evidence mited to, traumatic brain off sided hemiplegia memory loss, pain (or pain), seizures and/or lever divalproex was being hypothyroidism (thyroid pression. The plan of care ce a diabetic diet (also known sweets) due to the patient being on 2 diabetic oral min and myrbetric), if the or drug allergies, any goals ated to all the medications e, patient's risk for its and hospitalization with less the underlying risk caregiver education to large, patient specific lucation, durable medical a toilet riser, advance, and information regarding grand guardian with contact do of patient #2 was reviewed cated a start of care date of contained a plan of care for lod of 8/27/20-10/25/20 which skilled nursing (SN) 1 time tion set up, head to toe supervise the aides, and HA) 3 hours per day for 7 sonal activities of daily living activities of	G 9	68			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _			C 11/20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, Z 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE A CROSS-REFERENCED T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
G 968	indicated "the anticip care services and fre skilled nursing 1 hour hours a day, and wai A office visit encounter physician dated 8/14. diagnoses of COPD pulmonary disease), hypercholesterolemia infarction, history of rarthritis, arthritis, and A recertification compcompleted on 10/25/2 stated the assessme "skilled intervention revidence what was not be revidence and the re	ated apple tree home health equency to be provided," was a weekly, home health aide 2 ver 3 times a week. Ber from the patient's /20 indicated the patient had (chronic obstructive hypertension, history of a, history of myocardial right hand fracture, gouty a compression fractures. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed," but failed to needed for the patient. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed," but failed to needed for the patient. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed," but failed to needed for the patient. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed," but failed to needed for the patient. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed," but failed to needed for the patient. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed, "but failed to needed for the patient. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed, "but failed to needed for the patient. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed, "but failed to needed for the patient. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed, "but failed to needed for the patient. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed, "but failed to needed for the patient. Borehensive assessment was 20 by the director of nursing nt "conclusions" were needed, "but failed to needed for the patient "conclusions" were needed, "but failed to needed for the patient "conclusions" were needed, "but failed to needed for nursing nt "conclusions" were needed, "but failed to needed for the patient "conclusions" had not needed for nursing nt "conclusions" had needed for nursing nt "conclusions" had needed for nursing nt "conclusions" had needed for nursing nt "conclusi	GS	968		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		15K164	B. WING		C 11/20/2020		
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	11720/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
G 968	the certification pericindicated the medica "toujeo [injectable medicates] 300/10 unit diagnoses of lupus, hypertension, and o every other week for and aide and skilled HHA 3 hours, 5 days range of motion, ame An office note dated physician indicated not limited to, iron doubypass status for obtaining the counter medicate her an additional 5 passessment was incompatient has diabetes surgery, all which we Patient #3's plan of diagnoses, but not limited assessment, waiver duration with tasks to measurable goals at the diagnoses above room visits and hospitals.	I contained a plan of care for od of 9/18/20-11/16/20 which ation, but not limited to, ledication used for its daily subcutaneous "type II diabetes, orders for a registered nurse or med set up, assessment, nurse supervision as well as its per week for personal care,	G 9	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		15K164	B. WING _			C 11/20/2020		
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP C 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
G 968	specific interventions advance directive into advance directive into 5. The clinical record on 10/30/20 and indid 4/22/20. The record the certification periodicated SN orders supervisory visits an and HHA orders for week to assist with Adisease process." A comprehensive redocumented on 10/2 nursing (DON). The patient has dysphasidaily/weekly weights had nausea/vomiting. During an interview of mother of patient #4 stayed with grandmodevery other weekend gastrostomy tube (Gothings by mouth such snacks and the aide taking things in orally the mother, a call was at 1:03 PM. She indigetup which all med that the patient's grathe day due to being helping with that. St	e timely discharge, patient s and education, and	G	968				
