STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	This was a Federal home health recertification survey. Survey Dates: 7-28-16, 7-29-16, 8-1-16, and 8-2-16 Facility #: 005362 Medicaid Vendor #: 201054680 Medicare Provider # 15-7200 Angels of Mercy Homecare was found to be out of compliance with the Conditions of Participation 42 CFR 484.14 Organization, Services, and Administration; 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 42 CFR 484.30 Skilled Nursing Services; and 42 CFR 484.55 Comprehensive Assessment of Patients. Angels of Mercy Homecare is precluded from providing its own home health aide training and/or competency evaluation program for a period of two (2) years beginning 8-2-16 due to being found out of compliance with the Conditions of Participation 42 CFR 484.14 Organization, Services, and	G 0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administration; 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision; 42 CFR 484.30 Skilled Nursing Services; and 42 CFR 484.55 Comprehensive Assessment of Patients.			
G 0101 Bldg. 00	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. Based on record review, interview, and observation, the agency failed to ensure the agency had provided patients with written patient rights information that accurately identified the agency as the agency that would be providing care to the patient in 5 (#s 1, 2, 3, 6, & 10) of 10 records reviewed. The findings include: 1. Clinical record number 1 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 7-14-16 at the time of admission. The forms had	G 0101	G101 The Director of Professional Services will ensure that the Agency provides patients with written patient rights information that accurately identifies the Agency that will be providing care to the patient as Angels of Mercy. All forms placed in the Patient Home Folder will be titled Angels of Mercy. All current clinical staff, and all new employees, caring for Angels of Mercy patients will be provided with, and instructed to wear, name badges identifying themselves as Angels of Mercy employees and to advise patients that Angels of Mercy is the agency providing care. All patient packets will be kept at the Angels of Mercy office. The Director of	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. The forms failed to evidence any mention of this agency. Observation noted, during a home visit with the physical therapist, employee L, on 7-29-16 at 9:55 AM, the admission folder found in the home included forms with OMNI Home Care. The forms included "HHCN Form" and the "Notice of Medicare Non-Coverage" form. 2. Clinical record number 2 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 7-12-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. A. During a home visit to patient number 2 observation noted the folder provided to the patient at the time of admission identified OMNI Home Care as the agency that would provide care to the patient. The folder included multiple forms and a "Patient Information Guide"		Professional Services will be responsible for monitoring these corrective actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	labeled OMNI Home Care. The "Patient Information Guide" included a written notice of patient rights. B. When the patient was asked why the folder said OMNI, the patient replied, "Because that's who they are, the agency taking care of me." The registered nurse (RN) present at the time of the visit, employee A, stated, "OMNI is a sister company." C. Observation noted the RN present at the time of the visit, employee A, was wearing a name tag that identified him as an employee of OMNI Home Care. 3. Clinical record number 3 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 6-21-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. 4. Clinical record number 6 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 7-7-16 at the time of admission. The forms had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. 5. Clinical record number 10 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 5-27-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. The record included a "Face-to-Face Certification" form, signed by the physician on 6-11-16, with OMNI Home Care identified as the agency that would be providing care to the patient. 6. A copy of the agency's admission packet was requested on 7-28-16 at 2:10 PM. The Director of Professional Services, employee J, was observed to print the forms included in the admission packet from the computer. The forms received included the "Standard Charge Rates for Medicare and Non-Medicare Visits", the "Indiana Addendum to Condition of Admission", a "Notice of Medicare Non-Coverage" forms. The forms had OMNI Home Care at the top			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and failed to evidence this agency's name. The Director stated, "The nurses have pre-made packets they carry with them all the time." 7. On 7-29-16 at 9:35 AM, an admission packet (not printed from the computer) was received. The admission packet included a "Home Health Change of Care Notice (HHCN) form, a "Notice of Medicare Non-Coverage" form, a "Visit Log", a "Standard Charge Rates For Medicare and Non-Medicare Visits" form, a "Standard Charge Rates For Medicare and Non-Medicare Visits" form, and an "Indiana Addendum to Condition of Admission Form" with OMNI Home Care identified as the agency. The forms failed to evidence any mention of this agency. The Director of Professional Services, employee J, stated, "I brought the packet up from Evansville [the OMNI Home Care] office." 8. The Supervising Nurse, employee I, and the Administrator, employee H, were unable to provide any additional documentation and/or information when asked on 8-2-16 at 10:45 AM. 9. On 8-2-16 at 11:45 AM, the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administrator stated, regarding the OMNI forms in the packets and in the patient's home, "That is an issue we need to work on. We will work straighten it out." 10. The agency's 12/2014 "Patients Rights and Responsibilities" policy number 2.1 states, "Almost Family, Inc. and its subsidiaries will protect, promote, and honor patient's rights and responsibilities. All patients who are admitted to the Agency will be informed of the Patient Bill of Rights and Patient Responsibilities to ensure active and informed participation in their plan of care."			
G 0102 Bldg. 00	484.10(a)(1) NOTICE OF RIGHTS The HHA must provide the patient with a written notice of the patient's rights in advance of furnishing care to the patient or during the initial evaluation visit before the initiation of treatment. Based on record review, interview, and observation, the agency failed to ensure the written information regarding patient rights provided to the patient at the time of admission was accurate in 5 (#s 1, 2, 3, 6, & 10) of 10 records reviewed. The findings include:	G 0102	G102 The Director of Professional Services will ensure that the Agency provides patients with written patient rights information that accurately identifies the Agency that will be providing care to the patient as Angels of Mercy. All forms placed in the Patient	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Clinical record number 1 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 7-14-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. The forms failed to evidence any mention of this agency. Observation noted, during a home visit with the physical therapist, employee L, on 7-29-16 at 9:55 AM, the admission folder found in the home included forms with OMNI Home Care. The forms included "HHCN Form" and the "Notice of Medicare Non-Coverage" form. 2. Clinical record number 2 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 7-12-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. A. During a home visit to patient		Home Folder will be titled Angels of Mercy. All current clinical staff, and all new employees, caring for Angels of Mercy patients will be provided with and instructed to wear name badges identifying themselves as Angels of Mercy employees and to advise patients that Angels of Mercy is the agency providing care. All patient packets will be kept at the Angels of Mercy office. The Director of Professional Services will be responsible for monitoring these corrective actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	number 2 observation noted the folder provided to the patient at the time of admission identified OMNI Home Care as the agency that would provide care to the patient. The folder included multiple forms and a "Patient Information Guide" labeled OMNI Home Care. The "Patient Information Guide" included a written notice of patient rights. B. When the patient was asked why the folder said OMNI, the patient replied, "Because that's who they are, the agency taking care of me." The registered nurse (RN) present at the time of the visit, employee A, stated, "OMNI is a sister company." C. Observation noted the RN present at the time of the visit, employee A, was wearing a name tag that identified him as an employee of OMNI Home Care. 3. Clinical record number 3 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 6-21-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4. Clinical record number 6 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 7-7-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. 5. Clinical record number 10 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 5-27-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. The record included a "Face-to-Face Certification" form, signed by the physician on 6-11-16, with OMNI Home Care identified as the agency that would be providing care to the patient. 6. A copy of the agency's admission packet was requested on 7-28-16 at 2:10 PM. The Director of Professional Services, employee J, was observed to print the forms included in the admission packet from the computer. The forms			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	received included the "Standard Charge Rates for Medicare and Non-Medicare Visits", the "Indiana Addendum to Condition of Admission", a "Notice of Medicare Non-Coverage" forms. The forms had OMNI Home Care at the top and failed to evidence this agency's name. The Director stated, "The nurses have pre-made packets they carry with them all the time." 7. On 7-29-16 at 9:35 AM, an admission packet (not printed from the computer) was received. The admission packet included a "Home Health Change of Care Notice (HHCN) form, a "Notice of Medicare Non-Coverage" form, a "Visit Log", a "Standard Charge Rates For Medicare and Non-Medicare Visits" form, a "Standard Charge Rates For Medicare and Non-Medicare Visits" form, and an "Indiana Addendum to Condition of Admission Form" with OMNI Home Care identified as the agency. The forms failed to evidence any mention of this agency. The Director of Professional Services, employee J, stated, "I brought the packet up from Evansville [the OMNI Home Care] office." 8. The Supervising Nurse, employee I,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and the Administrator, employee H, were unable to provide any additional documentation and/or information when asked on 8-2-16 at 10:45 AM. 9. On 8-2-16 at 11:45 AM, the Administrator stated, regarding the OMNI forms in the packets and in the patient's home, "That is an issue we need to work on. We will work straighten it out." 10. The agency's 12/2014 "Patients Rights and Responsibilities" policy number 2.1 states, "Almost Family, Inc. and its subsidiaries will protect, promote, and honor patient's rights and responsibilities. All patients who are admitted to the Agency will be informed of the Patient Bill of Rights and Patient Responsibilities to ensure active and informed participation in their plan of care."			
