

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K070	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2015
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NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 108 N MAIN STREET STE 305 SOUTH BEND, IN 46601
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G 000 Bldg. 00	<p>This visit was for a Federal Home Health complaint investigation.</p> <p>Complaint #: IN00157541 - Substantiated; Federal deficiencies related to the allegations are cited.</p> <p>Facility #: 011556</p> <p>Medicaid Vendor #: 201022100</p> <p>Survey Date: May 7, 2015</p> <p>QR: JE 5/12/15</p>	G 000		
G 108 Bldg. 00	<p>484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE</p> <p>The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.</p> <p>The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished.</p> <p>The HHA must advise the patient in advance of any change in the plan of care before the change is made.</p> <p>Based on clinical record review, policy review, and interview, the agency failed</p>	G 108	G 0108: Findings / Corrections for #1.) A. B. C. #	06/12/2015

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.

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	<p>to ensure the patient was informed of any changes in the care to be furnished in 2 of 3 clinical records reviewed. (#1 and #3)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 12/10/13, contained a Home Health Certification and Plan of Care for certification period 4/4 to 6/2/15 with orders to include home health aide services 1 visit per week for week 1, 7 visits per week for 8 weeks, and 3 visits per week for 1 week. Missed visit records evidenced the agency missed the sixth and seventh home health aide visit week 2, evidenced a seventh home health aide visit missed week 3, and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document signed by employee A (administrator) dated 4/7/15 titled "Canceled Visit" stating, "Date: 4-5-2015 ... Missed Visit Discipline HHA [home health aide] Unable to staff 'Did not have an available aide'"</p> <p>B. The record evidenced a document signed by employee A (administrator) dated 4/7/15 titled "Canceled Visit" stating, "Date: 4-6-2015 ... Missed Visit Discipline HHA 'Did not have an</p>		<p>2.) A. B. -1-2, C. D. E. F. 1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. 2. A copy of the minutes is pasted below and will also be faxed to accompany this plan of correction. A.) Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. Meeting called to order at 4:05 PM by Teri Miller, RN 1. Instruct staff on current deficiencies TMG was cited for, how to rectify the issue, and prevent recurrence. 2. Create educational information and provide in-service on Federal, State, and Local Rules and Regulations. All employees must partake and provide input/suggestions on measures to improve performance issues. Deliver Friday with paychecks and obtain signature. 3. Provide staff educational materials needed to accomplish compliance with R&R and attain high quality care. Create educational information and provide in-service on Federal,</p>				

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	<p>available aide'"</p> <p>C. On 5/7/15 at 2:25 PM, employee A (administrator) indicated being unable to locate documentation of the patient's notification of the missed visits.</p> <p>2. Clinical record #3, start of care 11/20/13 and discharge date 9/13/14, contained a Home Health Certification and Plan of Care for certification period 7/18 to 9/15/14 with orders for home health aide services 1 visit for week 1, 2-3 visits per week for 8 weeks, and 1 visit per week for 1 week. The record evidenced a physician's verbal order with a clinician's signature as employee A (administrator) dated 7/28/14 to increase the home health aide frequency of visits to 5 days per week. The order was written the second day of week 3.</p> <p>A. The record evidenced 2 home health aide visits were conducted week 3.</p> <p>B. The record evidenced one home health aide visit was conducted week 4.</p> <p>1.) The record evidenced a document signed by employee A (administrator) titled "Canceled Visit" stating, "Missed Visit Discipline HHA [home health aide] 'Aide was sick, could not service client. No additional staff</p>		<p>State, and Local Rules and Regulations. All employees must partake and provide input/suggestions on measures to improve performance issues. 4. Generate a test for employees on Federal, State, and Local Rules and Regulations (R&R). Assess and measure employee knowledge gain from in-service. 5. Review new Policies and Procedures make needed revisions. 6. Administrator and Alternate Administrator to continue self education of Administrative duties, evaluate problem areas within the agency, and implement needed revisions. 7. Prepare new orientation packets for new employees and review in detail upon hire. 8. Educate staff members on proper and complete documentation. 9. Begin on Plan of Correction with review of charts. 10. Review survey when complete. 11. Complete Plan of Correction. Meeting adjourned at 5:18 PM 2. The Administrator has updated a copy of the Patient Rights for employees to read and sign. Employees will receive this Friday, May 29, 2015 and it will be a permanent part of their employee record. The form will be utilized for clients also. A copy will be delivered to client's home for signature via staff. Clients will receive the update by June 5, 2015. 3. The Administrator or designee shall prepare a written exam to test employee</p>		

