

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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
--------------------	--	---------------	---	----------------------

G 0000 Bldg. 00	<p>This visit was for a federal home health recertification survey, The survey was fully extended on 5/27/2016.</p> <p>Survey dates 5/26/2016-5/27/2016 and 5/31/2016 -6/2/ 2016</p> <p>Facility ID # 5647</p> <p>Provider ID 15-7598</p> <p>Medicaid Vendor # 200875210</p> <p>Skilled 12 Month Unduplicated Census 160</p> <p>Home Visits 6 Records Reviewed 12</p> <p>Angels of Mercy Homecare was found to be out of compliance with 42 CFR 484.18, Acceptance of Patients, Plan of Care, Medical Supervision.</p> <p>The agency is precluded from conducting a home health aide training or competency evaluation program for a period of two years : June 2,2016 through June 2, 2018</p>	G 0000		
G 0156	484.18			

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: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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
Bldg. 00	<p>ACCEPTANCE OF PATIENTS, POC, MED SUPER</p> <p>Based on record review, observation and interview the agency failed to ensure that patient's were accepted with the expectation that the individuals needs could be met for 2 (#4 and 7) of 12 records reviewed (see G 157), failed to ensure care was provided which followed the written care plan established by the physician for 1 (#4) of 12 records reviewed.(see G 158 and failed to include all equipment, types of services, measurable, disease specific goals and clinical parameters for 8 of 12 records reviewed. The cumulative effect of these findings caused the agency to be found not in compliance with 42 CFR 484.18, Acceptance of Patients, Plan of Care and Medical Supervision.</p>	G 0156	<p>Re-education with all agency staff regarding professional expectations as they relate to acceptance of patients (G157), provision of care in accordance with physician orders (G158), and plan of care (G159) was done at the 7/7/16 mandatory staff meeting. This re-education was completed by the Director of Professional Services on 7/7/16. Continued re-education of all agency staff on policies & requirements as they relate to: acceptance of patients (G157), provision of care in accordance with physician orders (G158) and plan of care (G159), Education was completed by DPS on 7/7/16. All staff will be re-educated in the principles of the following policies: · 2.6 Assessment/Reassessment · 2.17 Plan of Care · 2.18 Verbal Orders · 2.19 Care Planning 5.8 Medical Record · 2.5 Patient Admission</p> <p>See CAP for G157, G158, G159 for complete plan.DPS will be responsible for ongoing compliance. Additionally every agency receives at least one corporate audit annually. One desk/chart audit or one on site audit. The purpose of the internal on site audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses</p>	07/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/02/2016
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201		
(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	
G 0157 Bldg. 00	<p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Based on record review and interview agency failed to ensure that patient's were accepted with the expectation that the individuals needs could be met for 2 (#4 and 7) of 12 records reviewed.</p> <p>Findings Include :</p> <p>1, Clinical record #4 was reviewed on 5/27/2016. The record contained orders from the referring physician dated 5/11/2016 for home health aide services.</p> <p>A. The comprehensive assessment completed by the registered nurse at start of care on 5/14/2016 indicated the patient required assistance with upper and lower</p>	G 0157	<p>medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated.</p> <p>Re-education with all agency staff regarding professional expectations as they relate to acceptance of patients (G157) was done at the 7/7/16 mandatory staff meeting. This re-education was completed by the Director of Professional Services on 7/7/16. Continued re-education of all agency staff on policies & requirements as they relate to: acceptance of patients (G157). Education was completed by DPS on 7/7/16. A home health aide was competency checked available for care 5/31/16. All staff will be re-educated in the principles of the following policy: ·2.5 Patient Admission ·2.6 Assessment Reassessment</p>	07/07/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>body dressing, bathing, transferring, toileting hygiene and had no willing caregiver.</p> <p>B. A home health aide assignment was created by the registered nurse assigning assistance with ADLs including bathing, transferring, dressing and toileting to the home health aide on admission 5/14/2016.</p> <p>C. The plan of care established by the physician for the certification period 5/14/2016 through 7/12/2016 included orders for the home health aide to visit 2 times weekly . The record failed to evidence clinical notes from the home health aide.</p> <p>D. When interviewed on 5/26/2016, the nursing supervisor stated the agency " did not have aides who had completed competency check off at the time of the patient's admission" The agency was unable to provide an aide at the time of the patient's admission.</p> <p>2. Clinical record #7, with a start of care date 5/4/2016, included orders for social work services from the referring physician dated 4/29/2016.</p> <p>A. No evidence of an evaluation by a licensed social worker was located in the record.</p>		<p>DPS will complete 100% review of all Referrals and Initial Comprehensive Assessments and POCs to ensure proper establishment of the POC related to ordered disciplines are trained and available to provide care as ordered. DPS is responsible for ongoing compliance. To ensure ongoing compliance 10% of charts will be audited quarterly with all results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. Additionally every agency receives at least one corporate audit annually. One desk/chart audit or one on site audit. The purpose of the internal on site audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/02/2016	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201			
