

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE												
N 000 Bldg. 00	<p>This was an offsite licensure investigation survey.</p> <p>Survey Date: 2/2/15-5/14/15</p> <p>Facility Number: #012597</p> <p>Facility Active Patient Census by Community (Branch location):</p> <table> <tr><td>Clearwater Commons</td><td>18</td></tr> <tr><td>Forest Creek</td><td>29</td></tr> <tr><td>Rosewalk Commons</td><td>36</td></tr> <tr><td>Forum at the Crossing</td><td>21</td></tr> <tr><td>Northwood Commons</td><td>47</td></tr> <tr><td>Total</td><td>151</td></tr> </table> <p>During this offsite investigation, the agency was found to be operating without a current Indiana Home Health license.</p> <p>QR: JE 5/19/15</p>	Clearwater Commons	18	Forest Creek	29	Rosewalk Commons	36	Forum at the Crossing	21	Northwood Commons	47	Total	151	N 000	no response required	
Clearwater Commons	18															
Forest Creek	29															
Rosewalk Commons	36															
Forum at the Crossing	21															
Northwood Commons	47															
Total	151															
N 400 Bldg. 00	<p>410 IAC 17-10-1(a) Licensure</p> <p>Rule 10 Sec. 1(a) No home health agency shall:</p> <ol style="list-style-type: none"> (1) be opened; (2) be operated; (3) be managed; (4) be maintained; or (5) otherwise conduct business; 															

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:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>without a license issued by the department.</p> <p>Based on document review and interview, the agency failed to ensure it was operating with a current Indiana Home Health Agency license in 7 of 7 offsite patient documents reviewed (#1-#7).</p> <p>Findings include:</p> <p>1. The following is the Indiana statute for licensure of home health agencies, "IC [Indiana Code] 16-27-1-8 Licensing Sec. [section] 8. (a) To operate a home health agency, a person must first obtain a license from the state health commissioner."</p> <p>2. A letter from Indiana State Department of Health dated 6/26/14 stated, "Dear [administrator's name]: Our records indicate that your agency's license to operate a home health agency in the State of Indiana will expire 10/31/14. Enclosed is a renewal application for you to complete and submit with requested documentation and \$250 license fee to: ... Please ensure your application is complete and arrives in advance of your facility's license expiration 10/31/14."</p> <p>3. The Indiana State Department of Health did not receive the renewal</p>	N 400	<p>The renewal application along with the appropriate fee was submitted to ISDH. N-400/434</p> <p>1. The Administrator responsible for the failure to renew the license is no longer with the agency. 5 Star Home Health has entered into a contract with Nightingale Home Health to provide services to the 5 Star clients.</p> <p>2. How we plan to prevent the deficiency from reoccurring:</p> <p>1. A renewal application along with the appropriate fee will be sent to ISDH at least 60 days prior to the expiration date of the current license.</p> <p>2. The Administrator will send the completed renewal application to the licensing division at the Newton Massachusetts corporate office. The Administrator will follow up with the corporate licensing division to assure the renewal has been submitted in advance of the license expiration.</p> <p>1. The Administrator will be responsible for correcting and monitoring this POC. The Regional Director of Operations will oversee the Administrator.</p> <p>2. 5/24/15</p>	05/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>application by 10/31/14 when the agency's license expired.</p> <p>4. The agency was called on 2/2/15 at 2:18 p.m. and the administrative assistant answered the phone as Five Star Home Health and indicated the administrator was out in one of the communities. The administrative assistant indicated they were still operating their home health agency, but would have the administrator contact the Indiana State Department of Health.</p> <p>5. On 2/2/15 at 2:25 p.m., the administrator contacted the Indiana State Department of Health. The administrator indicated all home health services had been placed on hold since their license had not been renewed after 10/31/14. The administrator indicated corporate takes care of license renewals and the agency had not considered calling the Indiana State Department of Health to determine the status of their license and approximately 100 patient's home health services were placed on hold. The administrator indicated private caregivers were providing the patients' care until they received their state license. The administrator indicated the corporate headquarters was located in Massachusetts and she/he would contact them to determine the status of the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>renewal application. The Indiana State Department of Health requested Five Star Home Health Inc. provided a list of all patients that have been placed on hold since October 31, 2014.</p> <p>6. A letter from the Indiana State Department of health dated 2/17/15 stated, "RE: Offsite Licensure Survey ... The Acute Care Division of the Indiana State Department of Health (ISDH) is conducting an offsite licensure survey of Five Star Home Health Inc. On February 2, 2015, ISDH contacted and spoke with [Administrator] and [Administrative Assistant]. [Administrator] indicated all home health agency patients had been placed 'on hold' since the expiration of the agency's home health license on October 31, 2014 ... Please consider this a request under 410 IAC 17-12-1(c)(7) and provide to the Indiana State Department of Health the following information within 72 hours of receipt of this notice: Provide a listing of all patients Five State Home Health Inc. provided home health services to on and after October 31, 2014, identified by: name, address, telephone number, primary care physician and the assisted living location (i.e. Clearwater Commons or Forum at the Crossing). If there are patients who receive(d) care from Five Star Home Health Inc. and do not reside</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2015	
NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC				STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227			
(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>in an assisted living setting please list those patients separately ... Provide a copy of physician signed plan/s of care for ALL patients who received service(s) on October 31, 2014. Provide copies of physician orders for all patients for whom home health services were placed on hold or discharged on or after October 31, 2014. Provide a list of patients who were admitted into service after October 31, 2014, along with their physician signed plan of care"</p> <p>7. On 2/26/15 at 2:45 p.m., Five Star Home Health Inc. was contacted and the phone was answered with "Hello, Five Star Home Health" by the administrative assistant. The administrator was requested and the administrative assistant indicated the administrator was not available and provided the administrator's cell phone number. The administrative assistant indicated their job responsibilities included handling new clients, reports, administrative handling of clinical documents, and taking calls from clinical directors. The administrative assistant indicated Five Star Home Health was still accepting patients and had current patients on census. The administrative assistant indicated he/she would email a current list of clients listed by assisted living community. The administrative assistant</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>indicated the home health agency did not serve patients outside of the assisted living communities.</p> <p>8. On 2/26/15 at 3:10 p.m., the administrator contacted the Indiana State Department of Health and indicated the company was currently reviewing budget and was strongly considering not renewing their home health license. When queried regarding why the phone was being answered as Five Star Home Health in the absence of a home health agency license the administrator indicated they had not discharged all of their employees and did not realize the agency could not advertise themselves as operational.</p> <p>9. On 3/3/15 at 9:50 a.m., the administrator contacted the Indiana State Department of Health and indicated, "You were right we have a major issue ... we have been seeing patients since November of 2014." The administrator indicated he/she had informed staff their license would take approximately 5 days to process and during this time placed all patients "on hold" and after 5 days the agency resumed care on all patients in the absence of possessing a new license. The administrator indicated he/she had been off on FML (family medical leave) for 12 weeks and did not resume work until the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2015	
NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC				STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227			
(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>day Indiana State Department of Health contacted the agency on 2/2/15, and then after one week was off an additional week. When queried who the alternate administrator was the administrator indicated he/she was one of the clinical directors. When again requested name of the individual, he/she stated [name of alternate administrator/employee #3] and indicated the individual had never been an administrator before so was unaware of what was required. The administrator indicated the agency was currently providing care to approximately 130 patients. The administrator was queried regarding how he/she was unaware of the operational status of the agency during conversations with the Indiana State Department of Health on 2/2/15 and 2/26/15. The administrator indicated he/she had been absent so was unaware. The administrator indicated the agency's plan was to discharge all patients.</p> <p>10. On 4/10/15, the Indiana State Department of Health received documents from Five Star Home Health Inc. in response to the 2/17/15 request. The documents were reviewed and indicated the following:</p> <p>a. There were a total of 151 active patients receiving services since October 31, 2014, when the agency's home health</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>license expired.</p> <p>b. Patient #1's medical plans of care for service periods 11/15/14-1/14/15, 1/15/15-3/14/15, and 4/7/15-6/6/15 indicated a start of care (SOC) date of 11/15/14 and orders for home health aide (HHA) services.</p> <p>c. Patient #2's medical plan of care for service periods 10/1/14-11/29/14, 11/30/14-1/28/15, and 1/29/15-3/29/15 indicated a SOC date of 6/5/14 and orders for HHA and skilled nursing (SN) services.</p> <p>d. Patient #3's medical plan of care for service periods 9/20/14-11/18/14 and 11/19/14-1/17/15 indicated a SOC date of 7/22/14 and orders for HHA and SN services.