

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15K024	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/17/2015
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NAME OF PROVIDER OR SUPPLIER  ABOVE & BEYOND HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1320 E 53RD ST STE A ANDERSON, IN 46013
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G 0000  Bldg. 00	<p>This visit was a home health federal recertification survey. This was a partial extended survey.</p> <p>Survey Dates: July 13-17, 2015</p> <p>Facility #: 004808</p> <p>Medicaid Vendor #: 200829700</p> <p>Current census at time of survey: 106 patients, Anderson (Parent) Office 64 patients, Marion (Branch) Office Total: 170 patients</p> <p>Census By Service Type (Unduplicated Last 12 Months): 66 Patients, Skilled 128 Patients, Home Health Aide 49 Patients, Personal Service Only Total: 243 patients</p> <p>QR: je 7/21/15</p>	G 0000		

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

TITLE

(X6) DATE

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

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G 0108  Bldg. 00	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record review, admission packet review, and interview, the agency failed to ensure the patient was informed, in advance, of any changes in the care to be furnished in 1 of 10 active patient records reviewed. (#6)</p> <p>Findings include:</p> <p>1. Clinical record #6 contained physician's plans of care for certification periods 5/2 to 6/30/15 and 7/1 to 8/29/15 with orders to include homemaker services 1-2 hour visits, 1-2 days per week for 60 days to assist with homemaking services. The record failed to evidence homemaker services were conducted on May 12 and 15, 2015, June 19, 2015, and July 10, 2015, and failed to evidence documentation of the patient's notification prior to the missed visits.</p>	G 0108	<p>The Administrator and Director of Nursing have in-serviced nursing staff, case managers and schedulers on Patients' Rights. Focusing on the patient's right to advance notice of any changes in the plan of care before a change is made. Supervisory Nurses will review missed visit reports and patient communication to ensure compliance. Director of Nursing will audit 20 percent of all weekly missed visits. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected. The Director of Nursing will report any findings to the administrator. These findings will also be used and incorporated into the Quality Assurance Meetings to evaluate care.</p>	07/23/2015

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	<p>A. The record evidenced a document dated 5/19/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 5/12/15 2:15 p [PM] - 4:15 p Date/Time of Client/Office Notification: 5/19/15 10:00 a [AM] Homemaker [checked] Reason For Cancellation ... Other [checked]: 'No Aide to cover' Will Visit be Made up: NO [circled]."</p> <p>B. The record evidenced a document dated 5/19/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 5/15/15 1:15 p - 3:15 p Date/Time of Client/Office Notification: 5/19/15 9:25 a Homemaker [checked] Reason For Cancellation ... Client/Family Cancellation [checked] ... Will Visit be Made up: NO [circled]."</p> <p>1.) A document from the electronic medical record titled "Client Notes for : [patient #6]" by employee I (scheduler), stating, "Date: 5/15/15 Time: 3:12 PM ... [Patient] called to see if the aide was coming today. I reminded [him/her] that [his/her] aide was going to be gone today and asked if [he/she] would like me to find someone else for</p>			
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	<p>[him/her] today. [He/She] stated that [he/she] did not know that [aide] was not going to be there and we should have let [him/her] know."</p> <p>2.) On 7/16/15 at 11:40 AM, employee A (director of nursing) indicated being unsure why the scheduler wrote the patient had canceled the visit on the missed visit report dated 5/19/15.</p> <p>C. The record evidenced a document dated 7/2/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 6/19/15 1:15 p - 3:15 p ... Homemaker [checked] Reason For Cancellation ... Other [checked]: 'No aide to cover' ... Will Visit be Made up: NO [circled]."</p> <p>D. The record evidenced a document dated 7/10/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 7/10/15 1:15 p - 3:15 p Date/Time of Client/Office Notification: 7/10/15 Homemaker [checked] Reason For Cancellation ... Client/Family Cancellation [checked] ... 'No aide available' ... Will Visit be Made up: NO [circled]."</p>			

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G 0121 Bldg. 00	<p>2. On 7/14/15 at 2 PM, a home visit was conducted with patient #6. The patient indicated receiving homemaker services 2 times per week with recent cancellations by agency staff. The patient indicated he/she is not notified of the canceled visit in advance and states, "If they are going to be late or not show up, I wish they would call and let us know."</p> <p>3. The agency admission packet [page 13 of 57] states, "Your Rights and Responsibilities as a Health Care Client Client Rights ... 8. the client has the right to be informed in advance about the care to be furnished. the agency will inform the client in writing in advance of the disciplines that will furnish care and the frequency of proposed visits to be furnished. The agency will inform the client in advance of any change in the plan of care before the change is made."</p> <p>484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on clinical record review, agency</p>	G 0121	The Administrator and Director of Nursing have in-serviced nursing	07/23/2015