G 0111 Bldg. 00	484.10(d) CONFIDENTIALITY OF MEDICAL RECORDS The patient has the right to confidentiality of the clinical records maintained by the HHA. Based on record review and interview, the agency failed to ensure patient's medical record had been kept confidential in 1 (# 5) of 10 records	G 0111	G111 The Director of Professional Services will ensure that patients' Medical Record will be kept confidental. All current clinical staff and new hires will be	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed. The findings include: 1. Clinical record number 5 included a skilled nurse (SN) visit note dated 7-26-16 that states, "Labs drawn via venipuncture from right forearm on the 1st attempt with 25G [gauge] butterfly . . . Results to be faxed to [name of physician] and OMNI Home Health." 2. The Supervising Nurse, employee I, stated, on 8-2-16 at 10:45 AM, "The results were probably faxed to OMNI in Evansville because there is someone here in this office only once per week." 3. The agency's 12/2014 "Patients Rights and Responsibilities" policy number 2.1 states, "All staff members shall be instructed and are expected to comply with the Patient Bill of Rights and Responsibilities." The agency's "Patient's Bill of Rights" states, "Patients have the right: to confidentiality of information about their health, social, and financial circumstances, and about what takes place in the home."		in-serviced on VN Policy 2.1, "Patient Rights and Responsibilities" to include the patient's right to confidentiality of information about their health, social, and financial circumstances, and about what takes place in the home. All information concerning Angels of Mercy patients' information will be communicated only to the Angels of Mercy office or Angels of Mercy staff on a need to know basis. 10% of all clinical records will be monitored monthly for evidence that this is occurring. The Director of Professional Services will be responsible for auditing monthly for compliance with Policy 2.1 and reporting findings quarterly per the PI Process.	
G 0122 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Based on record review, observation, and	G 0122	G122 The Executive Director will ensure	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interview, it was determined this agency failed to maintain compliance with this condition by failing to ensure all services had been included in the organizational chart and failed to evidence clear lines of authority for the corporate structure of the agency (See G 123); by failing to ensure the agency's administrative and supervisory functions were conducted by employees of this agency (See G 124); by failing to ensure an alternate supervising nurse had been appointed to assume the responsibilities of the supervising nurse as needed (See G 139); and by failing to ensure a contract was in place for the provision of physical and occupational therapy services in 6 (#s 1, 2, 3, 6, 8, 9, and 10) of 6 records reviewed of patients that received therapy services from the agency of the 10 total records reviewed (See G 142). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition 42 CFR 484.14 Organization, Services, and Administration.		that all services have been included in the Organizational Chart, that there are clear lines of authority for the Corporate structure, that the agency's administrative and supervisory functions are conducted by employees of Angels of Mercy, that an Alternate Supervising Nurse has been appointed, and that a contract is in place for the provision of therapy services, as detailed in Standards G123, G124, G139, and G142.	
G 0123 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Organization, services furnished, administrative control, and lines of authority			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Based on record review and interview, the agency failed to ensure all services had been included in the organizational chart and failed to evidence clear lines of authority for the corporate structure of the agency. The findings include: 1. The agency's undated "Angels of Mercy Home Care Western KY Market Huntingburg, Indiana" organizational chart failed to include contracted therapy services. A. During the entrance conference, on 7-28-16 at 12:10 PM, the Director of Professional Services, employee J, indicated all therapy services provided by the agency were contracted services. The Director indicated the agency did not have any direct employee therapists. B. Physical therapist L indicated, on 7-29-16 at 9:35 AM, he was unsure who the administrator of the agency was. He indicated he would contact registered nurse M if he needed anything and she would "put me in touch with the right person." The therapist indicated he was an employee of a therapy provider, not	G 0123	G123 The Executive Director will ensure that the Angels of Mercy Organizational Chart includes contracted therapy services. Contracted therapy employees will be given a copy of the organizational chart and instructed on the lines of authority. The chart will be included in the orientation of new contract employees and updated as changes occur. The Company Organizational Chart will include a direct line of authority for Angels of Mercy and will be updated as changes occur. The Director of Professional Services will be responsible for monitoring this corrective action as part of our Company's PI process and updating as changes occur.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the agency. 2. The agency's administrative records included 2 organizational charts, "Angels of Mercy Home Care Western KY Market Huntingburg, Indiana" and "Almost Family KY/So. IN". The Almost Family organizational chart failed to evidence any mention of this agency. The chart included the Executive Director and identified she reports to the "Regional Manager-KY/So.IN" who reports to the COO.			
G 0124 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Administrative and supervisory functions are not delegated to another agency or organization. Based on record review, interview, and observation, the agency failed to ensure the agency's administrative and supervisory functions were conducted by employees of this agency. The findings include: 1. Upon arrival to the agency on 7-28-16 at 10:10 AM, the office was found to be locked and no lights were visible. A sign on the door stated, "Out of office for assistance please call 812-683-4256. A	G 0124	G124 The Executive Director will ensure that Angels of Mercy's administrative and supervisory functions are conducted by employees of the agency. Office hours will be maintained from 8 a.m. - 5 p.m., Monday - Friday with staff at the agency during operational hours. All binders and folders pertinent to Angels of Mercy will be kept at that office. Admission packets with forms specific to Angels of Mercy will	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	telephone call was placed to this number at 10:35 AM. An answering service indicated their location was in Kentucky and that the "transition nurse", registered nurse (RN) M, would be notified the surveyor was on-site at the agency. A. Indiana State Department of Health documents indicated the agency had reported office hours of 8 AM to 5 PM, Monday through Friday. B. RN M was not listed as an employee of the agency on the ISDH "Employee Records" form completed by employee J on 8-1-16 at 9:35 AM. 2. On 7-28-16 at 12:35 PM, the Director of Professional Services, employee J, was observed to carry in two (2) large boxes with containing binders and folders. The second container included binders labeled "Compliance", "Infection Control", QAPI [quality assessment and performance improvement]", "Case Conferences", "Complaints", Occurrences", and "OASIS Validation Reports". The Director indicated she had brought the boxes from the Evansville OMNI Home Care office. 3. A copy of the agency's admission packet was requested on 7-28-16 at 2:10 PM. The Director of Professional Services, employee J, was observed to		be available at that office, and given to employees of the agency. Only employees of Angels of Mercy, or their contracted services, will provide care for their patients. Two full time employees have been hired to work for Angels of Mercy, a Clinical Manager and a Clinical Team Assistant. In addition, we have hired PRN staff assigned to and working out of the Angels of Mercy office. Each of these employees were hired as Angels of Mercy personnel and have files in the Angels of Mercy office, and they have received orientation specific to Angels of Mercy policies and processes as evidenced by hiring and orientation documentation in their files. All current clinical staff, and all new employees, caring for Angels of Mercy patients will be given and instructed to wear name badges identifying themselves as Angels of Mercy employees and to advise patients that Angels of Mercy is the agency providing care.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	print the forms included in the admission packet from the computer. The forms received included the "Standard Charge Rates for Medicare and Non-Medicare Visits", the "Indiana Addendum to Condition of Admission", a "Notice of Medicare Non-Coverage" forms. The forms had OMNI Home Care at the top and failed to evidence this agency's name. A. The Director stated, "The nurses have pre-made packets they carry with them all the time." B. On 7-29-16 at 9:35 AM, an admission packet (not printed from the computer) was received. The admission packet included a "Home Health Change of Care Notice (HHCN) form, a "Notice of Medicare Non-Coverage" form, a "Visit Log", a "Standard Charge Rates For Medicare and Non-Medicare Visits" form, a "Standard Charge Rates For Medicare and Non-Medicare Visits" form, and an "Indiana Addendum to Condition of Admission Form" with OMNI Home Care identified as the agency. The forms failed to evidence any mention of this agency. The Director of Professional Services, employee J, stated, "I brought the packet up from Evansville [the OMNI Home Care] office."		The Company Organizational Chart will include a direct line of authority for Angels of Mercy. All personnel files, including contract therapy files, will be located at the Angels of Mercy office. Personnel files will be audited quarterly as a part of our company's PI Process as evidence that this orientation is occurring. The Director of Professional Services will be responsible for monitoring these corrective actions twice a year as a part of our Company's facility audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	C. On 8-2-16 at 11:45 AM, the Administrator stated, regarding the OMNI forms in the packets and in the patient's home, "That is an issue we need to work on. We will straighten it out." 4. Upon arrival to the agency on 7-29-16 at 9:15 AM, the office was locked and there was no visible lights on. At 9:25 AM, the Director of Professional Services, employee J arrived. 5. The administrator, RN H stated, on 7-29-16 at 11:55 AM, "We do not have a home health aide assigned here. She is working out of the Evansville [OMNI Home Care] office. 