	of the spine), but the	rgery for Scoliosis (curvature physicians would not do the ent's weight had reached and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING _	B. WING		C 11/20/2020	
	ROVIDER OR SUPPLIER	E SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP COD 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220)E	20.2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
G 968	maintained at 70 pour A physician's "final redated 6/21/20 indicate hospitalized for maint. The patient was dischthe feeding that state pump over 1 hour 4 tirequired AFO's to be vendor to be readjust the patient had "No from flush meds with free vendor to be readjust the patient had "No from flush meds with free vendor to be readjust the patient had "No from flush meds with free vendor to be readjust the patient had "No from flush meds with free vendor to be readjust the patient had "No from flush meds with free vendor to be readjust the patient H4's plan of cancer (GER [gastroesophage Patient H4's plan of cancer (GER	port," from the hospital ed the patient had been strition and failure to thrive. Harged with a new pump for down and patient taken to an outpatient taken to an outpatient ed. Additionally, it stated ee water needs but may evater. [patient] may eat every thick liquids by mouth." and diagnoses listed as rocephalus, scoliosis, failure erebral palsy, constipation, eal reflux] with vomiting." are (and all care plans since expected to evidence expected to evidence expected to evidence expected to evidence and order, orders for feeding tinuous), water/flush orders of a carseat, AFO's, type of explication precautions (due to expected to evidence of the edings, expiration precautions (due to expected to evidence of the edings, expiration precautions (due to expected to evidence of the edings, expiration precautions (due to expected to evidence or vital sign the physician, any down the expected to all patient's risk for emergency talization with interventions ying risk factors, patient timely discharge, patient and education, and	G 9	68			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		15K164	B. WING _			C 11/20/2020		
	ROVIDER OR SUPPLIER	ARE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	•	20.2020		
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	TION SHOULD BE COMPLE THE APPROPRIATE DATE			
G 968	on 10/30/20 and inc 9/20/17. The record the certification peri indicated HHA orde per week for persor light housekeeping, that the patient had pulmonary disease] and goals stated "cl understanding of prothe end of the care free of S&S [signs a complications or fur free from falls durin remain safe in homopresent." A physician office in patient had a past in limited to, arteriove stomach, bursitis of artery disease, COF vitamin D deficiency hyperlipidemia, mic obesity, and unstable Patient #5's plan of diagnoses of arteric stomach, bursitis of artery disease, COF vitamin D deficiency hyperlipidemia, mic obesity, unstable arto notify the physician interventions related patient's risk for emhospitalization with	rd of patient #5 was reviewed dicated a start of care date of dicated a plan of care for od of 9/4/20-11/2/20 which is for 2 hours per day, 4 days hal care, meal preparation, and weight log at each visit, "COPD [chronic obstructive with oxygen use at 2L[liters]," ient will verbalize oper use pain medication by period. Neuro status will be and symptoms] of their deterioration client will be go the care period. Client will be while home health aide is note dated 9/12/17 stated the nedical history of, but not hous malformation of the the left shoulder, coronary PD with asthma, deafness, y, hypertension, rocytic anemia, morbid le angina. care failed to evidence ovenous malformation of the the left shoulder, coronary PD with asthma, deafness, which is the left shoulder, coronary PD with asthma, deafness, which is the left shoulder, coronary PD with asthma, deafness, which is the left shoulder, coronary PD with asthma, deafness, which is the left shoulder, coronary PD with asthma, deafness,	G	968				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		15K164	B. WING _			C / 20/2020
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
G 968	Continued From page facilitate timely discharanterventions and educatirective information. IAC 410 17-4-1(a)(1)	arge, patient specific ucation, and advance	G 9			