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	<p>policy review, and interview, the agency failed to ensure corrections to the clinical record were made according to professional standards in 1 of 12 clinical records reviewed. (#4)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>The undated agency policy titled "Electronic Signature &amp; Error Procedure Policy" states, "Policy To ensure that all medial record entries will be made by appropriate staff and authenticated by the author of the entry. Purpose ... Special Instructions ... 6. In the case of an alteration needing to be made in the medical record, one line should be made through the entry and then the health care provider should initial the change."</li> <li>Clinical record #4, start of care 9/30/10, evidenced a comprehensive adult assessment, start of care version originally dated 9/29/10 on pages 1 and 14 by the registered nurse. A "30" was marked (in ink) over the "29." The correction failed to include one line through the error and failed to include the initials of the person(s) making the change.</li> <li>On 7/15/15 at 12:20 PM, employee A (director of nursing) indicated the appropriate way to correct an entry into</li> </ol>		<p>staff, case managers and schedulers on ElectronicSignature &amp; Error Procedure Policy. Directorof Nursing will review 20 percent of patient charts monthly to ensurecompliance with Electronic Signature &amp; Error Procedure Policy. Director of Nursing will be responsible for monitoringthese corrective actions to ensure that this deficiency is corrected. TheDirector of Nursing will report any findings to the administrator. Thesefindings will also be used and incorporated into the Quality Assurance Meetingsto evaluate care.</p>	

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G 0125 Bldg. 00	<p>the medical record is one line through the error and initials of the person making the correction.</p> <p>484.14 ORGANIZATION, SERVICES &amp; ADMINISTRATION All services not furnished directly, including services provided through subunits are monitored and controlled by the parent agency. Based on clinical record review, observation, document review, and interview, the agency failed to ensure branches were approved by the Centers for Medicare and Medicaid Services (CMS) prior to 1 location functioning as a branch for 1 of 1 agency.</p> <p>Findings include:</p> <p>1. On 7/13/15 during entrance conference, employee B (administrator) indicated the agency had 2 branch locations, one in Muncie, Indiana and one in Marion, Indiana. The employee indicated the Muncie branch was not currently being used but the Marion branch was.</p> <p>Form CMS-1572 (a) was completed by agency staff and presented to surveyor on 7/13/15. The form titled "Home</p>	G 0125	<p>Agency submitted a branch application on March 17, 2015. On April 23, 2015, Agency received letter from MS. Bobbie Nelson, Program Coordinator for clarification. Agency responded on May 1, 2015. On July 23, 2015, Agency spoke with Ms. Nelson, Program Coordinator, and was informed application was pending and "shouldn't be much longer." Administrator is waiting on final determination of status of Marion and Muncie sites, the sites will be closed and advertising removed including web based advertising if a denial of application is issued. The Administrator will ensure compliance of this corrective action upon receiving notice of application status. IDR: Agency did notify Department of Health on March 17, 2015 by submitting an application for branches. Agency has been in communication with Ms. Bobbie</p>	08/04/2015	

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	<p>Health Agency Survey and Deficiencies Report" states, "1. Name of Facility: 'Above &amp; Beyond Home Care, Inc' ... 15. ... D. Does this home health agency or sub-unit operate branch(es)? YES [checked] If yes, how many: '02' If yes, give official name and mailing address of each branch (include street, state and zip code): '3304 N. [North] Reserve St. [Street], Muncie, IN 47304' '40 W. [West] 500 South, Suite B, Marion, IN 46953'."</p> <p>2. On 7/14/15 at 9:45 AM, the location at 40 West 500 South, Suite B, Marion, IN was observed and a sign was present which stated, "Above &amp; Beyond Home Care." Upon entering the branch office, surveyor was shown to a room to conduct clinical record review. The room contained a locked filing cabinet with patient's clinical records.</p> <p>A. On 7/17/15 at 12:35 PM, employee A (director of nursing) indicated the agency currently had 106 patient's in the Anderson, Indiana parent office and 64 patient's in the Marion, Indiana branch office.</p> <p>B. On 7/16/15 at 1:30 PM, employee A (director of nursing) indicated the Marion branch office staff consisted of employee I (scheduler/home health aide),</p>		<p>Nelson, Program Coordinator, Division of Acute Care. Last communication with Ms. Nelson was on July 23, 2015 Updated Plan of Correction: The Administrator has removed all personnel from Marion and Muncie sites. Agency will only use sites every Monday and Friday to collect time sheets and distribute pay-checks to home health aides and no other activity will be conducted at these sites. Agency has ceased any new or additional advertising of the branch sites. Agency has removed any reference of branch locations from website: <a href="http://www.indianahomecare.com">www.indianahomecare.com</a> The Administrator will ensure compliance of this corrective action.</p>				