(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			
G 0158 Bldg. 00	<p>B. No further assessment of the patient's psychosocial needs were evident in the comprehensive assessment completed by the RN on the date of admission.</p> <p>C. The nursing supervisor was unable to provide additional information to indicate a social work consult was completed when interviewed on 6/2 2016 at 2: 15 PM.</p> <p>3. The agency policy dated 2/2002 and revised 2/2016, titled Patient Admission stated, " There must be reasonable expectation that the patient's medical, nursing, psychosocial and or personal care needs can be adequately met in the patient's place of residence...The agency must have qualified personnel and necessary resources to provide the level of care required by the patient."</p> <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. Based on record review and interview, the agency failed to ensure care was provided which followed the written care plan established by the physician for 1 (#4) of 12 records reviewed.</p>	G 0158	Re-education with all agency staff regarding professional expectations as they relate to provision of care in accordance with physician orders including disciplines (G158) was done at	07/07/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/02/2016	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201			
(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>Findings Include:</p> <p>1, Clinical record #4 was reviewed on 5/27/2016. The record contained orders from the referring physician dated 5/11/2016 for home health aide services.</p> <p>A. The comprehensive assessment completed by the registered nurse at start of care on 5/14/2016 indicated the patient required assistance with upper and lower body dressing, bathing, transferring, toileting hygiene and had no willing caregiver.</p> <p>B. A home health aide assignment was created by the registered nurse assigning assistance with ADLs including bathing, transferring, dressing and toileting to the home health aide on admission 5/14/2016.</p> <p>C. The plan of care established by the physician for the certification period 5/14/2016 through 7/12/2016 included orders for the home health aide to visit 2 times weekly . The record failed to evidence clinical notes from the home health aide.</p> <p>D. When interviewed on 5/26/2016, the nursing supervisor stated the agency "</p>		<p>the 7/7/16 mandatory staff meeting. This re-education was completed by the DPS on 7/7/16. A home health aide was competency checked available for care 5/31/16.</p> <p>Continued re-education of all agency staff the policies & the requirements as they relate to provision of care in accordance with physician orders (G158). Education was completed by DPS on 7/7/16. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> · 2.17 Plan of Care · 2.18 Verbal Orders <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. DPS will be responsible for ongoing compliance.</p> <p>To ensure ongoing compliance 10% of charts will be audited quarterly with all results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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
G 0159 Bldg. 00	<p>did not have aides who had completed competency check off at the time of the patient's admission" The agency was unable to provide an aide as ordered in the plan of care.</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on record review, observation, and interview the plan of care failed to include all equipment, types of services, measurable, disease specific goals and</p>	G 0159	<p>provided as needed.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated.</p> <p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with physician orders was completed 7/7/16 at the</p>	07/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>clinical parameters for 8 of 12 records reviewed</p> <p>Findings Include:</p> <p>1. Clinical record #2, with a start of care 8/28/2015 was reviewed 5/27/2016. The record included a plan of care established by the physician for the certification period 10/27/2015 through 12/25/2015.</p> <p>A. The record included a comprehensive assessment at recertification completed on 10/26/2015. The assessment indicated durable medical equipement including a rolling walker, cane, standard walker, wheelchair, and elevated toilet seat were in use The plan of care for the certification period 10/27/2015 listed no durable medical equipment.</p> <p>B. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minumize associated risks." The plan failed to list a cardiac diagnosis for which the patient was to be monitored and failed to identify specific symptoms to be monitored and reported to the physician.</p> <p>C. The plan of care listed the</p>		<p>mandatory staff meeting. Re-education including review of policies & requirements as they relate to: plan of care and provision of care in accordance with physician orders. The plan of care will include equipment required in locator 14, DME. The plan of care will include measureable specific goals with time frames and clinical parameters outlining what is to be reported to the physician. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> ·2.17 Plan of Care ·2.19 Care Planning Policy ·5.8 Medical Record Policy <p>This re-education was completed by the Director of Nursing/Director of Professional Services (DPS) on 7/7/16. DPS will review each POC to ensure that the DME noted during the comprehensive assessment is listed in locator 14 on the CMS 485 POC vs locator 18b. DPS will review interventions and goals and vital sign parameters to ensure the POC outlines clinical parameters in which to be reported to the physician. DPS will be responsible for ongoing compliance. Ongoing monitoring of compliance will be incorporated into the 10% of medical records audited monthly by DPS/designee for purposes of performance improvement. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/02/2016
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201		
(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>following goal: "patient/caregiver will verbalize/demonstrate ability to care for cardiac disease by the end of the episode". The plan failed to include specific teaching and interventions to manage the patient's symptoms.</p> <p>D. The plan of care listed the following goal: "Skin breakdown will be identified and measures to resolve breakdown will be implemented promptly." The plan failed to include specific indicators of skin breakdown to be monitored the specific measures to be implemented when skin compromise was identified.</p> <p>2. Clinical record #4, with a start of care 5/14/2016 was reviewed 5/27/2016. The record included a plan of care established by the physician for the certification period 5/14/2016 through 7/12/2016.</p> <p>A. The record included a comprehensive assessment completed 5/14/2016 at start of care. The assessment listed supplies and equipment including a rolling walker, glucometer, wheelchair and oxygen concentrator were in use. The plan of care listed no durable medical equipment or supplies.</p> <p>B. The plan of care listed the</p>		<p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to identify specific symptoms to be monitored and reported to the physician.</p> <p>C, The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>D. The plan of care listed the following goal: " patient/caregiver will verbalize decreased incidence of complications of the genitourinary system. The plan failed to identify those symptoms that should be reported to the physician and failed to identify the area of the genitourinary system with potential for complications.</p> <p>E. The plan of care listed the following goal: " The patient/caregiver will demonstrate adequate knowledge of the respiratory system...changes in respiratory status will be identified and reported to the physician" The plan failed to identify specific teaching</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>goals, the specific area of the respiratory system with potential for complications and specific symptoms to be reported to the physician.</p> <p>F. The plan of care listed the following goal: "Skin breakdown will be identified and measures to resolve breakdown will be implemented promptly." The plan failed to include specific indicators of skin breakdown to be monitored the specific measures to be implemented when skin compromise was identified.</p> <p>G. The plan of care listed the following goal: "Exacerbations/complication of the peripheral vascular system will be identified and interventions initiated." The plan failed to identify specific potential complications of the peripheral vascular system for which the patient should be monitored and failed to list appropriate interventions.</p> <p>3. Clinical record #5, with a start of care 4/28/2016 was reviewed 6/1/2016. The record included a plan of care established by the physician for the certification period 4/28/2016 through 6/26/2016 and a diagnosis of syncope and collapse.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>A. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to identify specific symptoms to be monitored and reported to the physician.</p> <p>B. The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>C. The plan of care listed the following goal: "Skin breakdown will be identified and measures to resolve breakdown will be implemented promptly." The plan failed to include specific indicators of skin breakdown to be monitored the specific measures to be implemented when skin compromise was identified.</p> <p>D. During a home visit observation, employee G, a registered nurse assessed the patient for orthostatic changes (decrease in blood pressure and heart rate upon moving from lying or sitting to standing) in blood pressure and heart</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>rate. The plan of care failed to include a physician order for evaluation of orthostatic vital signs.</p> <p>4. Clinical record #6, with a start of care 5/12/2016 was reviewed 6/1/2016. The record included a plan of care established by the physician for the certification period 5/12/2016 through 7/10/2016 and diagnoses of chronic obstructive pulmonary disorder(COPD) and congestive heart failure (CHF).</p> <p>A. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minumize associated risks." The plan failed to identify symptoms to be monitored and reported to the physician.