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	<p>available '"</p> <p>2.) The record evidenced a document signed by employee A (administrator) dated 8/8/14 titled "Canceled Visit" stating, "Missed Visit Discipline HHA Unable to Staff 'Aide called off due to sickness. did not have another aide to send'"</p> <p>C. The record evidenced 3 home health aide visits were conducted week 5.</p> <p>D. The record evidenced 2 home health aide visits were conducted week 6.</p> <p>The record evidenced a document signed by employee A (administrator) dated 8/23/14 titled "Canceled Visit" stating, "Missed Visit Discipline HHA 'Aide called in enroute to client's home and advised [aide] was having car trouble. Did not have another aide to send'"</p> <p>E. The record evidenced no home health aide visits were conducted weeks 8 and 9.</p> <p>F. On 5/7/15 at 3:41 PM, employee B (owner) indicated being unable to locate documentation of the patient's notification of the missed visits.</p>		<p>knowledge of Patient Rights. The test will be prepared by June 12, 2015. The test will be administered to employees in the following 3 months, allowing a lapse in time. This will determine employee comprehension relevant to Patient Rights. 4. The Administrator created a new form, May 21, 2015, for canceled /missed visits. The form now includes a place to document evidence of patient notification, prior to the missed or canceled visits. The form includes a place to identify who received and or placed the call/notification. 5. The Administrator or designee will inform the patient about the care to be furnished. Staff shall advise the patient, in advance, of the disciplines that will furnish care and the frequency of visits to be furnished. 6. 3. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring. G 0108: Findings / Corrections for #3</p> <p>1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager &</p>				

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G 144 Bldg. 00	<p>3. The undated agency policy titled "PATIENT RIGHTS" states, "The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communications. The home health agency must protect and promote the exercise of these rights as follows: ... 2. The home health agency shall maintain documentation showing that it has complied with the requirements of this sections. ... 5. The patient has the right to be informed about the care to be furnished as follows A. The home health agency shall advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished."</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on clinical record review and interview, the agency failed to ensure the clinical record established effective coordination among staff of changes in patient care occurred in 2 of 3 clinical records reviewed. (#2 and #3)</p>	G 144	<p>Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction. 2. The undated agency policy titled "PATIENT RIGHTS" was updated and signed on May 20, 2015, by the Administrator. A copy will accompany this POC via fax. 3. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p> <p>G 0144 Finding / Correction # 1- A, B, C, D Finding # 2 – A, B, C, D, G, H 1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees</p>	06/12/2015			

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	<p>Findings include:</p> <p>1. Clinical record #2, start of care 10/2/13, contained a Home Health Certification and Plan of Care for certification period 3/26 to 5/24/15 that failed to include the frequency and duration of home health aide visits. The record contained a physician's verbal order signed and dated by employee A (administrator) on 3/30/15 stating, "3-30-15 Corrections to 485 dated 3-26-15 to 5-24-2015 Aide 3-5 hr [hour] visits - 1-3 w [week] 1; 3-4 w 8 ... To provide assistance with bathing/shower dressing meal prep [preparation]/set up, med reminders and supervision." The record failed to evidence documentation of communications of the physician's order for home health aide frequency and duration of visits among all personnel providing services to the patient.</p> <p>A. Aide visit notes evidenced home health aide visits were conducted on April 1, 8, 15, 22, and 29, 2015 with a visit duration of 8 hours each visit.</p> <p>B. Aide visit notes evidenced home health aide visits were conducted on April 2, 9, 16, 23, and 30, 2015 with a visit duration of 6 hours each visit.</p> <p>C. Aide visit notes evidenced home</p>		<p>present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction. 2. The Administrator educated office staff, Robert Bond and Eula Veasy, immediately following departure of surveyor, on accurate, detailed, and precise information to be included in all documentation. Administrator advised office staff, it is a requirement that all calls are recorded. They were instructed to include date and time of call, who they spoke with, and the facts concerning the conversation. Any additional forms are to be completed at that time. If the call is concerning a medical issue, inform the nurse so he/she can follow up on the concern. If a client is canceling a discipline, complete the canceled visit form and fax it to the physician, then staple the fax confirmation to the notice. 3. Administrator has provided a file for information to be placed for review. Review will determine appropriate and complete documentation. Staff has been informed they will be monitored</p>	

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	<p>health aide visits were conducted on April 3, 10, 17, and 24, 2015 and May 1, 2015 with a visit duration of 6 hours each visit.</p> <p>D. On 5/7/15 at 3:05 PM, employee A (administrator) indicated the aides were providing too many hours and they were not approved. The employee indicated there was no communication about the change in visit duration after receipt of the physician's verbal order.</p> <p>2. Clinical record #3, start of care 11/20/13 and discharge date 9/13/14, contained a Home Health Certification and Plan of Care for certification period 7/18 to 9/15/14 with orders for home health aide services 2-3 hour visits, 1 week 1, 2-3 visits per week for 8 weeks, and 1 visit per week for 1 week. A physicians verbal order with a clinicians signature as employee A (administrator) dated 7/28/14 indicated to increase the home health aide frequency and duration of visits to 3-5 hours per visit, 5 days per week. The order was written the second day of week 3. The record failed to evidence documentation of communications of the physician's order for home health aide frequency and duration of visits among all personnel providing services to the patient.</p>		<p>and educated on an ongoing basis, and disciplinary action will to follow, if this recurs. 4. Administrator re-educated office staff immediately following the departure of the surveyor, on proficient communication, interaction, and documentation of changes in patient care. Clinical records must validate effective coordination of care among staff members, the organization as a whole, and our clients.</p> <p>5. The Administrator will hold an in-service for staff on coordination of care and regarding policy when required to call office with changes in client care. This will be completed by June 15th, 2015. Field staff will require selected dates to choose from to meet their needs and continue to provide care.</p> <p>6. Effective immediately, Administrator shall decline referrals for new clients if staffing is not available. Clients will receive a 5 day discharge if staffing issues become a problem or if client refuses available staff. 7. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p>	