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	<p>employee M (scheduler/home health aide), and employee N (registered nurse). The employee indicated working at both the parent and the Marion branch office. When asked who oversees the branch office, employee A responded "I do, probably."</p> <p>3. On 7/15/15 at 9:30 AM during a home visit with patient #2, employee E (home health aide) indicated being employed with the agency for 3 1/2 years and states, "I work out of the Marion office."</p> <p>4. On 7/15/15 at 10:30 AM during a home visit with patient #4, employee F (home health aide) indicated she turns in all visit notes at the Marion branch office and has monthly in-services there also.</p> <p>5. On 7/16/15 at 2:43 PM, employee A (director of nursing) indicated the agency had not received an approval letter from ISDH for operation of either branch location and the last correspondence the agency had with ISDH was a letter from the department dated 4/23/15 requesting additional information.</p> <p>6. On 7/17/15, the web site <a href="http://www.homecareindiana.com">http://www.homecareindiana.com</a> was reviewed and stated, "About Us - Above &amp; Beyond Homecare, Inc. is a home health care company that is passionate</p>			

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G 0158 Bldg. 00	<p>about caring for those in need. Based in Anderson, Indiana and with offices in Muncie and Marion, we offer homecare throughout Indiana. ... Above &amp; Beyond Homecare, Inc. 1320 E. 53rd St., Ste A, Anderson, IN 46013 Phone: (765) 622-0999."</p> <p>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 clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care and failed to ensure the physician was notified of delays in the ordered start of care in 4 of 10 active patient records reviewed. (#3, 5, 6, and #10)  Findings include:  1. Clinical record #3 contained a plan of care for certification period 6/16 to 8/15/15 with orders to include homemaker services 1 day per week, 2 hour visits for 60 days. The record failed to evidence homemaker services were conducted weeks 1 and 4.</p>	G 0158	The Administrator and Director of Nursing have in-serviced nursing staff, case managers and schedulers on following the Plan of Care and Plan of Care Policy. Specific instruction was given on notification to Physicians when Start of Care is delayed and documentation of rescheduling of Patient visits. Director of Nursing will audit 20 percent of all weekly missed visits and Physician Orders. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected. The Director of Nursing will report any findings to the administrator. These findings will also be used and incorporated into the Quality Assurance Meetings to evaluate care.	07/23/2015

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	<p>On 7/14/15 at 11:10 AM, employee A (director of nursing) indicated week 1 of the certification period had homemaker services scheduled for 6/16/15 that were missed due to the aide called off. The employee indicated week 4 of the certification period had homemaker services scheduled for 7/7/15 and was canceled due to no available staff. Employee A indicated being unable to locate documentation of the attempt to reschedule the canceled visits.</p> <p>2. Clinical record #5, start of care 4/19/11 (4 days after physician ordered start of care), contained a plan of care for certification period 4/19 to 6/17/11 with a nurse's signature and date of physician's verbal order for start of care as 4/15/11. The record failed to evidence the physician was notified of the delay in start of care.</p> <p>On 7/16/15 at 11:40 AM, employee A (director of nursing) indicated being unable to locate documentation of reason for or the physician's notification of the delay in start of care.</p> <p>3. Clinical record #6 contained plans of care for certification periods 5/2 to 6/30/15 and 7/1 to 8/29/15 with orders to include homemaker services 1-2 hour visits, 1-2 days per week for 60 days to</p>			

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	<p>assist with homemaking services. The record failed to evidence homemaker services were conducted on May 12 and 15, 2015, June 19, 2015, and July 10, 2015.</p> <p>A. The record evidenced a document dated 5/19/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 5/12/15 2:15 p [PM] - 4:15 p Date/Time of Client/Office Notification: 5/19/15 10:00 a [AM] Homemaker [checked] Reason For Cancellation ... Other [checked]: 'No Aide to cover' Will Visit be Made up: NO [circled]."</p> <p>B. The record evidenced a document dated 5/19/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 5/15/15 1:15 p - 3:15 p Date/Time of Client/Office Notification: 5/19/15 9:25 a Homemaker [checked] Reason For Cancellation ... Client/Family Cancellation [checked] ... Will Visit be Made up: NO [circled]."</p> <p>C. The record evidenced a document dated 7/2/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name:</p>			