</p> <p>e. Patient #4's medical plan of care for the service period 2/27/15- 4/27/215 indicated a SOC date of 2/27/15 and orders for HHA and SN services.</p> <p>f. Patient #5's medical plan of care for service periods 11/16/14-1/14/15, 1/15/15-3/15/15, and 3/16/15-5/14/15 indicated a SOC date of 11/26/12 and orders for HHA services.</p> <p>g. Patient #6's medical plan of care</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 408 Bldg. 00	<p>for the service period 2/17/15- 4/17/15 indicated a SOC date of 2/17/15 and orders for HHA services.</p> <p>h. Patient #7's medical plan of care for services periods 2/16/15-4/16/15 and 4/17/15-6/15/15 indicated a SOC date of 2/16/15 and orders for HHA and SN services.</p> <p>410 IAC 17-10-1(d) Licensure Rule 10 Sec. 1(d) Disclosure of ownership and management information must be made to the department at the time of the home health agency's initial request for licensure, for each survey, and at the time of any change in ownership or management. The disclosure must include the names and addresses of the following: (1) All persons having at least five percent (5%) ownership or controlling interest in the home health agency. (2) Each person who is: (A) an officer; (B) a director; (C) a managing agent; or (D) a managing employee; of the home health agency and evidence supporting the qualifications required by this article.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>(3) The corporation, association, or other company that is responsible for the management of the home health agency.</p> <p>(4) The chief executive officer and the chairman or equivalent position of the governing body of that corporation, association, or other legal entity responsible for the management of the home health agency.</p> <p>Based on record review and interview, the agency failed to ensure the Indiana State Department of Health was notified of a change of administrator, alternate administrator, nursing supervisor, and alternate nursing supervisor in 1 of 1 agency.</p> <p>Findings include:</p> <p>1. A letter from Five Star Home Health Inc. dated April 2, 2014, stated, "Please accept this letter as notification that [employee #1] has been appointed as the Agency Administrator and Nursing Supervisor for Five Star Home Health Inc. effective 03/31/2014. Five Star Home Health has also appointed [employee #2] as the alternate Agency Administrator and Alt [alternate] Nursing Supervisor effective 03/31/2014...."</p> <p>2. On 2/2/15 at 2:18 p.m., the agency was contacted and the administrative assistant answered the phone. The administrator was requested. The</p>	N 408	<p>N 408/451</p> <p>1. The Administrator at the time of the cited deficiency failed to provide the information to ISDH at the time of the changes in the Administrator and Nursing Supervisor position. On 4/14/15 ISDH was notified of the management changes resulting from the previous Administrator leaving 5 Star Home Health</p> <p>2. How we plan to prevent the deficiency from reoccurring:</p> <p>1. All changes in the Administrator, Alternate Administrator, Nursing Supervisor or Alternate Nursing Supervisor will be promptly communicated to ISDH with the required documents outlined in the state regulations. Copies will be forwarded to the Regional Director of Operations for review.</p> <p>1. The Administrator will be responsible for correcting and monitoring compliance. The Regional Director of Operations will oversee the Administrator</p>	05/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 434 Bldg. 00	<p>administrative assistant indicated the administrator [employee #2] was out in one of the communities. The Indiana State Department of Health had not been notified of this change of administrator position.</p> <p>3. On 2/2/15 at 2:25 p.m., employee #2 contacted the Indiana State Department of Health. He/she indicated being the current administrator and was uncertain why the Indiana State Department of Health did not have this information on file. Employee #2 indicated he/she was the administrator/nursing supervisor and employee #3 was the alternate administrator/nursing supervisor. The Indiana State Department of Health was not aware of any of these four management changes.</p> <p>410 IAC 17-11-3 Renewal of home health licensure Rule 11 Sec. 3 An application for renewal of license shall be filed with the department at least sixty (60) days prior, but not sooner</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>than ninety (90) days before, the expiration date of the current license.</p> <p>Based on document review and interview, the home health agency failed to ensure the renewal application for licensure was filed at least 60 days prior to the expiration of the Indiana home health license.</p> <p>Findings include:</p> <p>1. The following was Indiana statute for licensure of home health agencies, "IC [Indiana Code] 16-27-1-8 Licensing Sec. [section] 8. (a) To operate a home health agency, a person must first obtain a license from the state health commissioner."</p> <p>2. A letter from Indiana State Department of Health dated 6/26/14 stated, "Dear [administrator's name]: Our records indicate that your agency's license to operate a home health agency in the State of Indiana will expire 10/31/14. Enclosed is a renewal application for you to complete and submit with requested documentation and \$250 license fee to: ... Please ensure your application is complete and arrives in advance of your facility's license expiration 10/31/14."