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	<p>A. Aide visit notes evidenced 2 home health aide visits were conducted week 3.</p> <p>B. Aide visit notes evidenced one home health aide visit was conducted week 4.</p> <p>C. Aide visit notes evidenced 3 home health aide visits were conducted week 5.</p> <p>D. Aide visit notes evidenced 2 home health aide visits were conducted week 6.</p> <p>G. Aide visit notes evidenced no home health aide visits were conducted weeks 8 and 9.</p> <p>H. On 5/7/15 at 3:45 PM, employee A (administrator) indicated the physician's order dated 7/28/14 was to increase home health aide frequency and duration to "3 to 5 hour visits, 5 days a week" until 8/23/14 (weeks 3-6). The administrator indicated there was no communication among staff about the increase in home health aide hours after receipt of the physician's verbal order on 7/28/15.</p>			

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G 158 Bldg. 00	<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 clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care for 3 of 3 clinical records reviewed. (#1, 2, and 3)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 12/10/13, contained a Home Health Certification and Plan of Care for certification period 4/4 to 6/2/15 with orders for skilled nursing services 3 times per week for 8 weeks and home health aide services 4 hour visits, 1 visit per week for week 1, 7 visits per week for 8 weeks, and 3 visits per week for 1 week. The record failed to evidenced a third skilled nursing visit was conducted weeks 2, 3, and 4, failed to evidence a sixth or seventh home health aide visit was conducted week 2, and failed to evidence a seventh home health aide visit was conducted week 3.</p>	G 158	<p>G 0158 FINDINGS / Corrections for 1- A, B, C; Finding/Corrections for # 2 ; Finding / Corrections for # 3-A, B-1-2, C,D, E, F; Finding / Corrections for # #4 1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction. 2. The Administrator created a new form, May 21, 2015, for canceled /missed visits. The form now includes a place to document evidence of patient notification, prior to the missed or canceled visits. The form includes</p>	06/12/2015

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	<p>A. The record evidenced a document signed by employee A (administrator) dated 4/7/15 titled "Canceled Visit" stating, "Date: 4-5-2015 ... Missed Visit Discipline HHA [home health aide] Unable to staff 'Did not have an available aide'"</p> <p>B. The record evidenced a document signed by employee A (administrator) dated 4/7/15 titled "Canceled Visit" stating, "Date: 4-6-2015 ... Missed Visit Discipline HHA 'Did not have an available aide'"</p> <p>C. On 5/7/15 at 2:25 PM, employee A (administrator) indicated the skilled nurse should have conducted 3 visits per week but only conducted 2 for weeks 2, 3, and 4.</p> <p>2. Clinical record #2, start of care 10/2/13, contained a Home Health Certification and Plan of Care for certification period 3/26 to 5/24/15 with orders for home health aide services 3-5 hour visits, 1 to 3 visits per week for 1 week and 3 to 4 visits per week for 8 weeks. The record evidenced 3 visits conducted weekly for weeks 2 through 6 with all visits being Wednesday for 8 hours per visit and Thursday and Friday for 6 hours per visit.</p>		<p>a place to identify who received and or placed the call/notification.</p> <p>3. Effective immediately, Administrator or designee will monitor frequency and duration of visit is concurrent with plan of care and supplemental physician's orders.</p> <p>4. Effective immediately, Administrator shall decline referrals for new clients if staffing is not available. Clients will receive a 5 day discharge if staffing issues become a problem or if client refuses available staff.</p> <p>5. The Administrator will hold an in-service for staff on coordination of care and regarding policy when required to call office with changes in client care. This will be completed by June 15th, 2015. Field staff will require selected dates to choose from to meet their needs and continue to provide care.</p> <p>6. Effective immediately, Administrator shall decline referrals for new clients if staffing is not available. Clients will receive a 5 day discharge if staffing issues become a problem or if client refuses available staff.</p> <p>8. Administrator re-educated office staff immediately following the departure of the surveyor, on proficient communication, interaction, and documentation of changes in patient care. Clinical records must validate effective coordination of care among staff members, the organization as a whole, and our clients.</p> <p>9. The Administrator or designee will audit 10% of client charts monthly</p>	

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	<p>On 5/7/15 at 3:05 PM, employee A (administrator) indicated home health aide visit duration should have been 3 to 5 hours. The employee indicated staff were providing too many hours that were not approved.</p> <p>3. Clinical record #3, start of care 11/20/13 and discharge date 9/13/14, contained a Home Health Certification and Plan of Care for certification period 7/18 to 9/15/14 with orders for home health aide services 2-3 hour visits, 1 week 1, 2-3 visits per week for 8 weeks, and 1 visit per week for 1 week. The record evidenced a physician's verbal order with a clinician's signature of employee A (administrator) dated 7/28/14 to increase the home health aide frequency and duration of visits to 3-5 hours per visit, 5 days per week. The order was written the second day of week 3.</p> <p>A. The record evidenced 2 home health aide visits were conducted week 3.</p> <p>B. The record evidenced one home health aide visit was conducted week 4.</p> <p>1.) The record evidenced a document signed by employee A (administrator) titled "Canceled Visit" stating, "Missed Visit Discipline HHA</p>		to if corrective actions are being completed and prevent deficiency from recurring.				

