## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 09/06/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K024		LDING	nstruction 00	(X3) DATE COMPL <b>08/24</b> /	ETED
NAME OF PROVIDER OR SUPPLIER  ABOVE & BEYOND HOMECARE INC				1320 E	ADDRESS, CITY, STATE, ZIP CODE 53RD ST STE A SON, IN 46013		
(X4) ID PREFIX TAG G0000	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	This visit was a home health federal recertification survey. This was a partial extended survey.  Survey Date: 8/20/12 to 8/22/12  Facility #: 004808  Medicaid Vendor #: 200829700  Surveyor: Tonya Tucker, RN, PHNS  Census: 142  Quality Review: Joyce Elder, MSN, BSN, RN  August 27, 2012		G00	000			

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15K024	B. WING		08/24/2012
			STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	K	1320 E	53RD ST STE A	
	BEYOND HOME	CARE INC	ANDE	RSON, IN 46013	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
G0158	484.18 ACCEPTANCE OSUPER Care follows a westablished and doctor of medicine.  Based on clinical observation, job interview, the agrae provided was care provided was care for 3 of 11 to affect all the assistance of the second Home Health As June 25-28, and 12-14, and 16; and the second Home Health As June 25-28, and 12-14, and 16; and the second Home Health Assive ROM". Certification per and 7-31-12 to 9 an order for range of The "Aide / dated 5-29-12 and 26-12, failed to been assigned to 2. Clinical recommendation.	oritten plan of care periodically reviewed by a ne, osteopathy, or podiatric all record review, description review, and gency failed to ensure the as ordered on the plan of patients with the potential agency's patients. (# 2, 3, and August 1-3, 2012, ne aide performed "ROM / The plans of care for the iods 6-1-12 to 7-30-12 or 28-12 failed to evidence ge of motion.  Homemaker Care Plan" and with review date of 7-evidence the aide had or perform range of motion.	G0158	G158 The Administrator and Director of Nursing has in-serviced nursing staff, home health aides, and case managers on following the Plat Care and Plan of Care Policy. Supervisory Nurses will conduct a field audit at least 1 days of not less than 10% of Patients to ensurecompliance with Plan of Care. Director of Nursing will be responsible for monitoring these corrective actions to ensure thatthis deficiency is corrected. The Director of Nursing will report findings to the administrator. These findings will also be use and incorporated into the Qua Assurance Meetings to evaluate care.	08/28/2012 e an of 20 ef
	Home Health A	ide Weekly Note[s]" dated			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BINL11

Facility ID: 004808

If continuation sheet Page 2 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLET			COMPLETED	
15K024			B. WING 08/24/2012				
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	₹			53RD ST STE A		
	ABOVE & BEYOND HOMECARE INC			ANDER	SON, IN 46013		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)	DATE	
		, 12-17, 19-21, 23, 24,					
		ast 1-4, 6, 7, and 9-11,					
		fied the aide performed a					
		e plan of care for the					
	•	iod 6-17-12 to 8-15-12					
	failed to evidence	ee an order for a bed bath.					
	A. The "PA	Home Health Aide					
	Weekly Note[s]'	' dated July 1-3, 5, 9, 10,					
		3, 24, and 26-31; August					
	2, 3, 6, 7, and 8-11, 2012, identified the aide performed "Hand / foot Care						
	Brace." The plan						
	_	iod of 6-17-12 to 8-15-12					
	•	te an order for a brace.					
	laned to evidence	ce all order for a prace.					
		Home Health Aide					
		' dated July 1-3, 5, 9, 10,					
	12-17, 19-21, 23	3, 24, and 26-31; August					
	2, 3, 6, 7, and 9-	12, 2012, identified the					
	aide performed '	'ROM / Passive ROM					
	PROM." The pl	an of care for the					
	certification peri	iod 6-17-12 to 8-15-12					
	failed to evidence	ce an order for passive					
	range of motion.	•					
	C. The "Aid	e / Homemaker Care					
		5-11 and with review					
		, 4-13-12, 6-12-12, and 8-					
		evidence the aide had been					
		orm passive range of					
	motion.						
	D. On 8-21-	-12 at 9 AM, employee D,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: BINL11

Facility ID: 004808

If continuation sheet Page 3 of 9

	OF CORRECTION  OF CORRECTION  15K024	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	LETED L/2012	
	PROVIDER OR SUPPLIER  & BEYOND HOMECARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE  1320 E 53RD ST STE A ANDERSON, IN 46013				
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	home health aide, was observed giving patient #2 a bed bath.					
	3. Clinical record #8 contained "PA Home Health Aide Weekly Note[s]" dated August 8-10, 2012, that identified the aide performed "Offer Oral Supplement." The plan of care for the certification period 8-8-12 to 10-6-12 failed to evidence an order for offering of oral supplements.  4. The undated document titled "Home Health Aide Job Description" states "The Home Health Aide performs personal care activities contained in a written assignment by the case manager which includes: personal hygiene, assisting with ambulation, oral care, skin care, hair care, cooking, feeding, dressing, shaving, vital signs, and nail care. Follows a written plan of care, which includes realistic goals and interventions, and is prepared by the case manager."					
	5. On 8-22-12 at 115 PM, employee B indicated all home health aides are required to read the employee handbook and, after orientation, a document stating they have read and understand all of the information, including the home health aide job description which is signed and dated by the home health aide.					