6. The Director of Professional Services, employee J, stated, on 7-29-16 at 2:50 PM, "The contracted personnel files [physical, occupational, and speech therapy] are kept in Evansville [OMNI Home Care] office. 7. During a home visit to patient number 2 observation noted the folder provided to the patient at the time of admission identified OMNI Home Care as the agency that would provide care to the patient. The folder included multiple forms and a "Patient Information Guide" labeled OMNI Home Care. The "Patient			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Information Guide" included a written notice of patient rights. When the patient was asked why the folder said OMNI, the patient replied, "Because that's who they are, the agency taking care of me." The registered nurse (RN) present at the time of the visit, employee A, stated, "OMNI is a sister company." 8. Eight (8) of 10 clinical records included plans of care and/or verbal orders co-signed by RN N. The Director of Professional Services stated, on 8-1-16 at 1:30 PM, "[RN N] is a clinical manager in Evansville [OMNI Home Care] office. All of the orders go to her to approve." RN N was not listed as an employee of the agency on the ISDH "Employee Records" form completed by employee J on 8-1-16 at 9:35 AM. A. Clinical record number 1 included a plan of care for the certification period 7-14-16 to 9-11-16 and a verbal order dated 7-15-16 co-signed by RN N. B. Clinical record number 2 included a verbal order dated 7-13-16 co-signed by RN N. C. Clinical record number 3 included a plan of care for the certification period			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6-21-16 to 8-19-16 and verbal orders dated 6-22-16 and 6-30-16 co-signed by RN N. D. Clinical record number 4 included verbal orders dated 6-16-16 , 6-23-16, and 7-8-16 co-signed by RN N. E. Clinical record number 5 included verbal orders dated 6-16-16, 6-22-16, 6-23-16, 6-30-16, 7-5-16, and 7-12-16, co-signed by RN N. F. Clinical record number 6 included a plan of care for the certification period 7-7-16 to 9-4-16 and verbal orders dated 7-11-16, 7-14-16, and 7-27-16 co-signed by RN N. G. Clinical record number 7 included verbal orders dated 6-68-16, 7-21-16, and 7-22-16 co-signed by RN N. H. Clinical record number 9 included a plan of care for the certification period 5-27-16 to 7-25-16 and verbal orders dated 5-27-16, 5-29-16, 6-2-16, 6-29-16, 6-30-16, and 7-1-16 co-signed by RN N. 9. Employee A, an RN, stated, on 8-2-16 at 11:10 AM, "My supervisor is [RN N] in the Evansville office. She is the clinical manager."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10. The administrator stated, on 8-2-16 at 9:30 AM, "I am the Executive Director for this agency, OMNI Home Care in Evansville, and other agencies in Kentucky. I am in each office at least weekly. My home office is in Madisonville, KY. I do not keep separate time records for each agency because I am an employee of Almost Family." The Executive Director indicated this agency was owned by Almost Family. A. ISDH documents identify this agency as "Angels of Mercy Homecare" doing business as "Caretenders Visiting Services of Kentuckiana, LLC". B. ISDH documents identify OMNI Homecare doing business as "Home Health Agency - Indiana, Inc. 11. On 8-1-16 at 2:00 PM, the Director of Professional Services stated, "I spent all weekend duplicating the personnel files so a copy could be kept up here [in this agency]." 12. The Director of Professional Services stated, per telephone call on 7-28-16 at 10:35 AM, "The clinicians can get into the office anytime. They have a key. The office is not open to the public. An administrative person comes up once a week to check the mail."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	13. On 7-28-16 at 11:30 AM, another tenant of the building stated, "I don't see a lot people going in and out of there [the agency]. It's sporadic. I don't know what's going on with them." 14. The agency's administrative records included 2 organizational charts, "Angels of Mercy Home Care Western KY Market Huntingburg, Indiana" and "Almost Family KY/So. IN". The Almost Family organizational chart failed to evidence any mention of this agency. The chart included the Executive Director and identified she reports to the "Regional Manager-KY/So.IN" who reports to the COO.			
G 0139 Bldg. 00	484.14(d) SUPERVISING PHYSICIAN OR REGIS. NURSE Services furnished are under the supervision and direction of a physician or a registered nurse (who preferably has at least one year of nursing experience and is a public health nurse). This person, or similarly qualified alternate, is available at all times during operating hours.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review and interview, the agency failed to ensure an alternate supervising nurse had been appointed to assume the responsibilities of the supervising nurse as needed. The findings include: 1. ISDH documents identified RN O as the agency's alternate supervising nurse. During the entrance conference, on 7-28-16 at 12 PM, employee J, the Director of Professional Services indicated RN O no longer is employed by this agency. When asked who the alternate supervising nurse was, the Director stated, "I assume that is me." 2. The agency's administrative records failed to evidence the Director of Professional Services had been identified as the agency's alternate supervising nurse. 3. The agency's 1/15 "Visiting Services Agency Organization" policy states, "The Administrator/Director of Professional Services shall appoint a supervising nurse who is responsible for directing the provision of patient care and services. A qualified alternate is appointed to act in the absence of the supervising nurse."	G 0139	G139 The Executive Director will ensure that an Alternate Supervising Nurse is appointed to assume the responsibilities of the supervising nurse as needed. An Alternate Supervising Nurse has been appointed in accordance with 42 CFR 484.14 (d). The Executive Director will be responsible for updating the appointments as changes occur and will be monitored as part of our Company's PI process.	09/02/2016
G 0142	484.14(f)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	PERSONNEL HOURLY/PER VISIT CONTRACT If personnel under hourly or per visit contracts are used by the HHA, there is a written contract between those personnel and the agency that specifies the following: (1) Patients are accepted for care only by the primary HHA. (2) The services to be furnished. (3) The necessity to conform to all applicable agency policies, including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary HHA. (6) The procedures for submitting clinical and progress notes, scheduling of visits, periodic patient evaluation. (7) The procedures for payment for services furnished under the contract.			
	Based on record review and interview, the agency failed to ensure a contract was in place for the provision of physical and occupational therapy services in 6 (#s 1, 2, 3, 6, 8, 9, and 10) of 6 records reviewed of patients that received therapy services from the agency of the 10 total records reviewed. The findings include: 1. During the entrance conference, on 7-28-16 at 12:10 PM, the Director of Professional Services, employee J, indicated all therapy services provided by the agency were contracted services. The	G 0142	G142 The Executive Director will ensure that there is a written contract, current and maintained for the provision of physical and occupational therapy services. The Director of Professional services will be responsible for monitoring this corrective action as part of the Company's bi-yearly Facility Audit.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director indicated the agency did not have any direct employee therapists. 2. The agency's administrative records failed to evidence a contract between this agency and the therapy provider. The contract presented for review, on 8-2-16 at 2:40 PM, was between the therapy provider and OMNI Home Care. 3. The Administrator stated, on 8-2-16 at 2:40 PM, "There is an addendum to the contract that makes this agency a party to the agreement." 4. Clinical records 1, 2, 3, 6, 8, 9, and 10 evidenced the patients had received physical and/or occupational therapy services from individuals that were not direct employees of the agency.			
G 0156 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on record review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure services, procedures and treatments had been provided in accordance with physician orders in 2 of 10 records reviewed (See G 158); by failing to ensure plans of care had been	G 0156	G156 The Director of Professional Services will ensure compliance with 42 CFR 484.18, Acceptance of Patients, Plan of Care, and Medical Supervision, as detailed in G158, G159, and G164.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	updated to include all medications in 1 of 10 records reviewed (See G 159); and by failing to ensure the physician had been informed of changes in the patients' condition in 1 of 10 records reviewed (See G 164). The cumulative effect of these systemic problems resulted in the agency's inability to maintain compliance with this condition, 42 CFR 484.18 Acceptance of Patients, Plan of Care, and Medical Supervision.			
G 0158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on record review and interview, the agency failed to ensure services, procedures and treatments had been provided in accordance with physician orders in 2 (#s 5 & 9) of 10 records reviewed. The finding include: 1. Clinical record number 5 included a plan of care established by the physician	G 0158	G158 The Director of Professional Services will ensure that services, procedures, and treatments are provided in accordance with physician orders. All current clinical staff and new employees will be inserviced on Policy 2.17, "Plan of Care". The Clinical Manager and Director of Professional Services will monitor	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for the certification period 5-23-16 to 7-21-16. The plan identified skilled nursing was to be provided 1 time per week for 9 weeks and home health aide visits 1 time per week for 9 weeks. A. The record failed to evidence any skilled nursing or home health aide visits had been provided the week of 7-17-16. B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 8-2-16 at 10:45 AM. 2. Clinical record number 9 included a skilled nurse (SN) visit note dated 6-1-16 that states, "Central line [an infusion tube located in or near the heart] dressing changed." The plan of care, established by the physician for the certification period 5-27-16 to 7-25-16 failed to evidence an order for the central line dressing change. The Supervising Nurse, employee I, indicated, on 8-2-16 at 12:50 PM, the record did not include an order for the central line dressing change. 3. The agency's 1/07 "Plan of Care" policy number 2.17 states, "The patient's needs, goals, and specific timeframes, settings, and services needed as identified		weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	by assessment data obtained during patient visits will determine the development of a patient specific plan for care, treatment, and services."			