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	<p>[patient #6] Date/Time of Missed Visit: 6/19/15 1:15 p - 3:15 p ... Homemaker [checked] Reason For Cancellation ... Other [checked]: 'No aide to cover' ... Will Visit be Made up: NO [circled]."</p> <p>D. The record evidenced a document dated 7/10/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 7/10/15 1:15 p - 3:15 p Date/Time of Client/Office Notification: 7/10/15 Homemaker [checked] Reason For Cancellation ... Client/Family Cancellation [checked] ... 'No aide available' ... Will Visit be Made up: NO [circled]."</p> <p>E. On 7/14/15 at 2 PM, a home visit was conducted with patient #6. The patient indicated receiving homemaker services 2 times per week with recent cancellations by agency staff.</p> <p>4. Clinical record #10, start of care 1/28/15 (one day after the physician ordered start of care), contained a plan of care for certification period 1/28 to 3/28/15 with a nurse's signature and date of physician's verbal order for start of care as 1/27/15. The record failed to evidence the physician was notified of the delay in start of care.</p>			

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G 0332	<p>484.55(a)(1)</p> <p>5. The undated agency policy titled "Admission Policy" states, "Policy Clients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the client's medical, nursing, and social needs can be met adequately by Agency in the client's place of residence. ... Special Instructions ... 3. Services for a client receiving skilled nursing or home health aide services must follow a written plan of care established and periodically reviewed by a doctor of medicine."</p> <p>6. The undated agency policy titled "Plan of Care Policy" states, "Policy Home care services are furnished under the supervision and direction of the client's physician. ... Purpose To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs. ... Special Instructions ... 3. If a physician refers a client under a Plan of Care that cannot be completed until after an assessment visit, the physician shall be consulted to approve additions or modifications to the original plan."</p>			

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Bldg. 00	<p><b>INITIAL ASSESSMENT VISIT</b></p> <p>The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.</p> <p>Based on clinical record review, policy review, and interview, the home health agency failed to ensure the initial assessment visit was completed within 48 hours of referral for 1 of 10 active patient records reviewed. (#2)</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>Clinical record #3, start of care 7/6/15, included an initial / comprehensive / assessment completed 7/6/15 by the registered nurse.</li> <li>On 7/14/15 at 11:40 AM, employee A (director of nursing) indicated the referral date for patient #2 was 6/29/15 and the initial/comprehensive assessment was completed by the registered nurse on 7/6/15. The employee was unable to provide documentation of why the assessment wasn't completed within 48 hours of referral.</li> <li>The undated agency policy titled "Initial Assessment Visit Policy" states, "Policy A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient ... Agency will complete a</li> </ol>	G 0332	<p>The Administrator and Director of Nursing have in-serviced nursing staff, case managers and schedulers on Initial Assessment Visit Policy. Specific instruction was given on providing detailed clinical charting. Director of Nursing will audit 20 percent of all new and resumed patients weekly. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected. The Director of Nursing will report any findings to the administrator. These findings will also be used and incorporated into the Quality Assurance Meetings to evaluate care.</p>	07/23/2015			

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G 0334 Bldg. 00	<p>comprehensive assessment in a timely manner consistent with patient's immediate needs. ... Purpose To comply with state and federal law and regulations."</p> <p>484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on clinical record review, policy review, and interview, the agency failed to ensure the comprehensive assessment was completed no later than 5 calendar days after the start of care in 7 of 10 active clinical records reviewed creating the potential to affect all new patients of the agency. (#1, 3, 5, 6, 8, 9, and #10)</p> <p>Findings include:</p> <p>1. Clinical record #1 contained a plan of care for certification period 6/30 to 8/29/15 with a start of care date of 6/30/14 and a document titled "Comprehensive Adult Assessment and Outcome and Assessment Information Set Start of Care Version" dated 6/26/15, before the start of care, and signed by employee J (Registered Nurse). The record failed to evidence the</p>	G 0334	<p>The Administrator and Director of Nursing have in-serviced nursing staff, case managers and schedulers on Comprehensive Assessment Policy. Specific instruction was given on not performing a comprehensive assessment until after the initial assessment. Director of Nursing will audit 20 percent of all new and resumed patients weekly. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected. The Director of Nursing will report any findings to the administrator. These findings will also be used and incorporated into the Quality Assurance Meetings to evaluate care. Reason for IDR: Section 484.55(b)(1) (Tag G334) States: The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no</p>	07/23/2015