</p> <p>3. The Indiana State Department of Health did not receive the renewal</p>	N 434	<p>The renewal application along with the appropriate fee was submitted to ISDH. N-400/434</p> <p>1. The Administrator responsible for the failure to renew the license is no longer with the agency. 5 Star Home Health has entered into a contract with Nightingale Home Health to provide services to the 5 Star clients.</p> <p>2. How we plan to prevent the deficiency from reoccurring:</p> <p>1. A renewal application along with the appropriate fee will be sent to ISDH at least 60 days prior to the expiration date of the current license.</p> <p>2. The Administrator will send the completed renewal application to the licensing division at the Newton Massachusetts corporate office. The Administrator will follow up with the corporate licensing division to assure the renewal has been submitted in advance of the license expiration.</p> <p>1. The Administrator will be responsible for correcting and monitoring this POC. The Regional Director of Operations will oversee the Administrator.</p> <p>2. 5/24/15</p>	05/24/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 450 Bldg. 00	<p>application by 10/31/14 when the agency's license expired.</p> <p>410 IAC 17-12-1(c)(7) Home health agency administration/management Rule 12 Sec. 1(c)(7) The administrator, who may also be the supervising physician or registered nurse required by subsection (d) of this rule, shall do the following: (7) Upon request, make available to the Commissioner or his or her designated agent all: (A) reports; (B) records; (C) minutes; (D) documentation; (E) information; and (F) files; required to determine compliance within seventy-two (72) hours of the request or, in the event the request is made in conjunction with a survey, by the time the surveyor exits the home health agency, whichever is sooner.</p> <p>Based on record review and interview the agency failed to ensure documents requested were submitted to the Indiana State Department of Health within 72 hours of the request.</p> <p>Findings include:</p> <p>1. A letter from the Indiana State</p>	N 450	<p>N 450</p> <p>1.The documents were sent to ISDH on 4/10/15. 2.How will we prevent this deficiency fromreoccurring: 1.5 Star Home Health will respond to any requestfrom ISDH within the 72 hour time frame. 2.The Regional Director of Operations will beadvised of any communication from ISDH by the Administrative Assistant. 3. The 5 Star license notification system has been changed to</p>	05/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>Department of Health dated 2/17/15 stated, "RE: Offsite Licensure Survey ... The Acute Care Division of the Indiana State Department of Health (ISDH) is conducting an offsite licensure survey of Five Star Home Health Inc. On February 2, 2015, ISDH contacted and spoke with [Administrator] and [Administrative Assistant]. [Administrator] indicated all home health agency patients had been placed 'on hold' since the expiration of the agency's home health license on October 31, 2014 ... Please consider this a request under 410 IAC 17-12-1(c)(7) and provide to the Indiana State Department of Health the following information within 72 hours of receipt of this notice: Provide a listing of all patients Five State Home Health Inc. provided home health services to on and after October 31, 2014, identified by: name, address, telephone number, primary care physician and the assisted living location (i.e. Clearwater Commons or Forum at the Crossing). If there are patients who receive(d) care from Five Star Home Health Inc. and do not reside in an assisted living setting please list those patients separately ... Provide a copy of physician signed plan/s of care for ALL patients who received service(s) on October 31, 2014. Provide copies of physician orders for all patients for whom home health services were placed on hold</p>		<p>notify the Regional Director of Operations if licensure information is not submitted within 5 days of notification 4.The Administrator will be responsible formaintaining compliance. The Regional Director of Operations will monitor theAdministrator.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 451 Bldg. 00	<p>or discharged on or after October 31, 2014. Provide a list of patients who were admitted into service after October 31, 2014, along with their physician signed plan of care."</p> <p>2. On 3/5/15 at 8:20 a.m., the administrator contacted the Indiana State Department of Health and left a voicemail indicating he/she was three-quarters complete with the items requested in the 2/17/15 notice.</p> <p>3. On 4/10/15, the Indiana State Department of Health received documents requested on 2/17/15 from Five Star Home Health Inc., a period of greater than 72 hours.</p> <p>410 IAC 17-12-1(c)(8) Home health agency administration/management Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>Based on interview and record review, the administrator failed to ensure there was an alternate administrator qualified and knowledgeable to perform the functions of an administrator in the administrator's absence.