G 0159 Bldg. 00	484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on record review and interview, the agency failed to ensure plans of care had been updated to include all medications in 1 (# 5) of 10 records reviewed. The findings include: 1. Clinical record number 5 included a plan of care for the certification period 5-23-16 to 7-21-16 that evidenced a start of care date of 11-25-15. The plan of care included all of the medications the patient was known to be taking. A. The record included a skilled nurse (SN) visit note dated 6-1-16 that identified the patient had been prescribed Neurontin. The note states, "Patient is	G 0159	G159 The Director of Professional Services will ensure that plans of care are updated to include all medications. All current clinical staff and new employees will be in-serviced on Policy 2.26, "Medication Administration" and Medication Reconciliation Process document. The Clinical Manager and Director of Professional Services will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director will be responsible	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not sure of dose and frequency, SN to update med profile at next visit." The record failed to evidence the medication profile or the plan of care had been updated with the new medication. B. The record included a SN visit note dated 6-8-16 that states, "Patient recently started on Gabapentin 100 mg bid [milligrams two times per day]." The record failed to evidence the medication profile or the plan of care had been updated to include the new medication. 2. The Supervising Nurse, employee I, indicated, on 8-2-16 at 12:50 PM, the plan of care had not been updated to include the new medications. 3. The agency's 1/07 "Plan of Care" policy number 2.17 states, "If changes are made in the plan of care prior to the 60-day episode requirement, the changes will be documented on a Verbal/telephone Order form and/or missed visit note, as appropriate, and a copy placed in the clinical record."		for monitoring these corrective actions.	
G 0164 Bldg. 00	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review and interview, the agency failed to ensure the physician had been informed of changes in the patients' condition in 1 (# 4) of 10 records reviewed. The findings include: 1. Clinical record number 4 included a skilled nurse (SN) visit note dated 6-15-16 that identifies 2+ pitting edema in the lower right extremity and 3+ pitting edema in the left lower extremity. The record failed to evidence the SN had notified the physician of the presence of the swelling the patient's lower extremities. The previous SN visit note, dated 6-8-16, did not evidence any lower extremity edema. 2. The Supervising Nurse, employee I, indicated, on 8-2-16 at 12:50 PM, the record did not evidence the SN had notified the physician of the swelling in the patient's lower extremities. 3. The agency's 1/15 "Careplanning Policy" number 2.19 states, "Written documentation of care coordination is placed in the clinical record within seven days."	G 0164	G164 The Director of Professional Services and the Clinical Manager will ensure that the physician is informed of changes in the patient's condition. All current clinical staff and new hires will be in-serviced on"Physician Notification Requirements". The Clinical Manager will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director of Professional Services will monitor monthly until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0168 Bldg. 00	484.30 SKILLED NURSING SERVICES Based on record review and interview, the agency failed to maintain compliance with this condition by failing to ensure nursing visits, procedures and treatments had been provided in accordance with physician orders in 2 of 9 records reviewed of patients that received skilled nursing services of the 10 total records reviewed (See G 170); to ensure the registered nurse had re-evaluated the patient's needs in 1 of 9 records reviewed of patients that received skilled nursing services of the 10 total records reviewed (See G 172); and by failing to ensure the physician had been informed of changes in the patients' condition in 1 of 9 records reviewed of patients that received skilled nursing services of the 10 total records reviewed (See G 176). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with this condition, 42 CFR 484.30 Skilled Nursing Services.	G 0168	G168 The Director of Professional Services will ensure compliance with 42 CFR 484.30, "Skilled Nursing Services" as detailed in G170, G172, and G176.	09/02/2016
G 0170 Bldg. 00	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on record review and interview,	G 0170	G170 The Director of Professional Services	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the agency failed to ensure nursing visits, procedures and treatments had been provided in accordance with physician orders in 2 (#s 5 & 9) of 9 records reviewed of patients that received skilled nursing services of the 10 total records reviewed. The finding include: 1. Clinical record number 5 included a plan of care established by the physician for the certification period 5-23-16 to 7-21-16. The plan identified skilled nursing was to be provided 1 time per week for 9 weeks and home health aide visits 1 time per week for 9 weeks. A. The record failed to evidence any skilled nursing or home health aide visits had been provided the week of 7-17-16. B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 8-2-16 at 10:45 AM. 2. Clinical record number 9 included a skilled nurse (SN) visit note dated 6-1-16 that states, "Central line [an infusion tube located in or near the heart] dressing changed." The plan of care, established by the physician for the certification period 5-27-16 to 7-25-16 failed to		will ensure that nursing visits, procedures, and treatments are provided in accordance with physician orders. All current clinical staff and new hires will be in-serviced on Policy 2.17, "Plan of Care" and Healthstream course "Documentation Guidelines and Physician Orders". The Clinical Manager will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director of Professional Services will monitor monthly until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	evidence an order for the central line dressing change. The Supervising Nurse, employee I, indicated, on 8-2-16 at 12:50 PM, the record did not include an order for the central line dressing change. 3. The agency's 1/07 "Plan of Care" policy number 2.17 states, "The patient's needs, goals, and specific timeframes, settings, and services needed as identified by assessment data obtained during patient visits will determine the development of a patient specific plan for care, treatment, and services."			
G 0172 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on record review and interview, the agency failed to ensure the registered nurse had re-evaluated the patient's needs in 1 (# 2) of 9 records reviewed of patients that received skilled nursing services of the 10 total records reviewed. The findings include: 1. Clinical record number 2 failed to evidence the registered nurse (RN) had re-evaluated the patient's needs related to the patient's blood glucose levels. The	G 0172	G172 The Director of Professional Services will ensure that the RN re-evaluates the patient's needs. All current clinical staff and new hires will be in-serviced on evaluating and documenting blood glucose levels. The Clinical Manager will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record evidenced the patient had been admitted on 7-12-16 with diagnoses of hemiplegia, primary hypertension, and type II diabetes. A. The start of care comprehensive assessment dated 7-12-16 identifies the patient takes an "antidiabetic agent", that "blood sugars are not routinely checked", that the blood glucose levels range was "unknown", how often the blood glucose levels were checked was "unknown", and the blood glucose target range was "unknown." B. A skilled nurse (SN) visit note dated 7-21-16 identifies the patient's blood sugars have "remained stable for the past two weeks", the blood glucose range was "150", the target goal was "100", and that blood glucose levels are checked "daily". C. A SN visit note dated 7-26-16 identifies that "blood sugars are not routinely checked", the blood glucose range was "unknown", and how often the blood glucose levels were checked was "unknown". 2. The Supervising Nurse, employee I, was unable to provide any additional documentation and/or information when asked on 8-2-16 at 10:45 AM.		The Director of Professional Services will monitor monthly until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0176 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on record review and interview, the registered nurse failed to ensure the physician had been informed of changes in the patients' condition in 1 (# 4) of 9 records reviewed of patients that received skilled nursing services of the 10 total records reviewed. The findings include: 1. Clinical record number 4 included a skilled nurse (SN) visit note dated 6-15-16 that identifies 2+ pitting edema in the lower right extremity and 3+ pitting edema in the left lower extremity. The record failed to evidence the SN had notified the physician of the presence of the swelling the patient's lower extremities. The previous SN visit note, dated 6-8-16, did not evidence any lower extremity edema. 2. The Supervising Nurse, employee I, indicated, on 8-2-16 at 12:50 PM, the record did not evidence the SN had notified the physician of the swelling in	G 0176	G176 The Director of Professional Services will ensure that the physician is informed of changes in the patient's condition. All current clinical staff and new hires will be in-serviced on "Physician Notification Requirements". The Clinical Manager will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director of Professional Services will monitor monthly until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the patient's lower extremities. 3. The agency's 1/15 "Careplanning Policy" number 2.19 states, "Written documentation of care coordination is placed in the clinical record within seven days."			
G 0250 Bldg. 00	484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. Based on record review and interview, the agency failed to ensure professionals representing at least the scope of the program had participated in the quarterly clinical record review in 2 (4th quarter 2015 and 1st quarter 2016) of 2 quarters reviewed. The findings include: 1. The agency's clinical record review documentation for the 4th quarter of 2015 and the 1st quarter of 2016 failed to evidence participation by any therapists or the medical social worker. 2. The Supervising Nurse, employee J, stated, on 8-2-16 at 12:40 PM, "We do	G 0250	G250 The Director of Professional Services will ensure that appropriate health professionals, representing at least the scope of the program, participate in the quarterly clinical record review. The Director of Professional Services will be responsible for monitoring this corrective action quarterly with the PI Process to ensure all disciplines are a part of the chart audit process.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not have therapists or the medical social worker participate in the quarterly clinical record review. [The Director of Professional Services] does the record review."			
