

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013	
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY				STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356			
(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
G000000	<p>This visit was a home health federal complaint investigation survey.</p> <p>Complaint # IN00131673 Substantiated: No deficiencies realted to the allegation are cited. An unrelated deficiency is cited.</p> <p>Survey Dates: July 23, 2013</p> <p>Facility # 011160</p> <p>Medicaid Vendor: 200836920</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 25, 2013</p>			G000000			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356
---	--

(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
G000158	<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.</p> <p>Based on clinical record and policy review and interview, the agency failed to ensure visits were made as ordered on the written plan of care in 2 of 5 clinical records reviewed with the potential to affect all patients. (1, 2 and 3)</p> <p>Findings:</p> <p>1. Clinical record 1, start of care (SOC) 3/15/13, with physician orders for skilled nurse 1 extended 8 hour visit a day x (for) 5 days a week and 1 extended 9 hour visit x 2 days a week x 9 weeks for 5/14/13 to 7/12/13.</p> <p>A. The clinical record failed to evidence visits for 5/21, 5/22, 5/23, 5/24, 5/25, 5/26, 5/27, 5/29, 6/8, 6/9/ 6/22, 6/23, 6/28, 7/8, 7/9, 7/10, 7/11, and 7/12/13.</p> <p>B. On 7/23/13 at 4 PM, the Administrator indicated the visits were missed or not documented.</p> <p>2. Clinical record 2, SOC 2/26/13, with physician orders for home health aides for</p>	G000158	The Administrator and DON has inserviced nursing staff and home health aides on following medical plans of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist. The Administrator and DON has inserviced the nursing staff and home health aides on completion of the Missed Visit Form. The Missed Visit Form documents client name, date of missed visit, type of visit missed, reason for missed visit, staff signature, staff discipline, date, notification to physician, cc: original to client chart and copy of billing. A missed visit form will be completed by the clinical staff at the time of the missed visit and submitted by the following Monday by 4pm or before to the office. All nursing staff will also document the reason the missed visit form was completed in the Nursing Note effective 7/24/13 and ongoing. The Nursing Assistant will record all services (including the missed visit report) on a calendar worksheet for each individual client to track all visits to ensure compliance with the Plan of Care. On Tuesday by 4pm the Nursing Assistant will	07/29/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013	
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY				STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356			
(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			
	<p>1 extended 6 hour visit and 1 - 1 hour visit x 7 days a week for 9 weeks.</p> <p>A. The clinical record failed to evidence visits for the 1 hour evening visit 4/29, 4/30, 5/1, 5/2, 5/3, 5/4, 5/5, 5/6, 5/7, 5/8, 5/9, 5/10, 5/13, 5/14, 5/15, 5/16/ 5/17, 5/21, 5/22, 5/23, 5/24, 5/27, 5/28, 5/29, 5/30, 5/31, 6/3, 6/4, 6/5, 6/7, 6/9, 6/10, 6/11, 6/12, 6/14, 6/15, 6/18, 6/19, and 6/21/13.</p> <p>B. On 7/23/13 at 4:15 PM, the Administrator indicated the visits were missed or not documented.</p> <p>3. A policy titled "Clinical Documentation", Approved 7/10/12, states, "Individual Support Home health Agency (ISHHA) will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the patient's care."</p>		<p>provide a completed tracking calendar worksheet to the nursing supervisor along with the client documentation, including Missed Visit Forms for review and submission of all Missed Visit Forms to Physician via fax. A fax confirmation will be obtained and attached to Missed Visit Form and filed in client clinical records within 48 hours by the Nursing Assistant. To prevent this in the future all new staff will be oriented on following plans of care and completion and compliance regulations and policy and procedures on Missed Visit Forms by Nursing Supervisor. An inservice has been developed on 7/24/13 for an annual training on plans of care and the completion of Missed Visit Forms for all clinical staff to be administered by Nursing Supervisor. This deficiency and plan to correct was implemented on 7/24/13 by the Administrator and DON. All Administrative Staff have been inserviced on returning all client documentation to client records by end of the day by Administrator and DON effective 7/24/13 and ongoing. A sign out sheet attached to the entrance door of the clinical records file room will be utilized by all staff to sign out client record documentation and sign back in. All staff inserviced and completion on 7/29/13. All new staff will be oriented on policy and procedures of signing</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356		
(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	
			<p>client documentation in and out effective 7/24/13 and ongoing by nursing supervisor. The on call nursing supervisor will ensure daily that all clinical records signed out are returned by day end effective 7/24/13 and ongoing. The on call nursing supervisor will retrieve al clinical records within 24 hours if not signed back in to the records room effective 7/24/13 and ongoing. 25% of all clinical records will be audited quarterly for evidence that medical plans of care, documentation sheets (physician review not required) and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optometrist or podiatrist auditing team. 100% of clinical records will be audited semi-annually for evidence that medical plans of care, documentation sheets (physician review not required) and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optometrist or podiatrist by Compliance Officer - this provides a triple check in our system. Effective 7/24/13 The DON and Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur by auditing a 10% random sample. Effective 7/24/13 The Administrator has</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356
---	--

