STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K113	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION IN HOME HEALTH CARE, LLC	190 W BECKS MILL ROAD STE F SALEM, IN 47167

(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	This visit was for a federal home health recertification Survey Dates: September 16 and September 19-22, 2016 Provider ID 15K113 Facility ID# 013112 Census: Unduplicated Skilled Admissions: 10 Unskilled: 16 Total Admissions: 26 Records Reviewed 10 Home Visits 5	G 0000		
G 0132 Bldg. 00	484.14(b) GOVERNING BODY The governing body oversees the management and fiscal affairs of the agency. Based on observation, record review and interview, the administrator failed to ensure appropriate clinical policies were developed and implemented for 1 of 1 observed procedure.	G 0132	1. The deficiency was corrected by developing a policy for Accessing and De-accessing Implanted Central Venous Access Ports. 2. The policy was used to train all Registered Nurses. The CVAD policy will be included in the training material for all newly	10/26/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K113	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 09/22/2016

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	Findings Include: 1. Clinical record # 6 was reviewed on 9/20/2016, the record included a plan of care for the certification period 9/19/2016 through 11/17/1016 with physician orders to access and implanted infusion port to administer medication. 2. During a home visit on 9/20/2016 at 1030 AM, the director of nursing was observed to access an implanted infusion port for patient #6. 3. A copy of the agency's policy for accessing an implanted infusion port was requested from the administrator/director of nursing on 9/20/2016 at 2 PM. The administrator stated that no policy was available. The policy was not provided by the exit of the survey on 9/22/2016 at 3 PM.		hired Registered Nurses. 3. The Director of Nursing will be responsible for ensuring the training is completed prior to delivering care to any patient with CVAD that is receiving intervention by the Agency. 4. The deficiency will be corrected on or before October 26th 2016.	
G 0159 Bldg. 00	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			

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	appropriate items. Based on record review, interview, and observation, the agency failed to ensure the plan of care included all services, equipment, diagnoses and specific measurable goals for 5 of 10 records reviewed. Findings Include: 1. During a visit observation at the home of patient #8, a gait belt was used by employee to assisst the patient to transfer, The plan of care for the certification period 7/29/2016 through 9/26/2016 failed to list the gait belt with the patient's durable medical equipment. 2. Clinical record #7 for a patient with diagnoses of dementia and hypertension was reviewed 9/22/2016. The record included a plan of care established by the physician for the certification period 6/24/2016 through 8/22/2016. The following goals were listed on the plan of care: ...will have no respiratory issues; ...will have no GI issues. A. The plan of care failed to identify specific respiratory symptoms for which the patient was to be monitored and failed to list a diagnosis involving the respiratory system.	G 0159	1. The deficiency was corrected by reviewing all patient charts to ensure that all durable medical equipment used by the patient was listed on the Plan of Care. Plans of Care for all patients were reviewed to ensure that all goals were specific to the patient's current medical condition and diagnosis. 2. To prevent the deficiency from reoccurring in the future all patient recertification will ensure the Plan of Care accurately reflects the comprehensive assessment and the patient's current medical condition and diagnosis. 3. The Registered Nurse completing the comprehensive assessment will be responsible for ensuring the information is accurate. 4. The deficiency will be corrected on or before October 26th 2016.	10/26/2016

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	B. The plan of care failed to identify specific gastro-intestinal (GI) symptoms for which the patient was to be monitored and failed to list a diagnosis involving the gastrointestinal system. 3, Clinical record #1 for a patient with diagnoses of cerebral palsy, weakness and Barrett's esophagus was reviewed 9/16/2016. The record included a plan of care established by the physician for the certification period 5/10/2016 through 7/8/2016. The following goal was listed on the plan of care:.. will have no respiratory issues. The plan of care failed to identify specific respiratory symptoms for which the patient was to be monitored and failed to list a diagnosis involving the respiratory system. 4. Clinical record #5 was reviewed 9/20/2016. The record included a comprehensive assessment dated 6/20/2016 which indicated the patient used oxygen 2 liters per nasal cannula and wore CPAP at night. A. The patient's plan of care for the certification period 6/24/2016 through 8/22/2016 failed to include a diagnoses to indicate use of oxygen and CPAP. B. The plan of care included the following goal: Will be without			