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NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 108 N MAIN STREET STE 305 SOUTH BEND, IN 46601
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	<p>[home health aide] 'Aide was sick, could not service client. No additional staff available '"</p> <p>2.) The record evidenced a document signed by employee A (administrator) dated 8/8/14 titled "Canceled Visit" stating, "Missed Visit Discipline HHA Unable to Staff 'Aide called off due to sickness. did not have another aide to send'"</p> <p>C. The record evidenced 3 home health aide visits were conducted week 5.</p> <p>D. The record evidenced 2 home health aide visits were conducted week 6.</p> <p>The record evidenced a document signed by employee A (administrator) dated 8/23/14 titled "Canceled Visit" stating, "Missed Visit Discipline HHA 'Aide called in enroute to client's home and advised [aide] was having car trouble. Did not have another aide to send'"</p> <p>E. The record evidenced no home health aide visits were conducted weeks 8 and 9.</p> <p>F. On 5/7/15 at 3:45 PM, employee A (administrator) indicated the physician's order dated 7/28/14 was to</p>			

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G 225 Bldg. 00	<p>increase home health aide frequency and duration to "3 to 5 hour visits, 5 days a week" until 8/23/14. The administrator indicated being unable to locate documentation of why the visits were not made for weeks 8 and 9.</p> <p>4. The undated agency policy titled "Plan of Care" states, "Policy Home care services are furnished under the supervision and direction of the client's physician. The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members. ... Purpose To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs."</p> <p>484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on clinical record review and interview, the agency failed to ensure the home health aide provided services that were ordered by the physician in the plan of care in 1 of 3 clinical records reviewed</p>	G 225	<p>G 0225 FINDINGS / Corrections for #1 1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with</p>	06/12/2015

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	<p>creating the potential to affect all patient's of the agency receiving home health aide services. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 10/2/13, contained a Home Health Certification and Plan of Care for certification period 3/26 to 5/24/15 with orders for home health aide services 3 to 5 hours visits, 1 to 3 visits week and 3 to 4 visits per week for 8 weeks to provide assistance with personal care, medication reminders, meal preparation, and perform light housekeeping.</p> <p>The record evidenced a document dated 4/10/15 titled "Aide Weekly Visit Record" stating, "Week Of '4/5/15' through '4/11/15' ". The document indicated the home health aide (employee C) had made an eight hour visit on 4/8/15 and six hour visits on 4/9 and 4/10/15. The document failed to evidence the home health aide performed any tasks ordered on the plan of care.</p> <p>2. On 5/7/15 at 3:05 PM, employee A (administrator) indicated employee C (home health aide) conducted the visits on 4/8, 4/9, and 4/10/15 but must have forgot to check off the tasks he/she performed at these visits. The employee</p>		<p>notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction. 2. Effective immediately, Administrator or designee will monitor frequency and duration of visit is concurrent with plan of care and supplemental physician's orders. 3. The Administrator will hold an in-service for staff on coordination of care and regarding policy when required to call office with changes in client care. This will be completed by June 15th, 2015. Field staff will require selected dates to choose from to meet their needs and continue to provide care. 4. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p> <p>G 0225 FINDINGS / Corrections for #2</p> <p>1. Correction was set in motion immediately following the departure</p>				

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	indicated being unsure what tasks were performed during the visits.		<p>of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction.</p> <p>2. Effective immediately, Administrator or designee will monitor frequency and duration of visit is concurrent with plan of care and supplemental physician's orders.</p> <p>3. The Administrator will hold an in-service for staff on coordination of care and regarding policy when required to call office with changes in client care. Aides are required to check the care plan in the home every visit to check for changes. They will be re-educated on frequency and duration of visits. They are required to call the office if uncertain about care to be provided. This will be completed by June 15th, 2015. Field staff will require selected dates to choose from to meet their needs and continue to provide care.</p>		

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N 000 Bldg. 00	This visit was for a State Home Health complaint investigation. Complaint #: IN00157541 - Substantiated; State deficiencies related to the allegations are cited. Facility #: 011556 Medicaid Vendor #: 201022100 Survey Date: May 7, 2015 QR: JE 5/12/15	N 000	4.The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.	
N 484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care.			