(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
			<p>inserviced the DON, nursing staff, and all administrative staff on missed visit reports and filing in charts timely and signing in and out client records. Nursing staff will document in nursing notes the reason for all missed visits effective 7/24/13 and ongoing. Missed visit reports were separated from the chart during the billing process. For clinical record #1 the clinical record visit on 5/21, 5/22, 5/23, 5/24, 5/25, 5/26, 5/27 - client was in hospital and a missed visit report was separated from chart during the billing process - Missed Visit Form Attached. 5/29 client had medical appointment and missed visit report was separated from chart during billing process - Missed Visit Form Attached. 6/8, 6/9 client requested no services and missed visit report was separated from chart during billing process - Missed Visit Form Attached. 6/22 & 6/23 client requested no services and missed visit report was separated from chart during billing process - Missed Visit Form Attached. 6/28 client had medical appointment and missed visit report was separated from chart during billing process - Missed Visit Form Attached 7/8, 7/9, 7/10, 7/11, 7/12 documentation sheets were separated from chart during billing process. The Financial Coordinator was on vacation during the survey and the Agency failed to look in</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356
---	--

(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
			<p>the department for missed visit reports and missing documentation. Upon her return on 7/29/13 missing documentation was retrieved and filed in clinical records and submitted to ISDH for review. To prevent the deficiency from recurring in the future all Administrative Staff including the Financial Coordinator have been inserviced on returning all client documentation to client records by end of the day by Administrator and DON effective 7/24/13 and completed 7/29/13 and ongoing. A sign out sheet attached to the entrance door of the clinical records file room will be utilized by all staff to sign out client record documentation and sign back in. All staff inserviced and completion on 7/29/13. All new staff will be oriented on policy and procedures of signing client documentation in and out effective 7/24/13 and ongoing by nursing supervisor. The on call nursing supervisor will ensure daily that all clinical records signed out are returned by day end effective 7/24/13 and ongoing. The on call nursing supervisor will retrieve all clinical records within 24 hours if not signed back in to the records room effective 7/24/13 and ongoing. 25% of all clinical records will be audited quarterly for evidence that medical plans of care, documentation sheets (physician review not</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356
---	--

(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
			<p>required) and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optometrist or podiatrist auditing team. 100% of clinical records will be audited semi-annually for evidence that medical plans of care, documentation sheets (physician review not required) and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optometrist or podiatrist by Compliance Officer - this provides a triple check in our system. Effective 7/24/13 The DON and Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur by auditing a 10% random sample. Effective 7/24/13</p> <p>The Administrator requested documentation sheets be pulled for client #2. All documentation sheets was found and the missing documents are attached. Client #2 had been given a 30 day notice, the Administrative Assistant had pulled May thru July 2013 documents to compile a report for the Board of Directors reporting indicating that we were providing adequate care with staffing two home health aides (one at the agencies expense - a non billable unit) at the same time and providing additional time to ensure adequate care, as you will</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356
---	--