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PRINTED: 09/06/2012 FORM APPROVED OMB NO. 0938-0391

		15K024	A. BUILDING B. WING	00	<del></del>	19LETED 24/2012	
ABOVE &	NAME OF PROVIDER OR SUPPLIER  ABOVE & BEYOND HOMECARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1320 E 53RD ST STE A ANDERSON, IN 46013			
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	

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Facility ID: 004808

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K024		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  08/24/2012		
	ROVIDER OR SUPPLIER		<i>5.</i> (12.)	1320 E	ADDRESS, CITY, STATE, ZIP CODE 53RD ST STE A SON, IN 46013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
N0522	a written medical and periodically redentist, chiroprace podiatrist, as follows:  Based on clinical observation, job interview, the age care provided was care for 3 of 11 pto affect all the affect all	o Medical care shall follow plan of care established eviewed by the physician, tor, optometrist or ows:  I record review, description review, and ency failed to ensure the as ordered on the plan of patients with the potential egency's patients. (# 2, 3, and 42 contained "PA de Weekly Note[s]" dated 30; July 1-6, 9, 10, and August 1-3, 2012, the aide performed "ROM / The plans of care for the ods 6-1-12 to 7-30-12 -28-12 failed to evidence	N05	522	N 522 The Administrator and Director of Nursing has in-serviced nursing staff, home health aides, and case managers on following the Pla Care and Plan of Care Policy. Supervisory Nurses will conduct a field audit at least 1 days of not less than 10% of Patients to ensurecompliance with Plan of Care. Director of Nursing will be responsible for monitoring these corrective actions to ensure thatthis deficiency is corrected. The Director of Nursing will report a findings to the administrator These findings was be used and incorporated into the Quality Assurance Meetings to evaluate care.	in of 20 f ·	08/28/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		15K024	B. WIN			08/24/2012	
NAME OF B	DOLUDED OD GUDDU ED			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	C		1320 E	53RD ST STE A		
	R BEYOND HOMEO				SON, IN 46013		
(X4) ID		TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION
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		, 12-17, 19-21, 23, 24,					
	, ,	ust 1-4, 6, 7, and 9-11,					
		fied the aide performed a					
		e plan of care for the					
	certification period 6-17-12 to 8-15-12						
	failed to evidence	ee an order for a bed bath.					
	A. The "PA Home Health Aide						
		' dated July 1-3, 5, 9, 10,					
		5, 24, and 26-31; August					
		11, 2012, identified the					
		'Hand / foot Care					
	Brace." The plan						
	•	od of 6-17-12 to 8-15-12					
	•						
	laned to evidence	ee an order for a brace.					
	B. The "PA	Home Health Aide					
		' dated July 1-3, 5, 9, 10,					
		, 24, and 26-31; August					
		12, 2012, identified the					
		'ROM / Passive ROM					
	•	an of care for the					
	*	iod 6-17-12 to 8-15-12					
	•	ee an order for passive					
	range of motion.	*					
	C. The "Aid	e / Homemaker Care					
	Plan" dated 12-1	5-11 and with review					
		, 4-13-12, 6-12-12, and 8-					
		vidence the aide had been					
		orm passive range of					
	motion.	racer, e range or					
	D. On 8-21-	-12 at 9 AM, employee D,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		15K024	B. WIN	G		08/24/2012	
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
4 D O \ / E (	DEVOND HOME	DADE INO			53RD ST STE A		
ABOVE & BEYOND HOMECARE INC			ANDER	SON, IN 46013			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION DATE
TAG				TAG	Dia lettike 17		DATE
		e, was observed giving					
	patient #2 a bed	batii.					
	2 Clinical races	rd #8 contained "PA					
		ide Weekly Note[s]" dated 12, that identified the aide					
		er Oral Supplement." The					
	•	the certification period					
	•	2 failed to evidence an					
	order for othersis	g of oral supplements.					
	4. The undated document titled "Home						
		Description" states "The					
		ide performs personal care					
	activities contain						
		ne case manager which					
		al hygiene, assisting with					
		care, skin care, hair care,					
	•	g, dressing, shaving, vital					
		are. Follows a written					
	_	ich includes realistic					
	-	entions, and is prepared					
	by the case man						
	by the case man	u501.					
	5 On 8-22-12 a	t 115 PM, employee B					
		ne health aides are					
		the employee handbook					
	_	ation, a document stating					
		nd understand all of the					
	_	luding the home health					
	· · · · · · · · · · · · · · · · · · ·	tion which is signed and					
	dated by the hon	_					
	duced by the non	no noutui uido.					

State Form Event ID: BINL11 Facility ID: 004808 If continuation sheet Page 8 of 9

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15K024		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE  A. BUILDING 00 COMPLETED  B. WING 08/24/2012				
NAME OF PROVIDER OR SUPPLIER  ABOVE & BEYOND HOMECARE INC  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1320 E 53RD ST STE A ANDERSON, IN 46013			
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	COVIDER OR SUPPLIED  BEYOND HOMEO  SUMMARY S  (EACH DEFICIEN	15K024 ROVIDER OR SUPPLIER	A. BUILDING B. WING  STREET A  1320 E  ANDER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  A. BUILDING B. WING  STREET A  1320 E  ANDER	A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CO  1320 E 53RD ST STE A  ANDERSON, IN 46013  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CO  1320 E 53RD ST STE A  ANDERSON, IN 46013  PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AFTER ACTION SHE	A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 1320 E 53RD ST STE A ANDERSON, IN 46013  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL  A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 1320 E 53RD ST STE A ANDERSON, IN 46013  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	

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