G 0330 Bldg. 00	484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary Based on record review and interview, it was determined the agency failed to maintain compliance with this condition by failing to ensure comprehensive assessments included a complete review of all medications the patient was known to be taking in 3 of 10 records reviewed	G 0330	G330 The Director of Professional Services will ensure compliance with 42 CFR 484.55, Comprehensive Assessment of Patients, as detailed in G337, G338, and G339.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(See G 337); by failing to ensure a policy had been established and maintained for defining a significant change in condition that would warrant an update to the comprehensive assessment (See G 338); and by failing to ensure day period in 1 of 4 records reviewed of patients that had been on service for greater than 60 days of the 10 total records reviewed (See G 339). The cumulative effect of these systemic problems resulted in the agency's inability to maintain compliance with this condition, 42 CFR 484.55 Comprehensive Assessment of Patients.			
G 0337 Bldg. 00	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the agency failed to ensure comprehensive assessments included a complete review of all medications the patient was known to be taking in 3 (#s 1, 3, and 9) of 10 records reviewed. The findings include:	G 0337	G337 The Director of Professional Services will ensure Medication Review and Reconciliation is performed on each patient at specific points of care to include Start of Care and Resumption of Care. All current clinical staff and new employees will be in-serviced on Policy 2.26, "Medication Administration" and	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Clinical record number 1 included a start of care comprehensive assessment dated 7-14-16. The assessment failed to evidence a review of all medications that included ineffective drug therapy, significant side effects and drug interactions, and duplicate drug therapy had been completed. 2. Clinical record number 3 included a start of care comprehensive assessment dated 6-21-16. The assessment failed to evidence a review of all medications that included ineffective drug therapy, significant side effects, and duplicate drug therapy had been completed. 3. Clinical record number 9 included a start of care comprehensive assessment dated 5-27-16. The assessment failed to evidence a review of all medications that included ineffective drug therapy, significant side effects and drug interactions, and duplicate drug therapy had been completed. 4. The Supervising Nurse, employee I, was unable to provide any additional information and/or documentation when asked on 8-2-16 at 10:45 AM and 12:50 PM. 5. The agency's 10/01/2015 "Guidelines		Medication Reconciliation Process document. The Clinical Manager and Director of Professional Services will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for the Standardized Screening Tools on the AFAM [?] SOC/ROC [start of care/resumption of care] Comprehensive Adult Assessment" states, "Reconcillation [sic] of medication with active participation of the Pt/CG [patient/caregiver] is conducted to confirm and document a complete Medication Profile."			
G 0338 Bldg. 00	484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status. Based on record review and interview, the agency failed to establish and maintain a policy and procedure for defining a significant change in condition that would warrant an update to the comprehensive assessment. The findings include: 1. The agency's administrative records and policies and procedures failed to evidence a policy and procedure defining a significant change in a patient's condition that would warrant an update to the comprehensive assessment. 2. The Director of Professional Services,	G 0338	G338 The Director of Professional Services will ensure that a comprehensive assessment is updated and revised as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status. 09/02/16 All current clinical staff and new employees will be in-serviced on Policy 2.6, Assessment/Reassessment, and "Reporting Patient Condition Changes" which address that a change in patient	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	employee J, indicated, on 8-2-16 at 10:40 AM, the agency did not have a policy and procedure that addressed updating the comprehensive assessment if the patient had a significant change in condition.		condition warrants an update to the assessment. 10% of all clinical records will be monitored weekly by the Clinical Manager for evidence that this is occuring. The Director of Professional Services will be responsible for monitoring these corrective actions.	
G 0339 Bldg. 00	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on record review and interview, the agency failed to ensure the comprehensive assessment had been updated the last 5 days of the previous 60 day period in 1 (# 7) of 4 records reviewed of patients that had been on service for greater than 60 days of the 10 total records reviewed. The findings include: 1. Clinical record number 7 included	G 0339	G339 The Director of Professional services will ensure that a recertification assessment and summary will occur at least every 56 - 60 days. All current clinical staff and new hires will be in-serviced on Policy 2.6, Assessment/Reassessment. The Clinical Manager and Director of Professional Services will monitor weekly with review of clinical	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plans of care for the certification periods 5-23-16 to 7-21-16 and 7-22-16 to 9-19-16. The plans of care evidenced the start of care date was 11-25-15. The record failed to evidence the update to the comprehensive assessment had been completed within the last 5 days of the previous certification period. The record included an update to the comprehensive assessment dated 7-22-16, the first day of the most recent certification period. 2. The Supervising Nurse, employee I, was unable to provide any additional information and/or documentation when asked on 8-2-16 at 10:45 AM and 12:50 PM. 3. The agency's 2/16 "Assessment/Reassessment" policy number 2.6 states, "Professional staff will complete a comprehensive reassessment and a Recertification Summary at least every 56-60 days."		documentation and Plans of Care until 100% compliance is attained. The Director will be responsible for monitoring these corrective actions.	
N 0000 Bldg. 00	This was a State home health re-licensure survey. Survey Dates: 7-28-16, 7-29-16, 8-1-16,	N 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and 8-2-16 Facility #: 005362 Medicaid Vendor #: 201054680 Medicare Provider # 15-7200			
N 0440 Bldg. 00	410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the agency failed to ensure all services had been included in the organizational chart and failed to evidence clear lines of authority for the corporate structure of the agency. The findings include: 1. The agency's undated "Angels of Mercy Home Care Western KY Market Huntingburg, Indiana" organizational chart failed to include contracted therapy services. A. During the entrance conference, on 7-28-16 at 12:10 PM, the Director of Professional Services, employee J,	N 0440	N0440 The Executive Director will ensure that the Angels of Mercy Organizational Chart includes contracted therapy services. Contracted therapy employees will be given a copy of the organizational chart and instructed on the lines of authority. The chart will be included in the orientation of new contract employees. The Director of Professional Services will be responsible for monitoring this corrective action during orientation of contracted employees and yearly thereafter. This will be included in our Company's quarterly PI Process.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated all therapy services provided by the agency were contracted services. The Director indicated the agency did not have any direct employee therapists. B. Physical therapist L indicated, on 7-29-16 at 9:35 AM, he was unsure who the administrator of the agency was. He indicated he would contact registered nurse M if he needed anything and she would "put me in touch with the right person." The therapist indicated he was an employee of a therapy provider, not the agency. 2. The agency's administrative records included 2 organizational charts, "Angels of Mercy Home Care Western KY Market Huntingburg, Indiana" and "Almost Family KY/So. IN". The Almost Family organizational chart failed to evidence any mention of this agency. The chart included the Executive Director and identified she reports to the "Regional Manager-KY/So.IN" who reports to the COO.			