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	<p>The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on clinical record review and interview, the agency failed to ensure the clinical record established effective coordination among staff of changes in patient care occurred in 2 of 3 clinical records reviewed. (#2 and #3)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 10/2/13, contained a Home Health Certification and Plan of Care for certification period 3/26 to 5/24/15 that failed to include the frequency and duration of home health aide visits. The record contained a physician's verbal order signed and dated by employee A (administrator) on 3/30/15 stating, "3-30-15 Corrections to 485 dated 3-26-15 to 5-24-2015 Aide 3-5 hr [hour] visits - 1-3 w [week] 1; 3-4 w 8 ... To provide assistance with bathing/shower dressing meal prep [preparation]/set up, med reminders and supervision." The record failed to evidence documentation of communications of the physician's order for home health aide frequency and duration of visits among all personnel providing services to the patient.</p> <p>A. Aide visit notes evidenced home</p>	N 484	<p>N 0484 FINDINGS / Corrections for #1 A, B, C, D; #2 A,B,C,D,G,H</p> <p>1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction.</p> <p>2. The Administrator will hold an in-service for staff on coordination of care and regarding policy when required to call office with changes in client care. Aides are required to check the care plan in the home every visit to check for changes. They will be re-educated on frequency and duration of visits. They are required to call the office if uncertain about care to be provided. This will be completed by June 15th, 2015. Field staff will require selected dates to choose</p>	06/12/2015

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	<p>health aide visits were conducted on April 1, 8, 15, 22, and 29, 2015 with a visit duration of 8 hours each visit.</p> <p>B. Aide visit notes evidenced home health aide visits were conducted on April 2, 9, 16, 23, and 30, 2015 with a visit duration of 6 hours each visit.</p> <p>C. Aide visit notes evidenced home health aide visits were conducted on April 3, 10, 17, and 24, 2015 and May 1, 2015 with a visit duration of 6 hours each visit.</p> <p>D. On 5/7/15 at 3:05 PM, employee A (administrator) indicated the aides were providing too many hours and they were not approved. The employee indicated there was no communication about the change in visit duration after receipt of the physician's verbal order.</p> <p>2. Clinical record #3, start of care 11/20/13 and discharge date 9/13/14, contained a Home Health Certification and Plan of Care for certification period 7/18 to 9/15/14 with orders for home health aide services 2-3 hour visits, 1 week 1, 2-3 visits per week for 8 weeks, and 1 visit per week for 1 week. A physicians verbal order with a clinicians signature as employee A (administrator) dated 7/28/14 indicated to increase the</p>		<p>from to meet their needs and continue to provide care.</p> <p>3. Administrator or nurse supervisor will immediately notify staff with a change in physician orders. This will be an ongoing assessment.</p> <p>4. Administrator will immediately check frequency and duration on client charts and determine that hours of service provided are correct and authorized. Staff will be notified immediately if a discrepancy is found. This will be an ongoing assessment.</p> <p>5. Administrator re-educated office staff immediately following the departure of the surveyor, on proficient communication, interaction, and documentation of changes in patient care. Clinical records must validate effective coordination of care among staff members, the organization as a whole, and our clients.</p> <p>6. The Administrator will hold an in-service for staff on coordination of care and regarding policy when required to call office with changes in client care. Aides are required to check the care plan in the home every visit to check for changes. They will be re-educated on frequency and duration of visits. They are required to call the office if</p>	

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	<p>home health aide frequency and duration of visits to 3-5 hours per visit, 5 days per week. The order was written the second day of week 3. The record failed to evidence documentation of communications of the physician's order for home health aide frequency and duration of visits among all personnel providing services to the patient.</p> <p>A. Aide visit notes evidenced 2 home health aide visits were conducted week 3.</p> <p>B. Aide visit notes evidenced one home health aide visit was conducted week 4.</p> <p>C. Aide visit notes evidenced 3 home health aide visits were conducted week 5.</p> <p>D. Aide visit notes evidenced 2 home health aide visits were conducted week 6.</p> <p>G. Aide visit notes evidenced no home health aide visits were conducted weeks 8 and 9.</p> <p>H. On 5/7/15 at 3:45 PM, employee A (administrator) indicated the physician's order dated 7/28/14 was to increase home health aide frequency and duration to "3 to 5 hour visits, 5 days a</p>		<p>uncertain about care to be provided. This will be completed by June 15th, 2015. Field staff will require selected dates to choose from to meet their needs and continue to provide care.</p> <p>7. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p>	

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N 504 Bldg. 00	<p>week" until 8/23/14 (weeks 3-6). The administrator indicated there was no communication among staff about the increase in home health aide hours after receipt of the physician's verbal order on 7/28/15.</p> <p>410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished.</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure the patient was informed of any changes in the care to be furnished in 2 of 3 clinical records reviewed. (#1 and #3)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 12/10/13, contained a Home Health Certification and Plan of Care for certification period 4/4 to 6/2/15 with orders to include home health aide services 1 visit per week for week 1, 7 visits per week for 8 weeks, and 3 visits</p>	N 504	<p>N 0504 FINDINGS / Corrections for # 1-A,B,C</p> <p>1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina</p>	06/12/2015