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NAME OF PROVIDER OR SUPPLIER MISSION IN HOME HEALTH CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 190 W BECKS MILL ROAD STE F SALEM, IN 47167	

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	respiratory issues through 8/22/15. The plan of care failed to identify the patient's specific respiratory problems. 5. Clinical record #10 for a patient with diagnoses congestive heart failure and spinal stenosis was reviewed 9/22/2016. The record included a plan for care established by the physician for the certification period 6/17/2016 through 8/15/2016. The plan of care included the following goal: ..will have no digestive issues. The plan failed to indicate a gastrointestinal diagnosis.			
G 0338 Bldg. 00	484.55(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status. Based on record review and interview, the agency failed to ensure that comprehensive assessments at recertification were updated, complete and accurately reflected the patient's status for 2 of 10 records reviewed.	G 0338	1. The deficiency was corrected by reviewing all patients charts to ensure that the comprehensive assessments reflect the patients current medical condition, assistive devices, safety precautions, and appropriate diagnosis' are specified on the Plan of Care.	10/26/2016

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	15K113		09/22/2016

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	Findings Include: 1. Clinical record #8 was reviewed 9/21/2016. The record included a comprehensive assessment completed on 7/28/2016. The comprehensive assessment stated the patient was to ambulate and use assistive devices but failed to list the specific device(s) to be used. 2. Clinical record #3 was reviewed 9/19/2016 and included a plan of care established by the physician for the certification period 6/5/2016 through 8/3/2016. Aspiration precautions were among the safety precautions listed on the plan of care. The comprehensive assessment completed at recertification on 6/3/2016 failed to identify risk for aspiration.		2. To prevent the deficiency from recurring in the future all information gathered during the comprehensive assessment for recertification or resumption will be compared with the previous assessment to ensure all areas have been addressed/updated. 3. The Registered Nurse completing the comprehensive assessment will be responsible for ensuring the information is accurate and complete. 4. The deficiency will be corrected on or before October 26th 2016.	
N 0000 Bldg. 00	This visit was for a state home health re-licensure Survey Dates: September 16 and September 19-22, 2016 Medicaid Provider # 201136540	N 0000		

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	Facility ID# 013112 Census: Unduplicated Skilled Admissions 10 Unskilled : 16 Total Admissions : 26 Records Reviewed 10 Home Visits 5			
N 0442 Bldg. 00	410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency. Based on observation, record review and interview, the administrator failed to ensure appropriate clinical policies were developed and implemented for 1 of 1 observed procedure. Findings Include: 1. Clinical record # 6 was reviewed on 9/20/2016, the record included a plan of	N 0442	1. The deficiency was corrected by developing a policy for Accessing and De-accessing Implanted Central Venous Access Ports. 2. The policy was used to train all Registered Nurses. The CVAD policy will be included in the training material for all newly hired Registered Nurses. 3. The Director of Nursing will be responsible for ensuring the training is completed prior to delivering care to any patient with	10/26/2016

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	care for the certification period 9/19/2016 through 11/17/1016 with physician orders to access and implanted infusion port to administer medication. 2. During a home visit on 9/20/2016 at 1030 AM, the director of nursing was observed to access an implanted infusion port for patient #6. 3. A copy of the agency's policy for accessing an implanted infusion port was requested from the administrator/director of nursing on 9/20/2016 at 2 PM. The administrator stated that no policy was available. The policy was not provided by the exit of the survey on 9/22/2016 at 3 PM.		CVAD that is receiving intervention by the Agency. 4. The deficiency will be corrected on or before October 26th 2016.	
N 0524 Bldg. 00	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.			