</p> <p>B. The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>C. The plan of care listed the following goal: " The patient/caregiver</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>will demonstrate adequate knowledge of the respiratory system...changes in respiratory status will be identified and reported to the physician" The plan failed to identify teaching goals,the specific area of the respiratory system with potential for complications and symptoms to be reported to the physician.</p> <p>D. The plan of care listed the following goal: " patient/caregiver will verbalize decreased incidence of complications of the genitourinary system. The plan failed to identify those symptoms that should be reported to the physician and failed to identify the area of the genitourinary system with potential for complications.</p> <p>E. The plan of care listed the following goal: Knowledge deficits will be identified and appropriate teaching provided. The plan failed to identify patient and diagnosis specific teaching goals.</p> <p>5. Clinical record #7, with a start of care 5/4/2016 was reviewed 6/2/2016. The record included a plan of care established by the physician for the certification period 5/4/2016 through 7/2/2016 and a diagnosis of acute cholecystitis, CHF and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>COPD.</p> <p>A. The plan of care listed the following goal: Knowledge deficits will be identified and appropriate teaching provided. The plan failed to identify patient and diagnosis specific teaching goals.</p> <p>B. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minumize associated risks." The plan failed to identify symptoms to be monitored and reported to the physician.</p> <p>C. The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>D. At a home visit observation for patient #7 on 6/1/2016 at 2:30 PM employee E, a registered nurse was observed to empty the patient's biliary drainage bag and change the dressing to the drain tube insertion site using a clear occlusive dressing, 4x4 gauze sponges</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>and normal saline and to flush the tube with 10 ml sterile normal saline. The plan of care failed to list dressing supplies, saline and a biliary drainage bag.</p> <p>6. Clinical record #9, with a start of care 5/13/2016 was reviewed 6/2/2016. The record included a plan of care established by the physician for the certification period 5/13/2016 through 7/11/2016 and diagnoses of hemiplegia, atrial fibrillation and hypertension.</p> <p>A. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to identify symptoms to be monitored and reported to the physician.</p> <p>B. The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>C. The plan of care listed the following goal: "exacerbations of the gastrointestinal disease will be promptly</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>identified and interventions implemented to minimize risks to patient by end of cert." The plan failed to identify interventions to be implemented, the area of the gastrointestinal system to be monitored or symptoms to be reported to the physician.</p> <p>D. The plan of care listed the following goal: " changes in neurological status will be identified and reported to the physician. The plan failed to identify neurologic symptoms to be reported to the physician.</p> <p>7. Clinical record #10, with a start of care 4/7/2016 was reviewed 6/2/2016. The record included a plan of care established by the physician for the certification period 4/7/2016 through 6/5/2016 and diagnoses of diabetes mellitus, atrial fibrillation and heart failure.</p> <p>A. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minumize associated risks." The plan failed to identify symptoms to be monitored and reported to the physician.</p> <p>B. The plan of care listed the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>C. The plan of care listed the following goal: "Skin breakdown will be identified and measures to resolve breakdown wil be implemented promptly." The plan failed to include specific indicators of skin breakdown to be monitored the specific measures to be implemented when skin compromise was identified.</p> <p>D. The plan of care listed the following goal: " The patient/caregiver will demonstrate adequate knowledge of the respiratory system...changes in respiratory status will be identified and reported to the physician" The plan failed to identify teaching goals,the specific area of the respiratory system with potential for complications and symptoms to be reported to the physician.</p> <p>8. Clinical record #12, with a start of care 10/29/2015 was reviewed 6/2/2016. The record included a plan of care established</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>by the physician for the certification period 2/26/2016 through 4/24/2016 and diagnoses of polymyalgia rheumatica, COPD and heart failure.</p> <p>A. The plan of care listed the following goal: " The patient/caregiver will demonstrate adequate knowledge of the respiratory system...changes in respiratory status will be identified and reported to the physician" The plan failed to identify teaching goals,the specific area of the respiratory system with potential for complications and symptoms to be reported to the physician.</p> <p>B. The plan of care listed the following goal: " changes in endocrine status will be identified and reported to the physician. The plan failed to identify endocrine symptoms to be reported to the physician and failed to identify the area of the endocrine system to be monitored.