G1008	Clinical records CFR(s): 484.110 Condition of participa The HHA must mainta containing past and of patient accepted by the health services. Information of practice, and be avoissuing orders for the and appropriate HHA be maintained electron this CONDITION is Based on record revagency failed to ensure the not copy and pasted documentation standareviewed (#1,5), failed summary and sent to (See Tag G 1022), fawere authenticated to when they were documentation standareviewed (#1,5), failed summary and sent to (See Tag G 1022), fawere authenticated to when they were documentation standareviewed against (See Tag G 1028). The cumulative effects	ation: Clinical records. ain a clinical record current information for every he HHA and receiving home mation contained in the be accurate, adhere to d documentation standards vailable to the physician(s) home health plan of care, a staff. This information may conically. not met as evidenced by: riew and interview, the ure staff documentation was each visit to ensure it met ards for 2 of 5 active records d to complete a discharge the primary practitioner illed to ensure staff visits c ensure the visits occurred umented (See Tag G 1024), all clinical records were loss or unauthorized use t of this systemic problem by being out of compliance Participation 42 CFR	G10	008		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		15K164	B. WING _			C 11/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	•	11/20/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G1008	on 10/27/20 and incompleted on 8/20/2 director of nursing cinformation as evides not have curred with each of the cartification period and indicated (SN) 1 time per week to toe assessment, and home health aid 7 days a week for p (ADL), instrumental (IADL), around the corresponding of the preparation, set up, light housekeeping. Recertification completed on 8/20/2 director of nursing completed on 8/20/2 director of nursing completed on sevides. Both stated "client hinjury and gets occasions and period on the curred writer reached out the regarding checks are bowel movement with the certification periodicated orders for week for medication well as HHA 2 hours personal care, meal	d of patient #1 was reviewed icated a start of care date of a contained a plan of care for ods of 8/24/20-10/22/20 and both which were identical with dates of the certification of orders for skilled nursing sk for medication set up, head and to supervise the aides, de (HHA) 12 hours per day for ersonal activities of daily living activities of daily living activities of daily living clock supervision, meal assist, bathing, dressing, and orehensive assessments 20 and 10/22/20 by the ontained copy/pasted enced by: as history of traumatic brain insional headaches," "client intorders for glucose checks. The office of patient #5 was reviewed icated a start of care date of a contained a plan of care for od of 9/4/20-11/2/20 which skilled nursing (SN) once per uset up and assessment as a per day, 4 days per week for	G10				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7. BOILD			С	
		15K164	B. WING			11/20/2020	
	ROVIDER OR SUPPLIER	E SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	Ē		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIVE PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROVIDENCY)		SHOULD BE	DATE	
G1008	Continued From page	e 141	G1	008			
G1022	visits were marked as was "WNL (within nor (AM) blood sugar rea date of the last bowel every visit documente completed at all visits care check bs [blood reg [regular]." Discharge and transfe CFR(s): 484.110(a)(6 (i) A completed dischathe primary care prace professional who will care and services to the from the HHA (if any) the patient's discharg (ii) A completed trans within 2 business day the patient's care will a health care facility; (iii) A completed trans within 2 business day unplanned transfer, if care in a health care the HHA becomes aware This ELEMENT is not Based on record revinurse (RN) failed to commary and sent to 3 of 3 discharged recordings include:	9/10/20-10/22/20. All the sthe cardiovascular system smal limits)," the morning ding was 150 every visit, the movement was 9/8/20 on ed, and interventions were "diabetic monitoring sugar] daily diet teaching er summaries (i-iii) arge summary that is sent to titioner or other health care be responsible for providing the patient after discharge within 5 business days of e; or fer summary that is sent as of a planned transfer, if be immediately continued in or sfer summary that is sent as of becoming aware of an the patient is still receiving facility at the time when the of the transfer. In the agency registered	G1	022			
	-	record provided by the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		15K164	B. WING	B. WING		11/20/2020	
	ROVIDER OR SUPPLIER REE HOME HEALTH CAR	E SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CO 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD B HE APPROPRIA	DATE.	