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	<p>per week for 1 week. Missed visit records evidenced the agency missed the sixth and seventh home health aide visit week 2, evidenced a seventh home health aide visit missed week 3, and failed to evidence documentation of the patient's notification prior to the missed visits.</p> <p>A. The record evidenced a document signed by employee A (administrator) dated 4/7/15 titled "Canceled Visit" stating, "Date: 4-5-2015 ... Missed Visit Discipline HHA [home health aide] Unable to staff 'Did not have an available aide'"</p> <p>B. The record evidenced a document signed by employee A (administrator) dated 4/7/15 titled "Canceled Visit" stating, "Date: 4-6-2015 ... Missed Visit Discipline HHA 'Did not have an available aide'"</p> <p>C. On 5/7/15 at 2:25 PM, employee A (administrator) indicated being unable to locate documentation of the patient's notification of the missed visits.</p> <p>2. Clinical record #3, start of care 11/20/13 and discharge date 9/13/14, contained a Home Health Certification and Plan of Care for certification period 7/18 to 9/15/14 with orders for home health aide services 1 visit for week 1,</p>		<p>Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction.</p> <p>2. The Administrator created a new form, May 21, 2015, for canceled /missed visits. The form now includes a place to document evidence of patient notification, prior to the missed or canceled visits. The form includes a place to identify who received and or placed the call/notification.</p> <p>3. Effective immediately, Administrator shall decline referrals for new clients if staffing is not available. Clients will receive a 5 day discharge if staffing issues become a problem or if client refuses available staff.</p> <p>4. Administrator re-educated office staff immediately following the departure of the surveyor, on proficient communication, interaction, and documentation of changes in patient care. Clinical records must validate effective coordination of care among staff members, the organization as a whole, and our clients.</p> <p>5. The Administrator has updated a copy of the Patient Rights for employees to read and sign. Employees will receive this Friday, May 29, 2015 and it will be a permanent part of their employee record. The form will be utilized for</p>		

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	<p>2-3 visits per week for 8 weeks, and 1 visit per week for 1 week. The record evidenced a physician's verbal order with a clinician's signature as employee A (administrator) dated 7/28/14 to increase the home health aide frequency of visits to 5 days per week. The order was written the second day of week 3.</p> <p>A. The record evidenced 2 home health aide visits were conducted week 3.</p> <p>B. The record evidenced one home health aide visit was conducted week 4.</p> <p>1.) The record evidenced a document signed by employee A (administrator) titled "Canceled Visit" stating, "Missed Visit Discipline HHA [home health aide] 'Aide was sick, could not service client. No additional staff available'"</p> <p>2.) The record evidenced a document signed by employee A (administrator) dated 8/8/14 titled "Canceled Visit" stating, "Missed Visit Discipline HHA Unable to Staff 'Aide called off due to sickness. did not have another aide to send'"</p> <p>C. The record evidenced 3 home health aide visits were conducted week 5.</p>		<p>clients also. A copy will be delivered to client's home for signature via staff. Clients will receive the update by June 5, 2015.</p> <p>6. The Administrator or designee shall prepare a written exam to test employee knowledge of Patient Rights. The test will be prepared by June 12, 2015. The test will be administered to employees in the following 3 months, allowing a lapse in time. This will determine employee comprehension relevant to Patient Rights.</p> <p>7. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p> <p>8. The Administrator or designee will inform the patient about the care to be furnished. Staff shall advise the patient, in advance, of the disciplines that will furnish care and the frequency of visits to be furnished.</p> <p>9. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p>	

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	<p>D. The record evidenced 2 home health aide visits were conducted week 6.</p> <p>The record evidenced a document signed by employee A (administrator) dated 8/23/14 titled "Canceled Visit" stating, "Missed Visit Discipline HHA 'Aide called in enroute to client's home and advised [aide] was having car trouble. Did not have another aide to send'"</p> <p>E. The record evidenced no home health aide visits were conducted weeks 8 and 9.</p> <p>F. On 5/7/15 at 3:41 PM, employee B (owner) indicated being unable to locate documentation of the patient's notification of the missed visits.</p> <p>3. The undated agency policy titled "PATIENT RIGHTS" states, "The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communications. The home health agency must protect and promote the exercise of these rights as follows: ... 2. The home health agency shall maintain documentation showing that it has complied with the requirements of this sections. ... 5. The patient has the right to be informed about the care to be</p>		<p>N0504 FINDINGS / Corrections for #2-A,B-1, B-2-C,D,E,F</p> <p>1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction.</p> <p>2. The undated agency policy titled "PATIENT RIGHTS" was updated and signed on May 20, 2015, by the Administrator. A copy will accompany this POC via fax. The Administrator has updated a copy of the Patient Rights for employees to read and sign. Employees will receive this Friday, May 29, 2015 and it will be a permanent part of their employee record. The form will be utilized for clients also. A copy</p>	