</p> <p>C. The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>D. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to identify symptoms to be monitored and reported to the physician.</p> <p>9. The administrator was unable to provide additional information to evidence compliance at the exit interview on June 2, 2016 at 3:50 PM.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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 0000 Bldg. 00	<p>This visit was for a state home health re-licensure survey, The survey was fully extended on 5/27/2016.</p> <p>Survey dates 5/26/2016-5/27/2016 and 5/31/2016 -6/2/ 2016</p> <p>Facility ID # 5647</p>	N 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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 0520 Bldg. 00	<p>Provider ID 15-7598</p> <p>Medicaid Vendor # 200875210</p> <p>Skilled 12 Month Unduplicated Census 160</p> <p>Home Visits 6 Records Reviewed 12</p> <p>410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.</p> <p>Based on record review and interview agency failed to ensure that patient's were accepted with the expectation that the individuals needs could be met for 2 (#4 and 7) of 12 records reviewed.</p> <p>Findings Include :</p> <p>1, Clinical record #4 was reviewed on 5/27/2016. The record contained orders from the referring physician dated 5/11/2016 for home health aide services.</p> <p>A. The comprehensive assessment completed by the registered nurse at start of care on 5/14/2016 indicated the patient required assistance with upper and lower</p>	N 0520	<p>Re-education with all agency staff regarding professional expectations as they relate to acceptance of patients (G157) was done at the 7/7/16 mandatory staff meeting. This re-education was completed by the Director of Professional Services on 7/7/16. Continued re-education of all agency staff on policies & requirements as they relate to: acceptance of patients (G157). Education was completed by DPS on 7/7/16. A home health aide was competency checked available for care 5/31/16. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> ·2.5 Patient Admission ·2.6 Assessment Reassessment 	07/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/02/2016
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201		
(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>body dressing, bathing, transferring, toileting hygiene and had no willing caregiver.</p> <p>B. A home health aide assignment was created by the registered nurse assigning assistance with ADLs including bathing, transferring, dressing and toileting to the home health aide on admission 5/14/2016.</p> <p>C. The plan of care established by the physician for the certification period 5/14/2016 through 7/12/2016 included orders for the home health aide to visit 2 times weekly . The record failed to evidence clinical notes from the home health aide.</p> <p>D. When interviewed on 5/26/2016, the nursing supervisor stated the agency " did not have aides who had completed competency check off at the time of the patient's admission" The agency was unable to provide an aide at the time of the patient's admission.</p> <p>2. Clinical record #7, with a start of care date 5/4/2016, included orders for social work services from the referring physician dated 4/29/2016.</p> <p>A. No evidence of an evaluation by a licensed social worker was located in the record.</p>		<p>DPS will complete 100% review of all Referrals and Initial Comprehensive Assessments and POCs to ensure proper establishment of the POC related to ordered disciplines are trained and available to provide care as ordered. DPS will ensure ongoing compliance. To ensure ongoing compliance 10% of charts will be audited quarterly with all results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed. Additionally every agency receives at least one corporate audit annually. One desk/chart audit or one on site audit. The purpose of the internal on site audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/02/2016	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201			
(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 0522 Bldg. 00	<p>B. No further assessment of the patient's psychosocial needs were evident in the comprehensive assessment completed by the RN on the date of admission.</p> <p>C. The nursing supervisor was unable to provide additional information to indicate a social work consult was completed when interviewed on 6/2 2016 at 2: 15 PM.</p> <p>3. The agency policy dated 2/2002 and revised 2/2016, titled Patient Admission stated, " There must be reasonable expectation that the patient's medical, nursing, psychosocial and or personal care needs can be adequately met in the patient's place of residence...The agency must have qualified personnel and necessary resources to provide the level of care required by the patient."</p> <p>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: Based on record review and interview, the agency failed to ensure care was provided which followed the written care plan established by the physician for 1 (#4) of 12 records reviewed.</p>			N 0522	Re-education with all agency staff regarding professional expectations as they relate to provision of care in accordance with physician orders including disciplines (G158) was done at		07/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/02/2016
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE			STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201		