N 0441 Bldg. 00	410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Administrative and supervisory responsibilities shall not be			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	delegated to another agency or organization, and all services not furnished directly, including services provided through a branch office, shall be monitored and controlled by the parent agency. Based on record review, interview, and observation, the agency failed to ensure the agency's administrative and supervisory functions were conducted by employees of this agency. The findings include: 1. Upon arrival to the agency on 7-28-16 at 10:10 AM, the office was found to be locked and no lights were visible. A sign on the door stated, "Out of office for assistance please call 812-683-4256. A telephone call was placed to this number at 10:35 AM. An answering service indicated their location was in Kentucky and that the "transition nurse", registered nurse (RN) M, would be notified the surveyor was on-site at the agency. A. Indiana State Department of Health documents indicated the agency had reported office hours of 8 AM to 5 PM, Monday through Friday. B. RN M was not listed as an employee of the agency on the ISDH "Employee Records" form completed by employee J on 8-1-16 at 9:35 AM.	N 0441	N0441 The Executive Director will ensure that Angels of Mercy's administrative and supervisory functions are conducted by employees of the agency. Office hours will be maintained from 8 a.m. - 5 p.m., Monday - Friday with staff at the agency during operational hours. All binders and folders pertinent to Angels of Mercy will be kept at that office. Admission packets with forms specific to Angels of Mercy will be available at that office, and given to employees of the agency. Only employees of Angels of Mercy, or their contracted services, will provide care for their patients. Two full time employees have been hired to work for Angels of Mercy, a Clinical Manager and a Clinical Team Assistant. In addition, we have hired PRN staff assigned to and working out of the Angels of Mercy office. Each of these employees were	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. On 7-28-16 at 12:35 PM, the Director of Professional Services, employee J, was observed to carry in two (2) large boxes with containing binders and folders. The second container included binders labeled "Compliance", "Infection Control", QAPI [quality assessment and performance improvement]", "Case Conferences", "Complaints", Occurrences", and "OASIS Validation Reports". The Director indicated she had brought the boxes from the Evansville OMNI Home Care office. 3. A copy of the agency's admission packet was requested on 7-28-16 at 2:10 PM. The Director of Professional Services, employee J, was observed to print the forms included in the admission packet from the computer. The forms received included the "Standard Charge Rates for Medicare and Non-Medicare Visits", the "Indiana Addendum to Condition of Admission", a "Notice of Medicare Non-Coverage" forms. The forms had OMNI Home Care at the top and failed to evidence this agency's name. A. The Director stated, "The nurses have pre-made packets they carry with them all the time." B. On 7-29-16 at 9:35 AM, an admission packet (not printed from the computer) was received. The admission		hired as Angels of Mercy personnel and have files in the Angels of Mercy office, and they have received orientation specific to Angels of Mercy policies and processes as evidenced by hiring and orientation documentation in their files. All current clinical staff, and all new employees, caring for Angels of Mercy patients will be given and instructed to wear name badges identifying themselves as Angels of Mercy employees and to advise patients that Angels of Mercy is the agency providing care. The Company Organizational Chart will include a direct line of authority for Angels of Mercy. All personnel files, including contract therapy files, will be located at the Angels of Mercy office. Personnel files will be audited quarterly as a part of our company's PI Process as evidence that this orientation is occurring. The Director of Professional Services will be responsible for monitoring these corrective actions twice a year as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	packet included a "Home Health Change of Care Notice (HHCN) form, a "Notice of Medicare Non-Coverage" form, a "Visit Log", a "Standard Charge Rates For Medicare and Non-Medicare Visits" form, a "Standard Charge Rates For Medicare and Non-Medicare Visits" form, and an "Indiana Addendum to Condition of Admission Form" with OMNI Home Care identified as the agency. The forms failed to evidence any mention of this agency. The Director of Professional Services, employee J, stated, "I brought the packet up from Evansville [the OMNI Home Care] office." C. On 8-2-16 at 11:45 AM, the Administrator stated, regarding the OMNI forms in the packets and in the patient's home, "That is an issue we need to work on. We will straighten it out." 4. Upon arrival to the agency on 7-29-16 at 9:15 AM, the office was locked and there was no visible lights on. At 9:25 AM, the Director of Professional Services, employee J arrived. 5. The administrator, RN H stated, on 7-29-16 at 11:55 AM, "We do not have a home health aide assigned here. She is working out of the Evansville [OMNI		a part of our Company's facility audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Home Care] office. 6. The Director of Professional Services, employee J, stated, on 7-29-16 at 2:50 PM, "The contracted personnel files [physical, occupational, and speech therapy] are kept in Evansville [OMNI Home Care] office. 7. During a home visit to patient number 2 observation noted the folder provided to the patient at the time of admission identified OMNI Home Care as the agency that would provide care to the patient. The folder included multiple forms and a "Patient Information Guide" labeled OMNI Home Care. The "Patient Information Guide" included a written notice of patient rights. When the patient was asked why the folder said OMNI, the patient replied, "Because that's who they are, the agency taking care of me." The registered nurse (RN) present at the time of the visit, employee A, stated, "OMNI is a sister company." 8. Eight (8) of 10 clinical records included plans of care and/or verbal orders co-signed by RN N. The Director of Professional Services stated, on 8-1-16 at 1:30 PM, "[RN N] is a clinical manager in Evansville [OMNI Home			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Care] office. All of the orders go to her to approve." RN N was not listed as an employee of the agency on the ISDH "Employee Records" form completed by employee J on 8-1-16 at 9:35 AM. A. Clinical record number 1 included a plan of care for the certification period 7-14-16 to 9-11-16 and a verbal order dated 7-15-16 co-signed by RN N. B. Clinical record number 2 included a verbal order dated 7-13-16 co-signed by RN N. C. Clinical record number 3 included a plan of care for the certification period 6-21-16 to 8-19-16 and verbal orders dated 6-22-16 and 6-30-16 co-signed by RN N. D. Clinical record number 4 included verbal orders dated 6-16-16 , 6-23-16, and 7-8-16 co-signed by RN N. E. Clinical record number 5 included verbal orders dated 6-16-16, 6-22-16, 6-23-16, 6-30-16, 7-5-16, and 7-12-16, co-signed by RN N. F. Clinical record number 6 included a plan of care for the certification period 7-7-16 to 9-4-16 and verbal orders dated 7-11-16, 7-14-16, and 7-27-16 co-signed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	by RN N. G. Clinical record number 7 included verbal orders dated 6-68-16, 7-21-16, and 7-22-16 co-signed by RN N. H. Clinical record number 9 included a plan of care for the certification period 5-27-16 to 7-25-16 and verbal orders dated 5-27-16, 5-29-16, 6-2-16, 6-29-16, 6-30-16, and 7-1-16 co-signed by RN N. 9. Employee A, an RN, stated, on 8-2-16 at 11:10 AM, "My supervisor is [RN N] in the Evansville office. She is the clinical manager." 10. The administrator stated, on 8-2-16 at 9:30 AM, "I am the Executive Director for this agency, OMNI Home Care in Evansville, and other agencies in Kentucky. I am in each office at least weekly. My home office is in Madisonville, KY. I do not keep separate time records for each agency because I am an employee of Almost Family." The Executive Director indicated this agency was owned by Almost Family. A. ISDH documents identify this agency as "Angels of Mercy Homecare" doing business as "Caretenders Visiting Services of Kentuckiana, LLC".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	B. ISDH documents identify OMNI Homecare doing business as "Home Health Agency - Indiana, Inc. 11. On 8-1-16 at 2:00 PM, the Director of Professional Services stated, "I spent all weekend duplicating the personnel files so a copy could be kept up here [in this agency]." 12. The Director of Professional Services stated, per telephone call on 7-28-16 at 10:35 AM, "The clinicians can get into the office anytime. They have a key. The office is not open to the public. An administrative person comes up once a week to check the mail." 13. On 7-28-16 at 11:30 AM, another tenant of the building stated, "I don't see a lot people going in and out of there [the agency]. It's sporadic. I don't know what's going on with them." 14. The agency's administrative records included 2 organizational charts, "Angels of Mercy Home Care Western KY Market Huntingburg, Indiana" and "Almost Family KY/So. IN". The Almost Family organizational chart failed to evidence any mention of this agency. The chart included the Executive Director and identified she reports to the "Regional Manager-KY/So.IN" who			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reports to the COO.			
N 0454 Bldg. 00	410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone, pager or other means. In addition, the person must be able to: (1) respond to an emergency; (2) provide guidance to staff; (3) answer questions; and (4) resolve issues; within a reasonable amount of time, given the emergency or issue that has been raised. Based on record review and interview, the agency failed to ensure an alternate supervising nurse had been appointed to assume the responsibilities of the supervising nurse as needed. The findings include: 1. ISDH documents identified RN O as the agency's alternate supervising nurse. During the entrance conference, on 7-28-16 at 12 PM, employee J, the Director of Professional Services indicated RN O no longer is employed by	N 0454	N0454 The Executive Director will ensure that an Alternate Supervising Nurse isappointed to assume the responsibilities of the supervising nurse as needed. An Alternate Supervising Nurse has been appointed in accordance with 42 CFR 484.14 (d).The Executive Director will be responsible for updating the appointments as changes occur and will be monitored as part of our Company's PI process.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	this agency. When asked who the alternate supervising nurse was, the Director stated, "I assume that is me." 2. The agency's administrative records failed to evidence the Director of Professional Services had been identified as the agency's alternate supervising nurse. 3. The agency's 1/15 "Visiting Services Agency Organization" policy states, "The Administrator/Director of Professional Services shall appoint a supervising nurse who is responsible for directing the provision of patient care and services. A qualified alternate is appointed to act in the absence of the supervising nurse."			
N 0460 Bldg. 00	410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment. Based on record review and interview,	N 0460	N0460 The Executive Director will	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the agency failed to ensure the personnel record of the supervising nurse included an annual performance evaluation. The findings include: 1. The agency's administrative records evidenced employee I had been appointed as the agency's supervising nurse effective 12-1-15. Personnel file I failed to evidence a performance evaluation had been completed. 2. The Director of Professional Services stated on 8-1-16 at 2:50 PM, "There is no evidence of a performance evaluation."		ensure that an Annual Performance Evaluation will be performed on every employee at least yearly.The Director of Professional Services willbe responsible for monitoring this correctiveaction as part of the bi-yearly Facility Audits.	