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NAME OF PROVIDER OR SUPPLIER TMG HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 108 N MAIN STREET STE 305 SOUTH BEND, IN 46601
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	furnished as follows A. The home health agency shall advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished."		<p>will be delivered to client's home for signature via staff. Clients will receive the update by June 5, 2015.</p> <p>3. The Administrator or designee shall prepare a written exam to test employee knowledge of Patient Rights. The test will be prepared by June 12, 2015. The test will be administered to employees in the following 3 months, allowing a lapse in time. This will determine employee comprehension relevant to Patient Rights.</p> <p>4. The Administrator created a new form, May 21, 2015, for canceled /missed visits. The form now includes a place to document evidence of patient notification, prior to the missed or canceled visits. The form includes a place to identify who received and or placed the call/notification.</p> <p>5. The Administrator or designee will inform the patient about the care to be furnished. Staff shall advise the patient, in advance, of the disciplines that will furnish care and the frequency of visits to be furnished.</p> <p>6. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p>	

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			<p>N0504 FINDINGS / Corrections for #3</p> <p>1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction.</p> <p>2. The undated agency policy titled "PATIENT RIGHTS" was updated and signed on May 20, 2015, by the Administrator. A copy will accompany this POC via fax. The Administrator has updated a copy of the Patient Rights for employees to</p>	

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N 522 Bldg. 00	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,		<p>read and sign. Employees will receive this Friday, May 29, 2015 and it will be a permanent part of their employee record. The form will be utilized for clients also. A copy will be delivered to client's home for signature via staff. Clients will receive the update by June 5, 2015.</p> <p>3. The Administrator or designee shall prepare a written exam to test employee knowledge of Patient Rights. The test will be prepared by June 12, 2015. The test will be administered to employees in the following 3 months, allowing a lapse in time. This will determine employee comprehension relevant to Patient Rights.</p> <p>4The Administrator or designee will inform the patient about the care to be furnished. Staff shall advise the patient, in advance, of the disciplines that will furnish care and the frequency of visits to be furnished.</p> <p>5. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p>	

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	<p>dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record review, policy review, and interview, the agency failed to ensure visits were made as ordered on the plan of care for 3 of 3 clinical records reviewed. (#1, 2, and 3)</p> <p>Findings include:</p> <p>1. Clinical record #1, start of care 12/10/13, contained a Home Health Certification and Plan of Care for certification period 4/4 to 6/2/15 with orders for skilled nursing services 3 times per week for 8 weeks and home health aide services 4 hour visits, 1 visit per week for week 1, 7 visits per week for 8 weeks, and 3 visits per week for 1 week. The record failed to evidenced a third skilled nursing visit was conducted weeks 2, 3, and 4, failed to evidence a sixth or seventh home health aide visit was conducted week 2, and failed to evidence a seventh home health aide visit was conducted week 3.</p> <p>A. The record evidenced a document signed by employee A (administrator) dated 4/7/15 titled "Canceled Visit" stating, "Date: 4-5-2015 ... Missed Visit Discipline HHA [home health aide] Unable to staff 'Did not have an available aide'"</p>	N 522	<p>N0522 FINDINGS / Corrections for #1-A,B,C</p> <p>1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction.</p> <p>2. The Administrator created a new form, May 21, 2015, for canceled /missed visits. The form now includes a place to document evidence of patient notification, prior to the missed or canceled visits. The form includes a place to identify who received and or placed the call/notification.</p> <p>3. Effective immediately, Administrator shall decline referrals for new clients if staffing is not available. Clients will receive a 5 day discharge if staffing issues become a</p>	06/12/2015			

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	<p>B. The record evidenced a document signed by employee A (administrator) dated 4/7/15 titled "Canceled Visit" stating, "Date: 4-6-2015 ... Missed Visit Discipline HHA 'Did not have an available aide'"</p> <p>C. On 5/7/15 at 2:25 PM, employee A (administrator) indicated the skilled nurse should have conducted 3 visits per week but only conducted 2 for weeks 2, 3, and 4.</p> <p>2. Clinical record #2, start of care 10/2/13, contained a Home Health Certification and Plan of Care for certification period 3/26 to 5/24/15 with orders for home health aide services 3-5 hour visits, 1 to 3 visits per week for 1 week and 3 to 4 visits per week for 8 weeks. The record evidenced 3 visits conducted weekly for weeks 2 through 6 with all visits being Wednesday for 8 hours per visit and Thursday and Friday for 6 hours per visit.</p> <p>On 5/7/15 at 3:05 PM, employee A (administrator) indicated home health aide visit duration should have been 3 to 5 hours. The employee indicated staff were providing too many hours that were not approved.</p>		<p>problem or if client refuses available staff.</p> <p>4. Administrator re-educated office staff immediately following the departure of the surveyor, on proficient communication, interaction, and documentation of changes in patient care. Clinical records must validate effective coordination of care among staff members, the organization as a whole, and our clients.</p> <p>5. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p> <p>N0522 FINDINGS / Corrections for #2 & 3 A,B-1, B-2, C, D, E, F</p> <p>1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO;</p>	