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	(vii) Activities permitted. (viii) Nutritional requirements. (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. Based on record review, interview, and observation, the agency failed to ensure the plan of care included all services, equipment, diagnoses and specific measurable goals for 5 of 10 records reviewed. Findings Include: 1. During a visit observation at the home of patient #8, a gait belt was used by employee to assisst the patient to transfer, The plan of care for the certification period 7/29/2016 through 9/26/2016 failed to list the gait belt with the patient's durable medical equipment. 2. Clinical record #7 for a patient with diagnoses of dementia and hypertension was reviewed 9/22/2016. The record included a plan of care established by the physician for the certification period 6/24/2016 through 8/22/2016. The following goals were listed on the plan of care: ...will have no respiratory issues; ...will have no GI issues.	N 0524	1. The deficiency was corrected by reviewing all patient charts to ensure that all durable medical equipment used by the patient was listed on the Plan of Care. Plans of Care for all patients were reviewed to ensure that all goals were specific to the patient's current medical condition and diagnosis. 2. To prevent the deficiency from reoccurring in the future all patient recertification will ensure the Plan of Care accurately reflects the comprehensive assessment and the patient's current medical condition and diagnosis. 3. The Registered Nurse completing the comprehensive assessment will be responsible for ensuring the information is accurate. 4. The deficiency will be corrected on or before October 26th 2016.	10/26/2016

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	A. The plan of care failed to identify specific respiratory symptoms for which the patient was to be monitored and failed to list a diagnosis involving the respiratory system. B. The plan of care failed to identify specific gastro-intestinal (GI) symptoms for which the patient was to be monitored and failed to list a diagnosis involving the gastrointestinal system. 3, Clinical record #1 for a patient with diagnoses of cerebral palsy, weakness and Barrett's esophagus was reviewed 9/16/2016. The record included a plan of care established by the physician for the certification period 5/10/2016 through 7/8/2016. The following goal was listed on the plan of care:.. will have no respiratory issues. The plan of care failed to identify specific respiratory symptoms for which the patient was to be monitored and failed to list a diagnosis involving the respiratory system. 4. Clinical record #5 was reviewed 9/20/2016. The record included a comprehensive assessment dated 6/20/2016 which indicated the patient used oxygen 2 liters per nasal cannula and wore CPAP at night.			

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	A. The patient's plan of care for the certification period 6/24/2016 through 8/22/2016 failed to include a diagnoses to indicate use of oxygen and CPAP. B. The plan of care included the following goal: Will be without respiratory issues through 8/22/15. The plan of care failed to identify the patient's specific respiratory problems. 5. Clinical record #10 for a patient with diagnoses congestive heart failure and spinal stenosis was reviewed 9/22/2016. The record included a plan for care established by the physician for the certification period 6/17/2016 through 8/15/2016. The plan of care included the following goal: ..will have no digestive issues. The plan failed to indicate a gastrointestinal diagnosis.			
N 0542 Bldg. 00	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.			

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	Based on record review and interview, the agency failed to ensure that comprehensive assessments at recertification were updated, complete and accurately reflected the patient's status for 2 of 10 records reviewed. Findings Include: 1. Clinical record #8 was reviewed 9/21/2016. The record included a comprehensive assessment completed on 7/28/2016. The comprehensive assessment stated the patient was to ambulate and use assistive devices but failed to list the specific device(s) to be used. 2. Clinical record #3 was reviewed 9/19/2016 and included a plan of care established by the physician for the certification period 6/5/2016 through 8/3/2016. Aspiration precautions were among the safety precautions listed on the plan of care. The comprehensive assessment completed at recertification on 6/3/2016 failed to identify risk for aspiration.	N 0542	1. The deficiency was corrected by reviewing all patients charts to ensure that the comprehensive assessments reflect the patients current medical condition, assistive devices, safety precautions, and appropriate diagnosis' are specified on the Plan of Care. 2. To prevent the deficiency from recurring in the future all information gathered during the comprehensive assessment for recertification or resumption will be compared with the previous assessment to ensure all areas have been addressed/updated. 3. The Registered Nurse completing the comprehensive assessment will be responsible for ensuring the information is accurate and complete. 4. The deficiency will be corrected on or before October 26th 2016.	10/26/2016