

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2012
NAME OF PROVIDER OR SUPPLIER  VITAL HOME & HEALTHCARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 8840 CALUMET AVE STE 102 B MUNSTER, IN 46321		
(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	
N0000	<p>This was a State home health complaint investigation.</p> <p>Complaint # IN00119050 - Substantiated: State deficiencies related to the allegation are cited. Referral to appropriate agency.</p> <p>Survey Dates: November 1 and 2, 2012.</p> <p>Facility #: IN002870.</p> <p>Medicaid Vendor #: N/A.</p> <p>Surveyor: Janet Brandt, PHNS.</p> <p>Unduplicated Census: 71. Records reviewed: 3</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN November 7, 2012</p>	N0000	<p>November 15, 2012 Kelly Hemmelgarn, BSN, RNP HNSS - Program Director Indiana State Department of Health Acute Care - Section 4A2 North Meridian Street Indianapolis, IN 46204 RE: Vital Home Healthcare, Inc. Facility # 002870 RE: Event ID 3NXR11 Dear Ms. Hemmelgarn, In response to the Indiana State Department of Health's Statement of Deficiencies from the Complaint Survey completed on November 2, 2012 we have data entered our Plan of Correction into the Survey Report System. Once again I wanted to express my appreciation for the convenience of receiving the documents electronically as well as the systems capability allowing us to enter responses electronically. High praise for your Survey Reporting System Please contact me if you have any questions or need additional information by phone at (708) 342-7076 or e-mail at <a href="mailto:carol.behnke@vitalhomehealth.com">carol.behnke@vitalhomehealth.com</a> Sincerely, Carol Behnke, RN Clinical Supervisor</p>		

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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N0494	<p>410 IAC 17-12-3(a)(1)&amp;(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.</p> <p>Based on medical record and bill of rights review and interview, the agency failed to protect and promote the rights provided to the patient for 3 of 3 records reviewed with the potential to affect all the agency's patients. (#1-3)</p> <p>Findings include:</p> <p>1. "Patient Bill of Rights" Policy No. C:2-003.1-2, revised October 2011, states, "Policy-Each patient will be an active, informed participant in his/her plan of care. ... Procedure: ... F. Be informed, verbally and in writing, of billing and reimbursement methodologies prior to the start of care/service as as changes occur, including fees for the services/products</p>	N0494	<p>1) The Clinical Supervisor/Alternate in-serviced the clinical field staff on: - Agency Policy C:2-003 Patient Bill of Rights which states in the procedure: The Patient Bill of Rights statement defines the right of the patient to: o Be informed, verbally and in writing, of billing and reimbursement methodologies prior to the start of care/service and as changes occur including fees for service/products provided, direct pay responsibilities, and notification of insurance coverage. - Process to complete the "Admission Service Addendum – Home Health" specifically Liability for Payment section to be checked appropriately indicating payer source - Appropriate completion of Notice of Payment</p>	11/26/2012			

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	<p>provided, direct pay responsibilities, and notification of insurance coverage."</p> <p>2. Medical record #1, Start of Care (SOC) 12-7-11, included a plan of care for the certification period from 8-3-12 to 10-1-12 with orders for skilled nursing, home health aide and social work services. The medical record did not contain documentation that the patient or POA (Power of Attorney) was accurately informed of patient liability as per agency policy and "Patient Rights" document. The "Admission Service Agreement - Home Health" signed by the POA on 12-7-11 states, "The services provided to me by this organization will be billed as follows: Medicare fee for service (Project 100% covered)."</p> <p style="text-align: center;">This facility is a state licensed only facility in Indiana. They are not certified to bill Medicare.</p> <p>3. Medical record #2, SOC 9-13-13, included a plan of care for the certification period 9-13-12 to 11-11-12 with orders for skilled nursing and Physical Therapy. Visits were completed per the Plan of Care. The medical record did not contain documentation the patient was informed of the patient liability as per the patient rights document.</p>		<p>Responsibility Form i.e. commercial insurance health plan. - Implementation of newly developed agency form "Service Agreement Addendum" to be completed upon admission, and as changes occur including but not limited to resumption of care, and recertification assessments. SEE ATTACHMENTS –Service Agreement Addendum &amp; Notice of Patient Payment Responsibility</p> <p>2) Clinical Supervisor/Alternate in-serviced support staff on concurrent audit of Medical Records for completion of "Service Agreement Addendum" and "Notice of Patient Payment Responsibility" with submission of paperwork by RN Case Manager; tracking compliance on computer spreadsheet. Vital Home &amp; Healthcare Inc. has a centralized billing process in Tinley Park, IL</p> <p>3) Clinical Supervisor/Alternate is responsible to ensure compliance with Agency Policy C:2-003 Patient Bill of Rights to ensure the patient is informed verbally and in writing of billing and reimbursement methodologies prior to the start of care, as changes occur, including fees for the services/products provided, direct pay responsibilities and notification of insurance coverage. 4) Performance Improvement Manager/Designee will audit Medical Records for compliance quarterly and is responsible for monitoring these corrective actions to ensure that</p>				