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	<p>comprehensive assessment was completed after the start of care.</p> <p>2. Clinical record #3 contained a plan of care for certification period 6/16 to 8/15/15 with a start of care date of 8/20/14 and a document titled "Comprehensive Adult Assessment and Outcome and Assessment Information Set Start of Care Version" dated 8/19/14, before the start of care, and signed by employee J (Registered Nurse). The record failed to evidence the comprehensive assessment was completed after the start of care.</p> <p>3. Clinical record #5 contained a plan of care for certification period 5/28 to 7/26/15 with a start of care date of 4/19/11 and a document titled "Comprehensive Adult Assessment and Outcome and Assessment Information Set Start of Care Version" dated 4/15/11, before the start of care, and signed by employee K (Registered Nurse). The record failed to evidence the comprehensive assessment was completed after the start of care.</p> <p>4. Clinical record #6 contained a plan of care for certification period 7/1 to 8/29/15 with a start of care date of 3/3/15 and a document titled "Comprehensive Adult Assessment and Outcome and</p>		<p>later than 5 calendar days after the start of care. In the Interpretive Guidelines to 484.55(b)(1) It states: Identify the start of care date. For all practical purposes, the start of care date is the first billable home visit. For payers other than Medicare, the first billable visit might be a visit made by a home health aide. First, the regulations does not prohibit a comprehensive assessment being completed prior to Start of Care. The regulation sets an end point: no later than 5 days after start of care. Second, the Agency thinks its best practice to know a patient's overall health assessment prior to starting a service.</p>	

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	<p>Assessment Information Set "Start of Care Version" dated 2/27/15, before the start of care, and signed by the registered nurse. The record failed to evidence the comprehensive assessment was completed after the start of care.</p> <p>5. Clinical record #8 contained a plan of care for certification period 5/29 to 7/27/15 with a start of care date of 5/29/15 and a document titled "Comprehensive Adult Assessment and Outcome and Assessment Information Set "Start of Care Version" dated 5/28/15, before the start of care, and signed by the registered nurse. The record failed to evidence the comprehensive assessment was completed after the start of care.</p> <p>6. Clinical record #9 contained a plan of care for certification period 6/16 to 8/14/15 with a start of care date of 2/16/15 and a document titled "Comprehensive Adult Assessment and Outcome and Assessment Information Set "Start of Care Version" dated 2/11/15, before the start of care, and signed by employee L (Registered Nurse). The record failed to evidence the comprehensive assessment was completed after the start of care.</p> <p>7. Clinical record #10 contained a plan of care for certification period 5/28 to</p>			

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	<p>7/26/15 with a start of care date of 1/28/15 and a document titled "Comprehensive Adult Assessment and Outcome and Assessment Information Set Start of Care Version" dated 1/23/15, before the start of care, and signed by employee L (Registered Nurse). The record failed to evidence the comprehensive assessment was completed after the start of care.</p> <p>8. On 7/14/15 at 11:07 AM, employee A (director of nursing) indicated the Comprehensive Adult Assessment and Outcome and Assessment Information Set, Start of Care version is the initial assessment and the comprehensive assessment combined and is completed on admission. The employee indicated after completion of this assessment, the agency has 5 days to start care. Employee A indicated most of the patient records would not contain a comprehensive assessment within 5 days of the start of care date due to the assessments being conducted on admission, prior to start of care.</p> <p>9. The undated agency policy titled "Comprehensive Client Assessment Policy" states, "Policy A thorough, well-organized, comprehensive and accurate assessment, consistent with the clients immediate needs will be</p>			

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N 0000  Bldg. 00	<p>completed for all clients in a timely manner, but not later than five (5) calendar days after the start of care. ... "</p> <p>This visit was a home health state re-licensure survey.</p> <p>Survey Dates: July 13-17, 2015</p> <p>Facility #: 004808</p> <p>Medicaid Vendor #: 200829700</p> <p>Current census at time of survey: 106 patients, Anderson (Parent) Office 64 patients, Marion (Branch) Office Total: 170 patients</p>	N 0000		

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	Census By Service Type (Unduplicated Last 12 Months): 66 Patients, Skilled 128 Patients, Home Health Aide 49 Patients, Personal Service Only Total: 243 patients  QR: JE 7/21/15			
N 0506 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights Rule 12 (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: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice. Based on clinical record review,	N 0506	The Administrator and Director of Nursing have in-serviced nursing	07/23/2015