</p> <p>Findings include:</p> <p>1. A letter from Five Star Home Health Inc. dated April 2, 2014, stated, "Please accept this letter as notification that [employee #1] has been appointed as the Agency Administrator and Nursing Supervisor for Five Star Home Health Inc. effective 03/31/2014. Five Star Home Health has also appointed [employee #2] as the alternate Agency Administrator and Alt [alternate] Nursing Supervisor effective 03/31/2014...."</p> <p>2. On 2/2/15 at 2:25 p.m., employee #2 contacted the Indiana State Department of Health. He/she indicated being the current administrator and was uncertain why the Indiana State Department of Health did not have this information on file. Employee #2 indicated he/she was the administrator/nursing supervisor and employee #3 was the alternate administrator/nursing supervisor. The Indiana State Department of Health was not aware of any of these four</p>	N 451	<p>N 408/451</p> <p>1. The Administrator at the time of the cited deficiency failed to provide the information to ISDH at the time of the changes in the Administrator and Nursing Supervisor position. On 4/14/15 ISDH was notified of the management changes resulting from the previous Administrator leaving 5 Star Home Health</p> <p>2. How we plan to prevent the deficiency from reoccurring:</p> <p>1. All changes in the Administrator, Alternate Administrator, Nursing Supervisor or Alternate Nursing Supervisor will be promptly communicated to ISDH with the required documents outlined in the state regulations. Copies will be forwarded to the Regional Director of Operations for review.</p> <p>1. The Administrator will be responsible for correcting and monitoring compliance. The Regional Director of Operations will oversee the Administrator</p>	05/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/14/2015	
NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC				STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
N 999 Bldg. 00	<p>management changes.</p> <p>3. On 3/3/15 at 9:50 a.m., the administrator/employee #2 contacted the Indiana State Department of Health. When queried who the alternate administrator was the administrator/employee #2 indicated he/she was one of the clinical directors. When the name of the individual was requested, he/she stated [name of alternate administrator/employee #3] and indicated the individual had never been an administrator before so was unaware of what was required.</p> <p>Based on interview and record review the agency failed to ensure the Indiana State Department of Health was notified of 3 of 5 branch locations to ensure the locations met the definition of branch office for operation and function.</p> <p>Findings include:</p> <p>1. 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</p>	N 999	0999 1.The applications for the 3 locations that werecited will be completed and submitted to ISDH by June 15, 2015. 2.How will we prevent this deficiency fromreoccurring: 1.Any new locations that provide services asoutlined in the "branch" definition will have a branch application completedand submitted prior to beginning service. 2.5 Star legal department will review theseapplications to ascertain that they are accurate and complete.	06/15/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>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"</p> <p>2. The home health agency renewal application signed by the president/CEO dated 9/9/13 indicated in "Section IV-Branch locations" the agency had two branch locations: Rosewalk Commons at 250 Shenandoah Drive, Lafayette, IN and Northwood Commons at 2501 Friendship Blvd., Kokomo, IN.</p> <p>3. On 2/2/15 at 2:18 p.m., the administrative assistant was interviewed and indicated there was not one nursing supervisor, rather each of the five communities had their own clinical director. He/she stated Five Star Home Health Inc. was positioned within five assisted living facilities: Clearwater Commons, Northwood Commons (Kokomo), Rosewalk Commons (Lafayette), Forum at the Crossing, and</p>		<p>3. The Administrator will be responsible for completing and forwarding the application and ascertaining that branch status has been granted prior to any services being provided.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>Forest Creek Commons.</p> <p>4. On 4/10/15, the Indiana State Department of Health received documents from Five Star Home Health Inc. following a request dated 2/17/15. The documents were reviewed and indicated the following:</p> <p>a. A marketing brochure that stated, "Five Star Home Health Inc. located 414 Creek Forest Lane, Indianapolis, IN 46227 ... with more than 250 communities in 32 states ... Five Star Home Health is a licensed home health care agency offering care and assistance exclusively to residents of Five Star Senior Living Communities"</p> <p>b. A separate employee listing specific for each 'community'/branch, including the three locations the Indiana State Department of Health was not notified of: Clearwater Commons, Forest Creek, and Forum at the Crossing. The name of each branch location was identified at the top of the employee listing provided..</p> <p>c. Clearwater Commons was located at 4519 E. 82nd Street, Indianapolis, IN.</p> <p>d. Forest Creek Commons was located at 6510 U.S. 31 South,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/14/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH INC	STREET ADDRESS, CITY, STATE, ZIP CODE 414 CREEK FOREST LANE INDIANAPOLIS, IN 46227
---	--

(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>Indianapolis, IN.</p> <p>e. Forum at the Crossing was located at 8505 Woodfield Crossing Blvd., Indianapolis, IN.</p>			