N 0466 Bldg. 00	410 IAC 17-12-1(j) Home health agency administration/management Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on record review and interview, the agency failed to maintain separate, confidential health files in 3 (files C, E, & F) of 7 personnel files reviewed. The findings include:	N 0466	N0466 The Director of Professional Services will ensure that the agency maintains separate, confidential health files on its employees. Personnel files will be audited quarterly as a part of our company's PI Process as evidence that this is occurring.The Director of	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Personnel file C evidenced the individual provides medical social services on behalf of the agency. The file included physical examination and tuberculosis (TB) test results. The agency failed to maintain a separate health file for the individual. 2. Personnel file E evidenced the individual provides home health aide services on behalf of the agency. The file included physical examination and TB test results. The agency failed to maintain a separate health file for the individual. 3. Personnel file F evidenced the individual provides occupational therapy services on behalf of the agency. The file included physical examination and TB test results. The agency failed to maintain a separate health file for the individual. 4. The Director of Professional Services, employee J, acknowledged, on 8-1-16 at 2:10 PM, the personnel files included medical information and that the medical information had not been kept in a separate, confidential files. 5. The agency's 3/15 "Employee Physical Examination Plan" policy number 7.11 states, "Results of the examination(s) will		Professional Services will be responsible for monitoring these corrective actions twice a year as a part of our Company's human resource audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	be maintained in employee's health file." The agency's 3/15 "Employee Surveillance for Tuberculosis" policy number 7.12 states, "A record of TB Skin testing, results, medical evaluation, chest X-ray results, treatment and fit testing for respirators will be maintained in the employee's health file."			
N 0478 Bldg. 00	410 IAC 17-12-2(d) Q A and performance improvement Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there shall be a written contract between those personnel and the home health agency that specifies the following: (1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all applicable home health agency policies including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency. (6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation. (7) The procedures for payment for services furnished under the contract. Based on record review and interview, the agency failed to ensure a contract was in place for the provision of physical and occupational therapy services in 6 (#s 1, 2, 3, 6, 8, 9, and 10) of 6 records reviewed of patients that received therapy	N 0478	N0478 The Executive Director will ensure that there is a written contract, currentand maintained for the provision of physical and occupational therapy services. The Director of Professional services will be responsible for	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	services from the agency of the 10 total records reviewed. The findings include: 1. During the entrance conference, on 7-28-16 at 12:10 PM, the Director of Professional Services, employee J, indicated all therapy services provided by the agency were contracted services. The Director indicated the agency did not have any direct employee therapists. 2. The agency's administrative records failed to evidence a contract between this agency and the therapy provider. The contract presented for review, on 8-2-16 at 2:40 PM, was between the therapy provider and OMNI Home Care. 3. The Administrator stated, on 8-2-16 at 2:40 PM, "There is an addendum to the contract that makes this agency a party to the agreement." 4. Clinical records 1, 2, 3, 6, 8, 9, and 10 evidenced the patients had received physical and/or occupational therapy services from individuals that were not direct employees of the agency.		monitoring this corrective action as part of the Company's bi-yearly Facility Audit.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0494 Bldg. 00	410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section. Based on record review, interview, and observation, the agency failed to ensure the agency had provided patients with written patient rights information that accurately identified the agency as the agency that would be providing care to the patient in 5 (#s 1, 2, 3, 6, & 10) of 10 records reviewed. The findings include: 1. Clinical record number 1 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 7-14-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of	N 0494	N0494 The Director of Professional Services will ensure that the Agency provides patients with written patient rights information that accurately identifies the Agency that will be providing care to the patient as Angels of Mercy. All forms placed in the Patient Home Folder will be titled Angels of Mercy. All current clinical staff, and all new employees, caring for Angels of Mercy patients will be provided with, and instructed to wear, name badges identifying themselves as Angels of Mercy employees and to advise patients that Angels of Mercy is the agency providing care. All patient packets will be kept at the Angels of Mercy office. The Director of Professional Services will be responsible for monitoring these corrective actions.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	admission to the agency and had OMNI Home Care at the top of the forms. The forms failed to evidence any mention of this agency. Observation noted, during a home visit with the physical therapist, employee L, on 7-29-16 at 9:55 AM, the admission folder found in the home included forms with OMNI Home Care. The forms included "HHCN Form" and the "Notice of Medicare Non-Coverage" form. 2. Clinical record number 2 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 7-12-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. A. During a home visit to patient number 2 observation noted the folder provided to the patient at the time of admission identified OMNI Home Care as the agency that would provide care to the patient. The folder included multiple forms and a "Patient Information Guide" labeled OMNI Home Care. The "Patient Information Guide" included a written			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notice of patient rights. B. When the patient was asked why the folder said OMNI, the patient replied, "Because that's who they are, the agency taking care of me." The registered nurse (RN) present at the time of the visit, employee A, stated, "OMNI is a sister company." C. Observation noted the RN present at the time of the visit, employee A, was wearing a name tag that identified him as an employee of OMNI Home Care. 3. Clinical record number 3 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 6-21-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. 4. Clinical record number 6 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 7-7-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	admission to the agency and had OMNI Home Care at the top of the forms. 5. Clinical record number 10 included a "Standard Charge Rates for Medicare and Non-Medicare Visits" and "Indiana Addendum to Condition of Admission" forms signed by the patient on 5-27-16 at the time of admission. The forms had been included as a part of the patient information provided at the time of admission to the agency and had OMNI Home Care at the top of the forms. The record included a "Face-to-Face Certification" form, signed by the physician on 6-11-16, with OMNI Home Care identified as the agency that would be providing care to the patient. 6. A copy of the agency's admission packet was requested on 7-28-16 at 2:10 PM. The Director of Professional Services, employee J, was observed to print the forms included in the admission packet from the computer. The forms received included the "Standard Charge Rates for Medicare and Non-Medicare Visits", the "Indiana Addendum to Condition of Admission", a "Notice of Medicare Non-Coverage" forms. The forms had OMNI Home Care at the top and failed to evidence this agency's name.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Director stated, "The nurses have pre-made packets they carry with them all the time." 7. On 7-29-16 at 9:35 AM, an admission packet (not printed from the computer) was received. The admission packet included a "Home Health Change of Care Notice (HHCN) form, a "Notice of Medicare Non-Coverage" form, a "Visit Log", a "Standard Charge Rates For Medicare and Non-Medicare Visits" form, a "Standard Charge Rates For Medicare and Non-Medicare Visits" form, and an "Indiana Addendum to Condition of Admission Form" with OMNI Home Care identified as the agency. The forms failed to evidence any mention of this agency. The Director of Professional Services, employee J, stated, "I brought the packet up from Evansville [the OMNI Home Care] office." 8. The Supervising Nurse, employee I, and the Administrator, employee H, were unable to provide any additional documentation and/or information when asked on 8-2-16 at 10:45 AM. 9. On 8-2-16 at 11:45 AM, the Administrator stated, regarding the OMNI forms in the packets and in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	patient's home, "That is an issue we need to work on. We will work straighten it out." 10. The agency's 12/2014 "Patients Rights and Responsibilities" policy number 2.1 states, "Almost Family, Inc. and its subsidiaries will protect, promote, and honor patient's rights and responsibilities. All patients who are admitted to the Agency will be informed of the Patient Bill of Rights and Patient Responsibilities to ensure active and informed participation in their plan of care."			
N 0508 Bldg. 00	410 IAC 17-12-3(b)(2)(E) Patient Rights Rule 12 Sec. 3(b)(2)(E) (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records. Based on record review and interview, the agency failed to ensure patient's medical record had been kept confidential in 1 (# 5) of 10 records reviewed.	N 0508	N0508 The Director of Professional Services will ensure that patients' Medical Record will be kept confidental. All current clinical staff and new hires will be in-serviced on VN Policy 2.1,	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The findings include: 1. Clinical record number 5 included a skilled nurse (SN) visit note dated 7-26-16 that states, "Labs drawn via venipuncture from right forearm on the 1st attempt with 25G [gauge] butterfly . . . Results to be faxed to [name of physician] and OMNI Home Health." 2. The Supervising Nurse, employee I, stated, on 8-2-16 at 10:45 AM, "The results were probably faxed to OMNI in Evansville because there is someone here in this office only once per week." 3. The agency's 12/2014 "Patients Rights and Responsibilities" policy number 2.1 states, "All staff members shall be instructed and are expected to comply with the Patient Bill of Rights and Responsibilities." The agency's "Patient's Bill of Rights" states, "Patients have the right: to confidentiality of information about their health, social, and financial circumstances, and about what takes place in the home."		"Patient Rights and Responsibilities" to include the patient's right to confidentiality of information about their health, social, and financial circumstances, and about what takes place in the home. All information concerning Angels of Mercy patients' information will be communicated only to the Angels of Mercy office or Angels of Mercy staff on a need to know basis. 10% of all clinical records will be monitored monthly for evidence that this is occurring. The Director of Professional Services will be responsible for auditing monthly for compliance with Policy 2.1 and reporting findings quarterly per the PI Process.	