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	<p>admission packet review, and interview, the agency failed to ensure the patient was informed, in advance, of any changes in the care to be furnished in 1 of 10 active patient records reviewed. (#6)</p> <p>Findings include:</p> <p>1. Clinical record #6 contained physician's plans of care for certification periods 5/2 to 6/30/15 and 7/1 to 8/29/15 with orders to include homemaker services 1-2 hour visits, 1-2 days per week for 60 days to assist with homemaking services. The record failed to evidence homemaker services were conducted on May 12 and 15, 2015, June 19, 2015, and July 10, 2015, and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document dated 5/19/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 5/12/15 2:15 p [PM] - 4:15 p Date/Time of Client/Office Notification: 5/19/15 10:00 a [AM] Homemaker [checked] Reason For Cancellation ... Other [checked]: 'No Aide to cover' Will Visit be Made up: NO [circled]."</p> <p>B. The record evidenced a document</p>		<p>staff, case managers and schedulers on Patients' Rights. Focusing on the patient's right to advance notice of any changes in the plan of care before a change is made. Supervisory Nurses will review missed visit reports and patient communication to ensure compliance. Director of Nursing will audit 20 percent of all weekly missed visits. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected. The Director of Nursing will report any findings to the administrator. These findings will also be used and incorporated into the Quality Assurance Meetings to evaluate care.</p>	

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	<p>dated 5/19/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 5/15/15 1:15 p - 3:15 p Date/Time of Client/Office Notification: 5/19/15 9:25 a Homemaker [checked] Reason For Cancellation ... Client/Family Cancellation [checked] ... Will Visit be Made up: NO [circled]."</p> <p>1.) A document from the electronic medical record titled "Client Notes for : [patient #6]" by employee I (scheduler), stating, "Date: 5/15/15 Time: 3:12 PM ... [Patient] called to see if the aide was coming today. I reminded [him/her] that [his/her] aide was going to be gone today and asked if [he/she] would like me to find someone else for [him/her] today. [He/She] stated that [he/she] did not know that [aide] was not going to be there and we should have let [him/her] know."</p> <p>2.) On 7/16/15 at 11:40 AM, employee A (director of nursing) indicated being unsure why the scheduler wrote the patient had canceled the visit on the missed visit report dated 5/19/15.</p> <p>C. The record evidenced a document dated 7/2/15, signed by employee I (scheduler), titled "Missed Visit Report."</p>			
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	<p>The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 6/19/15 1:15 p - 3:15 p ... Homemaker [checked] Reason For Cancellation ... Other [checked]: 'No aide to cover' ... Will Visit be Made up: NO [circled]."</p> <p>D. The record evidenced a document dated 7/10/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 7/10/15 1:15 p - 3:15 p Date/Time of Client/Office Notification: 7/10/15 Homemaker [checked] Reason For Cancellation ... Client/Family Cancellation [checked] ... 'No aide available' ... Will Visit be Made up: NO [circled]."</p> <p>2. On 7/14/15 at 2 PM, a home visit was conducted with patient #6. The patient indicated receiving homemaker services 2 times per week with recent cancellations by agency staff. The patient indicated he/she is not notified of the canceled visit in advance and states, "If they are going to be late or not show up, I wish they would call and let us know."</p> <p>3. The agency admission packet [page 13 of 57] states, "Your Rights and Responsibilities as a Health Care Client Client Rights ... 8. the client has the right</p>			

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N 0522 Bldg. 00	<p>to be informed in advance about the care to be furnished. the agency will inform the client in writing in advance of the disciplines that will furnish care and the frequency of proposed visits to be furnished. The agency will inform the client in advance of any change in the plan of care before the change is made."</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care and failed to ensure the physician was notified of delays in the ordered start of care in 4 of 10 active patient records reviewed. (#3, 5, 6, and #10)</p> <p>Findings include:</p> <p>1. Clinical record #3 contained a plan of care for certification period 6/16 to 8/15/15 with orders to include homemaker services 1 day per week, 2</p>	N 0522	The Administrator and Director of Nursing have in-serviced nursing staff, case managers and schedulers on following the Plan of Care and Plan of Care Policy. Specific instruction was given on notification to Physicians when Start of Care is delayed and documentation of rescheduling of Patient visits. Director of Nursing will audit 20 percent of all weekly missed visits and Physician Orders. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected. The Director of Nursing will report any findings to the administrator. These findings will also be used	07/23/2015

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	<p>hour visits for 60 days. The record failed to evidence homemaker services were conducted weeks 1 and 4.</p> <p>On 7/14/15 at 11:10 AM, employee A (director of nursing) indicated week 1 of the certification period had homemaker services scheduled for 6/16/15 that were missed due to the aide called off. The employee indicated week 4 of the certification period had homemaker services scheduled for 7/7/15 and was canceled due to no available staff. Employee A indicated being unable to locate documentation of the attempt to reschedule the canceled visits.</p> <p>2. Clinical record #5, start of care 4/19/11 (4 days after physician ordered start of care), contained a plan of care for certification period 4/19 to 6/17/11 with a nurse's signature and date of physician's verbal order for start of care as 4/15/11. The record failed to evidence the physician was notified of the delay in start of care.</p> <p>On 7/16/15 at 11:40 AM, employee A (director of nursing) indicated being unable to locate documentation of reason for or the physician's notification of the delay in start of care.</p> <p>3. Clinical record #6 contained plans of</p>		and incorporated into the Quality Assurance Meetings to evaluate care.				