(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
			note in the documentation sheets attached. The Administrator failed to ask the Administrative Assistant if they had client #2 documentation sheets (as it did not cross her mind). To prevent the deficiency from recurring in the future all Administrative Staff including the Administrative Assistant have been inserviced on returning all client documentation to client records by end of the day by Administrator and DON effective 7/24/13 and completed 7/29/13 and ongoing. A sign out sheet attached to the entrance door of the clinical records file room will be utilized by all staff to sign out client record documentation and sign back in. All staff inserviced and completion on 7/29/13 by DON and Administrator. All new staff will be oriented on policy and procedures of signing client documentation in and out effective 7/24/13 and ongoing by nursing supervisor. The on call nursing supervisor will ensure daily that all clinical records signed out are returned by day end effective 7/24/13 and ongoing. The on call nursing supervisor will retrieve all clinical records within 24 hours if not signed back in to the records room effective 7/24/13 and ongoing. 25% of all clinical records will be audited quarterly for evidence that medical plans of care, documentation sheets	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356		
(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	
			(physician review not required) and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optometrist or podiatrist auditing team. 100% of clinical records will be audited semi-annually for evidence that medical plans of care, documentation sheets (physician review not required) and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optometrist or podiatrist by Compliance Officer - this provides a triple check in our system. Effective 7/24/13 The DON and Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur by auditing a 10% random sample. Effective 7/24/13 The policy title "Clinical Documentation" now includes: A missed visit report will be completed by the staff scheduled for the services and submitted on Mondays by 4 pm when services are not delivered. All services will be monitored by supervising nurse responsible for managing the client's care. The Nursing Assistant will provide the nursing supervisor and the billing department a utilization report based on the plan of care for any missing documentation every Tuesday by 4pm and report to the supervising nurse responsible		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356		
(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 managing the client's care, the DON and the Administrator any discrepancies. The billing department will make contact with staff responsible for submitting documentation, if applicable. To prevent the deficiency from recurring in the future the Compliance Officer will update all policies effective 7/24/13 and present to Administrator and DON to present to the Board for approval. The Administrator received verbal approval from Board on change of policy and implemented policy with inservice to all staff on 7/29/13. A new Compliance Officer was hired on 6/25/13 to ensure that all policies meet requirements and will review annually with the Administrator and DON and present to Board.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356		
(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	
N000000	<p>This visit was a home health state complaint investigation survey.</p> <p>Complaint # IN00131673 Substantiated: No deficiencies realted to the allegation are cited. An unrelated deficiency is cited.</p> <p>Survey Dates: July 23, 2013</p> <p>Facility # 011160</p> <p>Medicaid Vendor: 200836920</p> <p>Surveyor: Susan E. Sparks, RN, PH Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN July 25, 2013</p>	N000000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356		
(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	
N000522	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:	N000522	N 522 The Administrator and DON has inserviced nursing staff and home health aides on following medical plans of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist. The Administrator and DON has inserviced the nursing staff and home health aides on completion of the Missed Visit Form. The Missed Visit Form documents client name, date of missed visit, type of visit missed, reason for missed visit, staff signature, staff discipline, date, notification to physician, cc: original to client chart and copy of billing. A missed visit form will be completed by the clinical staff at the time of the missed visit and submitted by the following Monday by 4pm or before to the office. All nursing staff will document in the nursing notes the reason a missed visit form was completed. The Nursing Assistant will record all services (including the missed visit form) on a calendar worksheet for each individual client to track all visits to ensure compliance with the Plan of Care. On Tuesday by 4pm the Nursing Assistant will	07/24/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/23/2013
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY			STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356		
(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	
			<p>provide a completed tracking calendar worksheet to the nursing supervisor along with the client documentation, including Missed Visit Forms for review and submission of all Missed Visit Forms to Physician for review via fax. A fax confirmation will be obtained and attached to Missed Visit Form and filed in client clinical records within 48 hours by the Nursing Assistant. To prevent this in the future all new staff will be oriented on following plans of care and completion and compliance regulations and policy and procedures on Missed Visit Forms by Nursing Supervisor. An inservice has been developed on 7/24/13 for an annual training on plans of care and the completion of Missed Visit Forms for all clinical staff to be administered by Nursing Supervisor. All Administrative staff have been inserviced on signing client record in and out of file room by Administrator and DON and was completed on 7/29/13. This deficiency and plan to correct was implemented on 7/24/13 and completed on 7/29/13 by Administrator and DON 25% of all clinical records will be audited quarterly for evidence that medical plans of care, documentation sheets (Physician review not required) and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optometrist or podiatrist auditing</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356
---	--

(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
			team. 100% of clinical records will be audited semi-annually for evidence that medical plans, documentation sheets (Physician review not required) of care and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optometrist or podiatrist by Compliance Officer - this provides a triple check in our system. Effective 7/24/13 The DON and Administrator will be responsible for monitoring this corrective action to ensure that this deficiency is corrected and will not recur by review and auditing a 10% random sample quarterly. Effective 7/24/13 and ongoing.	