(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>Findings Include:</p> <p>1, Clinical record #4 was reviewed on 5/27/2016. The record contained orders from the referring physician dated 5/11/2016 for home health aide services.</p> <p>A. The comprehensive assessment completed by the registered nurse at start of care on 5/14/2016 indicated the patient required assistance with upper and lower body dressing, bathing, transferring, toileting hygiene and had no willing caregiver.</p> <p>B. A home health aide assignment was created by the registered nurse assigning assistance with ADLs including bathing, transferring, dressing and toileting to the home health aide on admission 5/14/2016.</p> <p>C. The plan of care established by the physician for the certification period 5/14/2016 through 7/12/2016 included orders for the home health aide to visit 2 times weekly. The record failed to evidence clinical notes from the home health aide.</p> <p>D. When interviewed on 5/26/2016, the nursing supervisor stated the agency " did not have aides who had completed</p>		<p>the 7/7/16 mandatory staff meeting. This re-education was completed by the DPS on 7/7/16. A home health aide was competency checked available for care 5/31/16.</p> <p>Continued re-education of all agency staff the policies & the requirements as they relate to provision of care in accordance with physician orders (G158). Education was completed by DPS on 7/7/16. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> · 2.17 Plan of Care · 2.18 Verbal Orders <p>DPS and/or CLM will complete 100% review of all Initial Comprehensive Assessments and POC to ensure proper establishment of the POC. DPS will ensure ongoing compliance.</p> <p>To ensure ongoing compliance 10% of charts will be audited quarterly with all results are included in the Quarterly PI Meeting minutes and is approved by the Executive Director. Any concerns will be immediately reported to the Agency Director. Results will be submitted to the corporate office for review and analysis. Reinstruction will be provided as needed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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 0524 Bldg. 00	<p>competency check off at the time of the patient's admission" The agency was unable to provide an aide as ordered in the plan of care.</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements.</p>		<p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>(ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on record review, observation, and interview the plan of care failed to include all equipment, types of services, measurable, disease specific goals and clinical parameters for 8 of 12 records reviewed</p> <p>Findings Include:</p> <p>1. Clinical record #2, with a start of care 8/28/2015 was reviewed 5/27/2016. The record included a plan of care established by the physician for the certification period 10/27/2015 through 12/25/2015.</p> <p>A. The record included a comprehensive assessment at recertification completed on 10/26/2015. The assessment indicated durable medical equipment including a rolling walker, cane, standard walker, wheelchair, and elevated toilet seat were in use The plan of care for the certification period 10/27/2015 listed no durable medical equipment.</p> <p>B. The plan of care listed the</p>	N 0524	<p>Re-education with all agency staff regarding expectations as they relate to provision of care in accordance with physician orders was completed 7/7/16 at the mandatory staff meeting.</p> <p>Re-education including review of policies & requirements as they relate to: plan of care and provision of care in accordance with physician orders. The plan of care will include equipment required in locator 14, DME. The plan of care will include measureable specific goals with time frames and clinical parameters outlining what is to be reported to the physician. All staff will be re-educated in the principles of the following policy:</p> <ul style="list-style-type: none"> ·2.17 Plan of Care ·2.19 Care Planning Policy ·5.8 Medical Record Policy <p>This re-education was completed by the Director of Nursing/Director of Professional Services (DPS) on 7/7/16.</p> <p>DPS will review each POC to ensure that the DME noted during the comprehensive assessment</p>	07/07/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/02/2016	
NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE				STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201			
(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>following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to list a cardiac diagnosis for which the patient was to be monitored and failed to identify specific symptoms to be monitored and reported to the physician.</p> <p>C. The plan of care listed the following goal: "patient/caregiver will verbalize/demonstrate ability to care for cardiac disease by the end of the episode". The plan failed to include specific teaching and interventions to manage the patient's symptoms.</p> <p>D. The plan of care listed the following goal: "Skin breakdown will be identified and measures to resolve breakdown will be implemented promptly." The plan failed to include specific indicators of skin breakdown to be monitored the specific measures to be implemented when skin compromise was identified.</p> <p>2. Clinical record #4, with a start of care 5/14/2016 was reviewed 5/27/2016. The record included a plan of care established by the physician for the certification period 5/14/2016 through 7/12/2016.</p>		<p>is listed in locator 14 on the CMS 485 POC vs locator 18b. DPS will review interventions and goals and vital sign parameters to ensure the POC outlines clinical parameters in which to be reported to the physician.