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	<p>care for certification periods 5/2 to 6/30/15 and 7/1 to 8/29/15 with orders to include homemaker services 1-2 hour visits, 1-2 days per week for 60 days to assist with homemaking services. The record failed to evidence homemaker services were conducted on May 12 and 15, 2015, June 19, 2015, and July 10, 2015.</p> <p>A. The record evidenced a document dated 5/19/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 5/12/15 2:15 p [PM] - 4:15 p Date/Time of Client/Office Notification: 5/19/15 10:00 a [AM] Homemaker [checked] Reason For Cancellation ... Other [checked]: 'No Aide to cover' Will Visit be Made up: NO [circled]."</p> <p>B. The record evidenced a document dated 5/19/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 5/15/15 1:15 p - 3:15 p Date/Time of Client/Office Notification: 5/19/15 9:25 a Homemaker [checked] Reason For Cancellation ... Client/Family Cancellation [checked] ... Will Visit be Made up: NO [circled]."</p>			

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	<p>C. The record evidenced a document dated 7/2/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 6/19/15 1:15 p - 3:15 p ... Homemaker [checked] Reason For Cancellation ... Other [checked]: 'No aide to cover' ... Will Visit be Made up: NO [circled] ."</p> <p>D. The record evidenced a document dated 7/10/15, signed by employee I (scheduler), titled "Missed Visit Report." The document states, "Client's Name: [patient #6] Date/Time of Missed Visit: 7/10/15 1:15 p - 3:15 p Date/Time of Client/Office Notification: 7/10/15 Homemaker [checked] Reason For Cancellation ... Client/Family Cancellation [checked] ... 'No aide available' ... Will Visit be Made up: NO [circled]."</p> <p>E. On 7/14/15 at 2 PM, a home visit was conducted with patient #6. The patient indicated receiving homemaker services 2 times per week with recent cancellations by agency staff.</p> <p>4. Clinical record #10, start of care 1/28/15 (one day after the physician ordered start of care), contained a plan of care for certification period 1/28 to 3/28/15 with a nurse's signature and date</p>			

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	<p>of physician's verbal order for start of care as 1/27/15. The record failed to evidence the physician was notified of the delay in start of care.</p> <p>5. The undated agency policy titled "Admission Policy" states, "Policy Clients are accepted for treatment in the home on the basis of reasonable criteria and under the expectation that the client's medical, nursing, and social needs can be met adequately by Agency in the client's place of residence. ... Special Instructions ... 3. Services for a client receiving skilled nursing or home health aide services must follow a written plan of care established and periodically reviewed by a doctor of medicine."</p> <p>6. The undated agency policy titled "Plan of Care Policy" states, "Policy Home care services are furnished under the supervision and direction of the client's physician. ... Purpose To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs. ... Special Instructions ... 3. If a physician refers a client under a Plan of Care that cannot be completed until after an assessment visit, the physician shall be consulted to approve additions or modifications to the original plan."</p>			

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N 0608  Bldg. 00	<p>410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:</p> <p>(1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary.</p> <p>Based on clinical record review, agency policy review, and interview, the agency failed to ensure corrections to the clinical record were made according to professional standards in 1 of 12 clinical records reviewed. (#4)</p> <p>Findings include:</p> <p>1. The undated agency policy titled "Electronic Signature &amp; Error Procedure Policy" states, "Policy To ensure that all</p>	N 0608	The Administrator and Director of Nursing have in-serviced nursing staff, case managers and schedulers on Electronic Signature & Error Procedure Policy. Director of Nursing will review 20 percent of patient charts monthly to ensure compliance with Electronic Signature & Error Procedure Policy. Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected. The Director of Nursing will report any findings to the administrator.	07/23/2015
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N 9999 Bldg. 00	<p>medial record entries will be made by appropriate staff and authenticated by the author of the entry. Purpose ... Special Instructions ... 6. In the case of an alteration needing to be made in the medical record, one line should be made through the entry and then the health care provider should initial the change."</p> <p>2. Clinical record #4, start of care 9/30/10, evidenced a comprehensive adult assessment, start of care version originally dated 9/29/10 on pages 1 and 14 by the registered nurse. A "30" was marked (in ink) over the "29." The correction failed to include one line through the error and failed to include the initials of the person(s) making the change.</p> <p>3. On 7/15/15 at 12:20 PM, employee A (director of nursing) indicated the appropriate way to correct an entry into the medical record is one line through the error and initials of the person making the correction.</p> <p>Based on interview and record review the agency failed to ensure the Indiana State Department of Health was notified of a</p>	N 9999	<p>These findings will also be used and incorporated into the Quality Assurance Meetings to evaluate care.</p> <p>Agency submitted a branch application on March 17, 2015. On April23, 2015, Agency received letter from MS. Bobbie Nelson, Program Coordinator for</p>	08/04/2015	

