

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157554	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE PLUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1800 N WABASH AVE STE 200 MARION, IN 46952
---	--

(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 was a home health federal complaint investigation.</p> <p>Complaint IN00128931 -Substantiated: No deficiencies related to the allegations are cited. An unrelated deficiency was cited.</p> <p>Survey Date: May 31, 2013</p> <p>Facility #003890</p> <p>Medicaid #: 200469840</p> <p>Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 4, 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: 157554		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE PLUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1800 N WABASH AVE STE 200 MARION, IN 46952			
(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			
G000125	<p>484.14 ORGANIZATION, SERVICES & ADMINISTRATION All services not furnished directly, including services provided through subunits are monitored and controlled by the parent agency. Based on observation, interview, and document review, the agency failed to ensure the branches were approved by the Centers for Medicare and Medicaid Services (CMS) prior to accepting clients in 1 of 1 agency with the potential to affect all clients of the agency receiving services from this branch. (Greenwood branch)</p> <p>Finding include:</p> <p>1. On 5/31/13 at 10:00 am, the surveyor entered Agency 1 for a complaint investigation at 973 Emerson Parkway, Suite D, in Greenwood, Indiana. The front door of the agency was labeled with the name of Agency 1. It was then determined the complaint was not against Agency 1, but against this agency. This was a branch of the agency in Marion, Indiana, and shared the same office space with Agency 1.</p> <p>2. On 5/31/13 at 10:30 am, E#2. Director of Nursing (DON), indicated this was a branch of the Muncie parent office. The DON was not employed by Agency 1.</p>	G000125	<p>G0125 – The Administrator has completed the branch questionnaire and written a letter of explanation. Each of these items are attached to this plan of correction as supporting documents.</p> <p>The Administrator will be responsible for monitoring that these corrective actions ensure this deficiency is corrected and will not recur.</p>	06/06/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157554	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE PLUS			STREET ADDRESS, CITY, STATE, ZIP CODE 1800 N WABASH AVE STE 200 MARION, IN 46952		
(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>When E#2 provided a list of patients that were cared for at this branch, it was determined the patients named in the complaint were patients of this branch.</p> <p>3. A call was placed to the Indiana State Department of Health (ISDH) to request the complaint be moved to this agency. At this time it was discovered the agency did not have a branch at this address in Greenwood. However, there was a branch in Indianapolis.</p> <p>4. At 11:00 am, the agency provided 3 letters dated 11/9/09, 9/9/10, and 8/30/12 from cooperate office requesting a change of address for the Indianapolis branch office to the Greenwood address.</p> <p>5. On 6/3/13 at 10:00 am, the ISDH Home Health Program Coordinator indicated the agency was informed in November of 2009 the address of the Indianapolis branch could not be changed as the move was across county lines and the agency would have to submit an application for a new branch in Johnson County. The ISDH never received an application for a branch in Greenwood / Johnson County.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157554		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/31/2013	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE PLUS				STREET ADDRESS, CITY, STATE, ZIP CODE 1800 N WABASH AVE STE 200 MARION, IN 46952			
(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 for a state home health complaint investigation.</p> <p>Complaint IN00128931 - Substantiated: No deficiencies related to the allegations are cited.</p> <p>Survey Date: May 31, 2013</p> <p>Facility #003890</p> <p>Medicaid #: 200469840</p> <p>Surveyors: Linda Dubak, R.N. Public Health Nurse Surveyor</p> <p>Angels of Mercy Homecare Plus was found to be in compliance with 410 IAC 17-12-1 Section 3 and 17-14-1 as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN June 4, 2013</p>	N000000					