</p> <p>Ongoing monitoring of compliance will be incorporated into the 10% of medical records audited monthly by DPS/designee for purposes of performance improvement. The DPS will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected.</p> <p>Additionally every agency receives at least one corporate audit annually. The purpose of this internal audit is to ensure compliance with all internal policy and procedures and external standards and regulations. It is unannounced and encompasses medical record review, HR file review, home visits and a facility review. The overall goal is 90% compliance for the audit. The agency must submit a corrective action plan for any item which scores less than the established benchmarks. This corrective action plan is submitted to the Internal Audit Department for review and approval. Follow up audits are completed, if indicated.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>A. The record included a comprehensive assessment completed 5/14/2016 at start of care. The assessment listed supplies and equipment including a rolling walker, glucometer, wheelchair and oxygen concentrator were in use. The plan of care listed no durable medical equipment or supplies.</p> <p>B. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to identify specific symptoms to be monitored and reported to the physician.</p> <p>C, The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>D. The plan of care listed the following goal: " patient/caregiver will verbalize decreased incidence of complications of the genitourinary system. The plan failed to identify those symptoms that should be reported to the physician and failed to identify the area</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>of the genitourinary system with potential for complications.</p> <p>E. The plan of care listed the following goal: " The patient/caregiver will demonstrate adequate knowledge of the respiratory system...changes in respiratory status will be identified and reported to the physician" The plan failed to identify specific teaching goals,the specific area of the respiratory system with potential for complications and specific symptoms to be reported to the physician.</p> <p>F. The plan of care listed the following goal: "Skin breakdown will be identified and measures to resolve breakdown will be implemented promptly." The plan failed to include specific indicators of skin breakdown to be monitored the specific measures to be implemented when skin compromise was identified.</p> <p>G. The plan of care listed the following goal: "Exacerbations/complication of the peripheral vascular system will be identified and interventions initiated." The plan failed to identify specific potential complications of the peripheral vascular system for which the patient should be monitored and failed to list</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>appropriate interventions.</p> <p>3. Clinical record #5, with a start of care 4/28/2016 was reviewed 6/1/2016. The record included a plan of care established by the physician for the certification period 4/28/2016 through 6/26/2016 and a diagnosis of syncope and collapse.</p> <p>A. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to identify specific symptoms to be monitored and reported to the physician.</p> <p>B. The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>C. The plan of care listed the following goal: "Skin breakdown will be identified and measures to resolve breakdown will be implemented promptly." The plan failed to include specific indicators of skin breakdown to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>be monitored the specific measures to be implemented when skin compromise was identified.</p> <p>D. During a home visit observation, employee G, a registered nurse assessed the patient for orthostatic changes (decrease in blood pressure and heart rate upon moving from lying or sitting to standing) in blood pressure and heart rate. The plan of care failed to include a physician order for evaluation of orthostatic vital signs.</p> <p>4. Clinical record #6, with a start of care 5/12/2016 was reviewed 6/1/2016. The record included a plan of care established by the physician for the certification period 5/12/2016 through 7/10/2016 and diagnoses of chronic obstructive pulmonary disorder(COPD) and congestive heart failure (CHF).</p> <p>A. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to identify symptoms to be monitored and reported to the physician.</p> <p>B. The plan of care listed the following goal: "Increased pain or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>C. The plan of care listed the following goal: " The patient/caregiver will demonstrate adequate knowledge of the respiratory system...changes in respiratory status will be identified and reported to the physician" The plan failed to identify teaching goals,the specific area of the respiratory system with potential for complications and symptoms to be reported to the physician.</p> <p>D. The plan of care listed the following goal: " patient/caregiver will verbalize decreased incidence of complications of the genitourinary system. The plan failed to identify those symptoms that should be reported to the physician and failed to identify the area of the genitourinary system with potential for complications.</p> <p>E. The plan of care listed the following goal: Knowledge deficits will be identified and appropriate teaching provided. The plan failed to identify</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>patient and diagnosis specific teaching goals.