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the agency failed to ensure procedures and treatments had been provided in accordance with physician orders in 2 (#s 5 & 9) of 10 records reviewed. The finding include: 1. Clinical record number 5 included a plan of care established by the physician for the certification period 5-23-16 to 7-21-16. The plan identified skilled nursing was to be provided 1 time per week for 9 weeks and home health aide visits 1 time per week for 9 weeks. A. The record failed to evidence any skilled nursing or home health aide visits had been provided the week of 7-17-16. B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 8-2-16 at 10:45 AM. 2. Clinical record number 9 included a skilled nurse (SN) visit note dated 6-1-16 that states, "Central line [an infusion tube located in or near the heart] dressing changed." The plan of care, established by the physician for the certification period 5-27-16 to 7-25-16 failed to	N 0522	N0522 The Director of Professional Services will ensure that services, procedures, and treatments are provided in accordance with physician orders. All current clinical staff and new employees will be inserviced on Policy 2.17, "Plan of Care". The Clinical Manager and Director of Professional Services will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	evidence an order for the central line dressing change. The Supervising Nurse, employee I, indicated, on 8-2-16 at 12:50 PM, the record did not include an order for the central line dressing change. 3. The agency's 1/07 "Plan of Care" policy number 2.17 states, "The patient's needs, goals, and specific timeframes, settings, and services needed as identified by assessment data obtained during patient visits will determine the development of a patient specific plan for care, treatment, and services."			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure plans of care had been updated to include all medications in 1 (# 5) of 10 records reviewed. The findings include: 1. Clinical record number 5 included a plan of care for the certification period 5-23-16 to 7-21-16 that evidenced a start of care date of 11-25-15. The plan of care included all of the medications the patient was known to be taking. A. The record included a skilled nurse (SN) visit note dated 6-1-16 that identified the patient had been prescribed Neurontin. The note states, "Patient is not sure of dose and frequency, SN to update med profile at next visit." The record failed to evidence the medication profile or the plan of care had been updated with the new medication. B. The record included a SN visit note dated 6-8-16 that states, "Patient recently started on Gabapentin 100 mg	N 0524	N0524 The Director of Professional Services will ensure that plans of care are updated to include all medications. All current clinical staff and new employees will be in-serviced on Policy 2.26, "Medication Administration" and Medication Reconciliation Process document. The Clinical Manager and Director of Professional Services will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director will be responsible for monitoring these corrective actions.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bid [milligrams two times per day]." The record failed to evidence the medication profile or the plan of care had been updated to include the new medication. 2. The Supervising Nurse, employee I, indicated, on 8-2-16 at 12:50 PM, the plan of care had not been updated to include the new medications. 3. The agency's 1/07 "Plan of Care" policy number 2.17 states, "If changes are made in the plan of care prior to the 60-day episode requirement, the changes will be documented on a Verbal/telephone Order form and/or missed visit note, as appropriate, and a copy placed in the clinical record."			
N 0527 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review and interview, the agency failed to ensure the physician had been informed of changes in the patients' condition in 1 (# 4) of 10 records reviewed.	N 0527	N0527 The Director of Professional Services and the Clinical Manager will ensure that the physician is informed of changes in the patient's condition. All current clinical staff and new hires will be in-serviced	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The findings include: 1. Clinical record number 4 included a skilled nurse (SN) visit note dated 6-15-16 that identifies 2+ pitting edema in the lower right extremity and 3+ pitting edema in the left lower extremity. The record failed to evidence the SN had notified the physician of the presence of the swelling the patient's lower extremities. The previous SN visit note, dated 6-8-16, did not evidence any lower extremity edema. 2. The Supervising Nurse, employee I, indicated, on 8-2-16 at 12:50 PM, the record did not evidence the SN had notified the physician of the swelling in the patient's lower extremities. 3. The agency's 1/15 "Careplanning Policy" number 2.19 states, "Written documentation of care coordination is placed in the clinical record within seven days."		on"Physician Notification Requirements". The Clinical Manager will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director of Professional Services will monitor monthly until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	
N 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review and interview, the agency failed to ensure nursing visits, procedures and treatments had been provided in accordance with physician orders in 2 (#s 5 & 9) of 9 records reviewed of patients that received skilled nursing services of the 10 total records reviewed. The finding include: 1. Clinical record number 5 included a plan of care established by the physician for the certification period 5-23-16 to 7-21-16. The plan identified skilled nursing was to be provided 1 time per week for 9 weeks and home health aide visits 1 time per week for 9 weeks. A. The record failed to evidence any skilled nursing or home health aide visits had been provided the week of 7-17-16. B. The supervising nurse was unable to provide any additional documentation and/or information when asked on 8-2-16 at 10:45 AM. 2. Clinical record number 9 included a skilled nurse (SN) visit note dated 6-1-16 that states, "Central line [an infusion tube located in or near the heart] dressing changed." The plan of care, established by the physician for the certification	N 0537	N0537 The Director of Professional Services will ensure that nursing visits, procedures, and treatments are provided in accordance with physician orders. All current clinical staff and new hires will be in-serviced on Policy 2.17, "Plan of Care" and Healthstream course "Documentation Guidelines and Physician Orders". The Clinical Manager will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director of Professional Services will monitor monthly until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	period 5-27-16 to 7-25-16 failed to evidence an order for the central line dressing change. The Supervising Nurse, employee I, indicated, on 8-2-16 at 12:50 PM, the record did not include an order for the central line dressing change. 3. The agency's 1/07 "Plan of Care" policy number 2.17 states, "The patient's needs, goals, and specific timeframes, settings, and services needed as identified by assessment data obtained during patient visits will determine the development of a patient specific plan for care, treatment, and services."			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the agency failed to ensure the registered nurse had re-evaluated the patient's needs in 1 (# 2) of 9 records reviewed of patients that received skilled nursing services of the 10 total records reviewed. The findings include:	N 0541	N0541 The Director of Professional Services will ensure that the RN re-evaluates the patient's needs. All current clinical staff and new hires will be in-serviced on evaluating and documenting blood glucose levels. The Clinical Manager will monitor weekly with review of clinical documentation and Plans	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Clinical record number 2 failed to evidence the registered nurse (RN) had re-evaluated the patient's needs related to the patient's blood glucose levels. The record evidenced the patient had been admitted on 7-12-16 with diagnoses of hemiplegia, primary hypertension, and type II diabetes. A. The start of care comprehensive assessment dated 7-12-16 identifies the patient takes an "antidiabetic agent", that "blood sugars are not routinely checked", that the blood glucose levels range was "unknown", how often the blood glucose levels were checked was "unknown", and the blood glucose target range was "unknown." B. A skilled nurse (SN) visit note dated 7-21-16 identifies the patient's blood sugars have "remained stable for the past two weeks", the blood glucose range was "150", the target goal was "100", and that blood glucose levels are checked "daily". C. A SN visit note dated 7-26-16 identifies that "blood sugars are not routinely checked", the blood glucose range was "unknown", and how often the blood glucose levels were checked was "unknown".		of Care until 100% compliance is attained. The Director of Professional Services will monitor monthly until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. The Supervising Nurse, employee I, was unable to provide any additional documentation and/or information when asked on 8-2-16 at 10:45 AM.			
N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on record review and interview, the registered nurse failed to ensure the physician had been informed of changes in the patients' condition in 1 (# 4) of 9 records reviewed of patients that received skilled nursing services of the 10 total records reviewed. The findings include: 1. Clinical record number 4 included a skilled nurse (SN) visit note dated 6-15-16 that identifies 2+ pitting edema in the lower right extremity and 3+ pitting edema in the left lower extremity. The record failed to evidence the SN had	N 0546	N0546 The Director of Professional Services will ensure that the physician is informed of changes in the patient's condition. All current clinical staff and new hires will be in-serviced on "Physician Notification Requirements". The Clinical Manager will monitor weekly with review of clinical documentation and Plans of Care until 100% compliance is attained. The Director of Professional Services will monitor monthly until 100% compliance is attained. The Director of Professional Services will be responsible for monitoring these corrective actions.	09/02/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157200	A. BUILDING 00 B. WING	08/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANGELS OF MERCY HOMECARE	511 E 4TH ST STE 111 HUNTINGBURG, IN 47542

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	notified the physician of the presence of the swelling the patient's lower extremities. The previous SN visit note, dated 6-8-16, did not evidence any lower extremity edema. 2. The Supervising Nurse, employee I, indicated, on 8-2-16 at 12:50 PM, the record did not evidence the SN had notified the physician of the swelling in the patient's lower extremities. 3. The agency's 1/15 "Careplanning Policy" number 2.19 states, "Written documentation of care coordination is placed in the clinical record within seven days."			