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	<p>4. Medical record #3, SOC 8-20-12, included a plan of care for the certification period 8-20-12 to 10-18-12 with orders for skilled nursing visits. Visits were completed per the Plan of Care. The medical record did not contain documentation the patient was informed of the patient liability as the patient rights document. A document that stated, "Notice of Patient Payment Responsibility" for Vital Home &amp; Healthcare, Inc. in Tinley Park, Ill. was partially filled out and did not match the Plan of Care for the certification period. This patient was not a patient of the Tinley Park, Illinois facility.</p> <p>5. In an interview with Employee E on 11/1/12 at 2:00 PM CST, Employee E indicated that the Indiana branch office of Vital Home Healthcare, Inc. is not a Medicare certified agency and cannot bill Medicare under its Indiana license.</p> <p>6. Employee D indicated that Medicare patients of the Indiana agency are billed through the Illinois agency on 11-1-12 at 2:30 PM.</p>		<p>this deficiency is corrected and will not recur. Per your request we are providing documentation RE: notification of CMS and Palmetto GBA our fiscal intermediary of the current physical location in Munster, IN providing Home Health Services in Indiana as an approved branch of Tinley Park, IL 1) 07-22-09 ISDH Letter to Dr. Nalini Thakrar – Administrator, confirming receipt of correspondence from Vital Home &amp; Healthcare, Inc. regarding change in facility physical address, telephone number, and fax number to the Munster, IN location. The letter from ISDH further states “As required by the Centers of Medicare and Medicaid Services, we are informing your fiscal intermediary/carrier of this change if applicable.” Upon receipt of ISDH Letter Vital did not notify CMS or Vital’s fiscal intermediary. Our understanding from the letter was that ISDH notifies CMS and our fiscal intermediary. Attachment 07-22-09 Letter from ISDH 2) 02-15-11 ISDH conducted re-licensure survey at the Munster, IN branch. Deficiencies noted during the survey did not include the physical branch location, patient rights and billing. We were not aware that there was a deficiency related to location and approval of the branch of the parent located in Tinley Park, IL by CMS and our</p>				

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			<p>fiscal intermediary. On 03-16-11 Vital received a letter from ISDH which reads <i>"The Plan of Correction you submitted has been found to be acceptable."</i> Attachment 03-16-11 Letter from ISDH 3) On 02-23-12 Administrator/designee submitted 855A form to Provider Enrollment / Palmetto seeking approval for deeming status in preparation for obtaining Medicare Certification in the State of Indiana. The application includes the address of the parent office in Tinley Park, IL (Section 2 page 13) and the branch office located in Munster, IN (Section 4 page 21). Parent office in Tinley Park, IL is being surveyed by CHAP for accreditation on 12-10 through 12-13-12. The Indiana office of Vital Home &amp; Healthcare will subsequently be surveyed by CHAP in 2013. Attachment: 02-23-12 Letter to Palmetto GBA &amp;MC Enrollment Application 855A</p> <p>4) Certification and Survey Provider Enhanced Reports (CASPER) generated by CMS identify Vital Home &amp; Healthcare Inc. branch; <b>Branch ID: 14Q7602001</b> The branch is numbered with the same Federally assigned provider number as the parent or sub-unit with two modifications. There is a "Q" between the state code and four-digit provider designation plus three more digits for a 10-character branch identifier. Attachment: 05-12 CASPER</p>		