</p> <p>5. Clinical record #7, with a start of care 5/4/2016 was reviewed 6/2/2016. The record included a plan of care established by the physician for the certification period 5/4/2016 through 7/2/2016 and a diagnosis of acute cholecystitis, CHF and COPD.</p> <p>A. The plan of care listed the following goal: Knowledge deficits will be identified and appropriate teaching provided. The plan failed to identify patient and diagnosis specific teaching goals.</p> <p>B. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to identify symptoms to be monitored and reported to the physician.</p> <p>C. The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>evaluate pain, location and pain level tolerable to the patient.</p> <p>D. At a home visit observation for patient #7 on 6/1/2016 at 2:30 PM employee E, a registered nurse was observed to empty the patient's biliary drainage bag and change the dressing to the drain tube insertion site using a clear occlusive dressing, 4x4 gauze sponges and normal saline and to flush the tube with 10 ml sterile normal saline. The plan of care failed to list dressing supplies, saline and a biliary drainage bag.</p> <p>6. Clinical record #9, with a start of care 5/13/2016 was reviewed 6/2/2016. The record included a plan of care established by the physician for the certification period 5/13/2016 through 7/11/2016 and diagnoses of hemiplegia, atrial fibrillation and hypertension.</p> <p>A. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to identify symptoms to be monitored and reported to the physician.</p> <p>B. The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>C. The plan of care listed the following goal: "exacerbations of the gastrointestinal disease will be promptly identified and interventions implemented to minimize risks to patient by end of cert." The plan failed to identify interventions to be implemented, the area of the gastrointestinal system to be monitored or symptoms to be reported to the physician.</p> <p>D. The plan of care listed the following goal: " changes in neurological status will be identified and reported to the physician. The plan failed to identify neurologic symptoms to be reported to the physician.</p> <p>7. Clinical record #10, with a start of care 4/7/2016 was reviewed 6/2/2016. The record included a plan of care established by the physician for the certification period 4/7/2016 through 6/5/2016 and diagnoses of diabetes mellitus, atrial fibrillation and heart failure.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>A. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minimize associated risks." The plan failed to identify symptoms to be monitored and reported to the physician.</p> <p>B. The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>C. The plan of care listed the following goal: "Skin breakdown will be identified and measures to resolve breakdown will be implemented promptly." The plan failed to include specific indicators of skin breakdown to be monitored the specific measures to be implemented when skin compromise was identified.</p> <p>D. The plan of care listed the following goal: " The patient/caregiver will demonstrate adequate knowledge of the respiratory system...changes in respiratory status will be identified and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>reported to the physician" The plan failed to identify teaching goals,the specific area of the respiratory system with potential for complications and symptoms to be reported to the physician.</p> <p>8. Clinical record #12, with a start of care 10/29/2015 was reviewed 6/2/2016. The record included a plan of care established by the physician for the certification period 2/26/2016 through 4/24/2016 and diagnoses of polymyalgia rheumatica, COPD and heart failure.</p> <p>A. The plan of care listed the following goal: " The patient/caregiver will demonstrate adequate knowledge of the respiratory system...changes in respiratory status will be identified and reported to the physician" The plan failed to identify teaching goals,the specific area of the respiratory system with potential for complications and symptoms to be reported to the physician.</p> <p>B. The plan of care listed the following goal: " changes in endocrine status will be identified and reported to the physician. The plan failed to identify endocrine symptoms to be reported to the physician and failed to identify the area of the endocrine system to be monitored.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157598	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/02/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ANGELS OF MERCY HOMECARE	STREET ADDRESS, CITY, STATE, ZIP CODE 522 FRANKLIN STREET COLUMBUS, IN 47201
--	--

(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>C. The plan of care listed the following goal: "Increased pain or ineffective pain control measures will be identified promptly and reported to the physician...reduction of pain will improve functional ability" The plan failed to identify the scale used to evaluate pain, location and pain level tolerable to the patient.</p> <p>D. The plan of care listed the following goal: "Cardiac exacerbations will be identified promptly and interventions initiated quickly to minumize associated risks." The plan failed to identify symptoms to be monitored and reported to the physician.</p> <p>9. The administrator was unable to provide additional information to evidence compliance at the exit interview on June 2, 2016 at 3:50 PM.</p>			