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	<p>3. Clinical record #3, start of care 11/20/13 and discharge date 9/13/14, contained a Home Health Certification and Plan of Care for certification period 7/18 to 9/15/14 with orders for home health aide services 2-3 hour visits, 1 week 1, 2-3 visits per week for 8 weeks, and 1 visit per week for 1 week. The record evidenced a physician's verbal order with a clinician's signature of employee A (administrator) dated 7/28/14 to increase the home health aide frequency and duration of visits to 3-5 hours per visit, 5 days per week. The order was written the second day of week 3.</p> <p>A. The record evidenced 2 home health aide visits were conducted week 3.</p> <p>B. The record evidenced one home health aide visit was conducted week 4.</p> <p>1.) The record evidenced a document signed by employee A (administrator) titled "Canceled Visit" stating, "Missed Visit Discipline HHA [home health aide] 'Aide was sick, could not service client. No additional staff available'"</p> <p>2.) The record evidenced a document signed by employee A (administrator) dated 8/8/14 titled</p>		<p>Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction.</p> <p>2. The Administrator educated office staff, Robert Bond and Eula Veasy, immediately following departure of surveyor, on accurate, detailed, and precise information to be included in all documentation. Administrator advised office staff, it is a requirement that all calls are recorded. They were instructed to include date and time of call, who they spoke with, and the facts concerning the conversation. Any additional forms are to be completed at that time. If the call is concerning a medical issue, inform the nurse so he/she can follow up on the concern. If a client is canceling a discipline, complete the canceled visit form and fax it to the physician, then staple the fax confirmation to the notice.</p> <p>3. Administrator has provided a file for information to be placed for review. Review will determine appropriate and complete documentation. Staff has been informed they will be monitored and educated on an ongoing basis, and disciplinary action will to follow, if this recurs.</p> <p>4. Administrator re-educated office staff immediately following the</p>				

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	<p>"Canceled Visit" stating, "Missed Visit Discipline HHA Unable to Staff 'Aide called off due to sickness. did not have another aide to send'"</p> <p>C. The record evidenced 3 home health aide visits were conducted week 5.</p> <p>D. The record evidenced 2 home health aide visits were conducted week 6.</p> <p>The record evidenced a document signed by employee A (administrator) dated 8/23/14 titled "Canceled Visit" stating, "Missed Visit Discipline HHA 'Aide called in enroute to client's home and advised [aide] was having car trouble. Did not have another aide to send'"</p> <p>E. The record evidenced no home health aide visits were conducted weeks 8 and 9.</p> <p>F. On 5/7/15 at 3:45 PM, employee A (administrator) indicated the physician's order dated 7/28/14 was to increase home health aide frequency and duration to "3 to 5 hour visits, 5 days a week" until 8/23/14. The administrator indicated being unable to locate documentation of why the visits were not made for weeks 8 and 9.</p>		<p>departure of the surveyor, on proficient communication, interaction, and documentation of changes in patient care. Clinical records must validate effective coordination of care among staff members, the organization as a whole, and our clients.</p> <p>5. The Administrator will hold an in-service for staff on coordination of care and regarding policy when required to call office with changes in client care. This will be completed by June 15th, 2015. Field staff will require selected dates to choose from to meet their needs and continue to provide care.</p> <p>6. The Administrator created a new form, May 21, 2015, for canceled /missed visits. The form now includes a place to document evidence of patient notification, prior to the missed or canceled visits. The form includes a place to identify who received and or placed the call/notification.</p> <p>7. Effective immediately, Administrator shall decline referrals for new clients if staffing is not available. Clients will receive a 5 day discharge if staffing issues become a problem or if client refuses available staff.</p> <p>8. Effective immediately, Administrator or designee will monitor frequency and duration of</p>	

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	4. The undated agency policy titled "Plan of Care" states, "Policy Home care services are furnished under the supervision and direction of the client's physician. The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members. ... Purpose To provide guidelines for agency staff to develop a plan of care individualized to meet specific identified needs."		<p>visit is concurrent with plan of care and supplemental physician's orders.</p> <p>9. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p> <p>N0522 FINDINGS / Corrections for #4</p> <p>1. Correction was set in motion immediately following the departure of ISDH surveyor, May 07, 2015, beginning with notification to CEO, Cathy Thomas. An emergency meeting has held at 4:05 PM. Attendees present in person; Teri Miller, Administrator; Robert Bond, C.O.O., Assistant Office Manager Coordinator,; Eula Veasy, Office Manager & Coordinator, Payroll & Billing Manager; Attendees present via phone; Cathy Thomas, CEO; Tamia Bridgeman, Secretary and Alternate Administrator; Trina Gordon, Chairman of the Board. A copy of the minutes will accompany this Plan of Correction.</p> <p>2. The Administrator updated the policy on "Plan of Care" Signed it and a copy will accompany this Plan of Correction via fax.</p>	

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			<p>3. Effective immediately, Administrator or designee will monitor frequency and duration of visit is concurrent with plan of care and supplemental physician's orders.</p> <p>4. The Administrator or designee will audit 10% of client charts monthly to if corrective actions are being completed and prevent deficiency from recurring.</p>	