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			Identifying Branch 5) Vital Home & Healthcare, Inc. received a letter from Palmetto GBA dated 05-16-12 confirming completion of the processing of the CMS Form 855A Enrollment Application submitted for Vital Home & Healthcare, Inc. to participate in the Medicare Program. The letter reads <i>"This application has been forwarded along with our recommendation to your state agency and CMS Regional Office..."</i> Therefore we understand as is stated in the letter that ISDH and the CMS Regional Office have received this application with Palmetto's recommendations. Attachment 05-16-12 Letter from Palmetto 6) On 07-19-12 the Illinois Department of Public Health (IDPH) conducted a survey at the Tinley Park, IL Parent location. During the survey IDPH requested that we complete Form CMS-1572(a). Completion of the form includes the question "Does this home health agency or sub-unit operate branches?" We responded "Yes". It further reads – <i>"If yes give official name and mailing address of each branch (include street, state and zip code):</i> We entered the following information; Vital Home & Healthcare, Inc. 8840 Calumet Avenue Suite 102B Munster, IN 46321 Please see attached as evidence that CMS has documentation of branch location address in Munster, IN		

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			<p>Attachment 07-19-12 Form CMS -1572 (a) 7)</p> <p>Administrator/Alternate in-servicrator/Vital's authorized representative / delegated officials including: o "Medicare Provider Enrollment" dated 10-04-12 by Decision Health on provider requirements. o The use of the application for updating provider information offers a standard way to collect information from providers, and offers a mechanism to ensure that only authorized representatives of the provider are requesting changes. Providers must notify the Medicare contractor of any changes to the information contained in the application within 90-days of the effective date of the change. o "Frequently Asked Questions" Provider Enrollment Application 855A8)</p> <p>Administrator/Designee responsible for monitoring compliance for notifying Medicare of changes of information to ensure compliance and that this deficiency will not recur.</p>		

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N0504	<p>410 IAC 17-12-3(b)(2)(D)(i) 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: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>Based on interview and review of the bill of rights document, the agency failed to ensure the patient was advised of the frequency of visits to be made in 3 of 3 records reviewed with the potential to affect all the agency's patients. (#1-3)</p> <p>Findings include:</p> <p>1. Medical record #1, Start of Care (SOC) 12-7-11, included a plan of care for the certification period from 8-3-12 to 10-1-12 with orders for skilled nursing, home health aide and social work services. The medical record did not contain documentation that the patient or POA (Power of Attorney) were informed of the frequency of treatment.</p> <p>2. Medical record #2, SOC 9-13-13,</p>	N0504	<p>1) The Clinical Supervisor/Alternate in-serviced the clinical field staff on ensuring that the patient is advised in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished. 2) Clinical Supervisor/Alternate developed, and in-serviced clinical field staff on implementation of "Service Agreement Addendum" completion upon admission, and as changes occurs including but not limited to resumption of care, and recertification assessments. 3) Clinical Supervisor/Alternate is responsible to ensure compliance of Patient Rights to make certain that the patient is advised in advance of the disciplines that will furnish care and the frequency of visits proposed to be furnished. 4) Performance Improvement Manager/Designee will audit Medical Records for compliance quarterly and is responsible for</p>	11/20/2012			

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	<p>included a plan of care for the certification period 9-13-12 to 11-11-12 with orders for skilled nursing and Physical Therapy. Visits were completed per the Plan of Care. A transfer OASIS was completed 9-19-12 for the patient due to an inpatient admission. The medical record did not contain documentation the patient was informed of the frequency of treatment.</p> <p>3. Medical record #3, SOC 8-20-12, included a plan of care for the certification period 8-20-12 to 10-18-12 with orders for skilled nursing visits. Visits were completed per the Plan of Care. The medical record did not contain documentation the patient was informed of the frequency of treatment.</p> <p>4. "Vital Home &amp; Healthcare, Inc. - Indiana: Bill of Rights and Responsibilities", undated, states, "The home health agency shall advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished."</p> <p>5. Employee E indicated on 11/2/12 at 9:30 AM that agency policy was not followed in that the medical records reviewed for patient #1, #2, and #3 did not contain documentation the patient and/or POA was informed of the</p>		<p>monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.</p>				

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	frequency of visits to be made to the patient by home health agency disciplines.			