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	<p>branch location to ensure the location met the definition of branch office for operation and function.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>410 IAC (Indiana Administrative Code) 17-9-5 states, "'Branch office' defined ... Sec. 5. 'Branch office' means a location or site from which a home health agency provides services for a portion of the total geographic area serviced by the parent home health agency. To be a branch office, the office must be part of the parent agency and share administration, supervision, and services with the parent agency. The parent agency and the branch office must be capable of sharing emergency functions, including services, on a daily basis. A branch office must be located within one hundred and [sic.] twenty (120) minutes driving time of the parent agency."</li> <li>On 7/13/15 during entrance conference, employee B (administrator) indicated the agency had 2 branch locations, one in Muncie, Indiana and one in Marion, Indiana. The employee indicated the Muncie branch was not currently being used but the Marion branch was.</li> <li>On 7/14/15 at 9:45 AM, the location</li> </ol>		<p>clarification. Agency responded on May 1, 2015. On July 23, 2015, Agency spoke with Ms. Nelson, Program Coordinator, and was informed application was pending and "shouldn't be much longer." Administrator is waiting on final determination of status of Marion and Muncie sites, the sites will be closed and advertising removed including web based advertising if a denial of application is issued. The Administrator will ensure compliance of this corrective action upon receiving notice of application status. IDR: Agency did notify Department of Health on March 17, 2015 by submitting an application for branches. Agency has been in communication with Ms. Bobbie Nelson, Program Coordinator, Division of Acute Care. Last communication with Ms. Nelson was on July 23, 2015 Updated Plan of Correction: The Administrator has removed all personnel from Marion and Muncie sites. Agency will only use sites every Monday and Friday to collect time sheets and distribute pay-checks to home health aides and no other activity will be conducted at these sites. Agency has ceased any new or additional advertising of the branch sites. Agency has removed any reference of branch locations from website: <a href="http://www.indianahomecare.com">www.indianahomecare.com</a> The Administrator will ensure</p>	

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	<p>at 40 West 500 South, Suite B, Marion, IN was observed and a sign was present which stated, "Above &amp; Beyond Home Care." Upon entering the branch office, surveyor was shown to a room to conduct clinical record review. The room contained a locked filing cabinet with patient's clinical records.</p> <p>A. On 7/17/15 at 12:35 PM, employee A (director of nursing) indicated the agency currently had 106 patient's in the Anderson, Indiana parent office and 64 patient's in the Marion, Indiana branch office.</p> <p>B. On 7/16/15 at 1:30 PM, employee A (director of nursing) indicated the Marion branch office staff consisted of employee I (scheduler/home health aide), employee M (scheduler/home health aide), and employee N (registered nurse). The employee indicated working at both the parent and the Marion branch office. When asked who oversees the branch office, employee A responded "I do, probably."</p> <p>4. On 7/15/15 at 9:30 AM during a home visit with patient #2, employee E (home health aide) indicated being employed with the agency for 3 1/2 years and states, "I work out of the Marion office."</p>		compliance of this corrective action.	

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	<p>5. On 7/15/15 at 10:30 AM during a home visit with patient #4, employee F (home health aide) indicated she turns in all visit notes at the Marion branch office and has monthly in-services there also.</p> <p>6. On 7/16/15 at 2:43 PM, employee A (director of nursing) indicated the agency had not received an approval letter from ISDH for operation of either branch location and the last correspondence the agency had with ISDH was a letter from the department dated 4/23/15 requesting additional information.</p> <p>7 On 7/17/15, the web site <a href="http://www.homecareindiana.com">http://www.homecareindiana.com</a> was reviewed and stated, "About Us - Above &amp; Beyond Homecare, Inc. is a home health care company that is passionate about caring for those in need. Based in Anderson, Indiana and with offices in Muncie and Marion, we offer homecare throughout Indiana. ... Above &amp; Beyond Homecare, Inc. 1320 E. 53rd St., Ste A, Anderson, IN 46013 Phone: (765) 622-0999."</p>			