G1022	agency for patient #8 which indicated a star and unknown dischart to complete and send 2. The clinical record on 11/2/20. The record care and discharge directord. The last admicare was completed with 11/4/19. A discharge completed on 12/6/19 complete and send a 3. The clinical record reviewed on 11/2/20, care date of 7/18/19, date. The agency failed discharge summary. IAC 410 17-15-1(a)(6 Authentication CFR(s): 484.110(b) Standard: Authentication	was reviewed on 11/2/20 rt of care date of 7/18/19, ge date. The agency failed l a discharge summary. of patient #9 was reviewed rd contained several start of ates combined into one ission consents and plan of with a start of care date of e OASIS assessment was b. The agency failed to discharge summary. of patient #29 was which indicated a start of and unknown discharge ed to complete and send a) attion.	G1	022			
	All entries must be legappropriately authent Authentication must in (occupation), or a secunique identifier, of a reviewed and approvement of the STANDARD is represented by the Based on record reviagency failed to ensurant authenticated to ensurance appropriately authenticated sometimes.	gible, clear, complete, and icated, dated, and timed. Include a signature and a title cured computer entry by a primary author who has ed the entry. In ot met as evidenced by: ew and interview, the re staff visits were the visits occurred when ad for 2 of 5 active records					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		15K164	B. WING				20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		5257	EET ADDRESS, CITY, STATE, ZIP CODE 'N TACOMA DR SUITE 4 IANAPOLIS, IN 46220			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
G1024	documentation," PoliPURPOSE: To ens record of the service 2. The clinical record on 10/30/20 and indi 4/22/20. The record the certification period indicated SN orders supervisory visits and HHA orders for Sweek to assist with Adisease process." A comprehensive record documented on 10/2 nursing (DON). During an interview of caregiver for patient a nurse to visit the particular and left a voicemail of the come assess the protocome assessed," and nurse back and make home and completed.	cy policy titled "clinical cy# C-680 stated " sure that there is an accurate is provided" d of patient #4 was reviewed cated a start of care date of contained a plan of care for it of 8/24/20-10/22/20 which conce per month for aide d head to toe assessment, Dhours per day, 5 days per Dhours, IADL's and "monitoring certification assessment was 2/20 by the director of on 11/2/20 at 1:03 PM, a #4 stated there had not been attent in over a month. atted a nurse called last week which indicated they needed be that family could call and to the nurse over the phone. It and stated the "patient and they were going to call the er sure a nurse went to the dan assessment.	G10	024	DEFICIENCY			
	on 10/30/20 and indi 9/20/17. The record the certification perio	d of patient #5 was reviewed cated a start of care date of contained a plan of care for od of 9/4/20-11/2/20 which s for 2 hours per day, 4 days						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
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		15K164	B. WING		11	/20/2020	
NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
G1024	light housekeeping, a On visits documented HHA documented tas signed, but they failed	e 144 I care, meal preparation, and weight log at each visit. I from 9/27/20-10/17/20, the eks completed, visits were do to evidence how many visit was conducted (not	G102	24			
G1028	The HHA must be in regarding protected had to the total to the total tot	of records. Is contents, and the If therein must be loss or unauthorized use. Compliance with the rules It therein must be loss or unauthorized use. Compliance with the rules It the rules	G102	28			
	services. All client in as confidential and avusersPURPOSE:	lient receiving home health formation shall be regarded vailable only to authorized To safeguard the integrity ined in clinical and billing					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED		
		15K164	B. WING _			C 1/20/2020	
	ROVIDER OR SUPPLIER	RE SERVICES, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220	· ·	1/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
G1028	record: 1. A confider pertinent past and cowith accepted profess maintained for every services9. Since the document, no form ronce it is filed within records: 1. clinical resix (6) years" 2. A required state for alternate administration unduplicated census 23 (16 home health only, and 4 skilled positions). During the entrare 1:05 PM, the alternation of items to submit limited to), active parall discharged patient (12/20/17). 4. The agency active active patients were 13, 14, 15, 16, 17, 1. 5. The agency disched discharged patients 17, 29, 30, 33, and 30. 6. Review of the prepatient # 20, which we lists provided. 7. Review of billing	INSTRUCTIONS: Clinical stall clinical record containing surrent findings in accordance sisional standards is a client receiving home health the clinical record is a legal may be removed or destroyed the chart Retention of ecords shall be retained for the last 12 months was aide only, 3 personal service attents). Indee conference on 10/26/20 at the administrator was given a st. The list included (but not tient census list, and a list of the since the last survey The econsus list revealed the standard for the last survey The econsus list revealed the standard for the last survey The econsus list revealed the standard for the survey of the standard for the survey of the standard for the standard for the survey of the	G10	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		15K164	B. WING				C 20/2020
NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC				525	REET ADDRESS, CITY, STATE, ZIP CODE 57 N TACOMA DR SUITE 4 DIANAPOLIS, IN 46220	1 11/	20/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G1028	Continued From page 146		G10	028			
	contained a list of par from billing and sche	ded by previous employee R tients the agency serviced duling documentation (but s # 21, 23, and 25 (not on ency).					
	9. An email that was sent by person D to the administrator and employee EE on 11/24/18 at 7:59 PM, was reviewed and contained a quality review document titled "285/certification review Q.A [quality assurance] chart," that listed patients # 31, 32, 34, 35, 36, 37, 40, and 41 (none were listed on the agency's census/discharge lists), had a spot for "Y" for yes and "N" for no and stated "auditor signature: [employee EE] each certification period needs audited. Each item missing needs corrected and a note made on how corrected."						
	patient #4 on 10/30/2 date of 4/22/20. The section of the hard ch with a start of care da certification period of record failed to evide the chart for that time administrator was qu of the older record or alternate administrator not in the office. Recadministrator to see i of the record. Six min administrator was local control of the record.	2/16/20-4/14/20. The nce any other documents in					
	11. During record rev	view of the clinical record for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
			A. BOILDII				
		15K164	B. WING _			11/20/2020	
NAME OF PROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE	' _		
APPLE TREE HOME HEALTH CARE SERVICES, LLC				5257 N TACOMA DR SUITE 4			
APPLE IN	KEE HOWE HEALTH	CARE SERVICES, LLC		INDIANAPOLIS, IN 46220			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G1028	Continued From p	age 147 0/20 it indicated a start of care	G10	028			
	date of 9/20/17 wi 9/4/20-11/2/20. T medical record sta 9/20/17. The "fina assignment of ber of the medical record the patient on 6/17/18 responsibilities," w patient on 2/18/18 discharge policy," patient on 6/17/18 disclosure of protedated and signed record failed to ev record from 9/20/2 administrator was missing document there had been do and indicated wheeless to state of the stated when the state of	th a plan of care dated the client profile in the electronic ated the start of care date was ancial responsibility and nefits, "consent in the hard chart ord was dated and signed by 7/18. The "home health ," was signed and dated by the 3. The "client rights and was dated and signed by the 3. The "revised admission and was dated and signed by the 3. The "consent for the use and ected health information, was by the patient on 6/17/18. The idence any documents in the 17 to 2/18/18. The alternate questioned regarding the tation on 10/30/20 at 2:00 PM. the previous administrator left ocuments which were shredded, en the office was moved from ianapolis some were found but					
	on 11/2/20 and ind 11/14/19 and a dis record contained a certification period indicated orders for certification period preparations, and	cord of patient #9 was reviewed dicated a start of care date of scharge date of 12/6/19. The a plan of care for the d of 11/14/19-1/12/20 which or HHA 12 hours per day for the d for personal care, meal light housekeeping. The record any HHA visits or start of care ertification period.					
		was completed on 11/2/20 at 10/20 at 8:35 AM with patient					

PRINTED: 01/04/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	15K164 B. WING		C 11/20/2020				
NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC		RE SERVICES, LLC		5	TREET ADDRESS, CITY, STATE, ZIP CODE 257 N TACOMA DR SUITE 4 NDIANAPOLIS, IN 46220		2012020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
G1028	the agency from app 2019-August 2019 ar services. An email wa which contained adm care, and assignment patient #21 while und The documents were which failed to be evicon survey. 14. During an interviet the alternate administ records were present the majority of record administrator had a scould bring them to the needed. During an interview of administrator was asked if there was a second bring them to the asked if there was a second there were currently a stated, "not that I know was then given the needed. 23, 24, 25, 26, 28, 31, and 41 and asked if a had ever been patien none had ever been patien why the names of the documents retained for previous surveys, or be stated patient #20 was that was my auntie."	ed they were a patient with roximately March and received HHA and SN as received on 11/20/20 ission, discharge, plan of a sheet documents for the care of Apple tree. Apple tree documents denced at the agency while ew on 10/26/20 at 2:18 PM, trator was asked if all in the office. She indicated in the office and the torage in Fort Wayne, but he	G1	0028			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3	(X3) DATE SURVEY COMPLETED	
		15K164	B. WING_			C	
NAME OF PROVIDER OR SUPPLIER APPLE TREE HOME HEALTH CARE SERVICES, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 5257 N TACOMA DR SUITE 4 INDIANAPOLIS, IN 46220		11/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
G1028	the chosen sample of more questioning of that patient #21 was member and had been indicated he did not have. Then changed could be records in have confident he was that garage he stated "I a could be" due to box he moved. When as and confidential the results in the confidential the confidential the results in the confidential the	f patients reviewed. After specific patients he indicated a family member of a board en a previous patient, but know where the records I his answer by stating there is garage. When asked how to their were records in the m very confident that there es in the garage from when ked how secure, protected ecords would be from family, e indicated they would be	G10	028			