

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
| N000000  | <p>This visit was for a state home health initial licensure survey.</p> <p>Survey dates: 4/15/2013 - 4/17/2013</p> <p>Facility#: 013112</p> <p>Survey Team: Dawn Snider, RN, PHNS</p> <p>Census Service Type: 10</p> <p>Skilled Patients: 3<br/>Home Health Aide Only Patients: 7<br/>Personal Service Only Patients: 0<br/>Total: 10</p> <p>Sample:</p> <p>RR w HV: 2<br/>RR w/o HV: 5</p> <p>Total RR: 7</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN</p> <p>April 29, 2013</p> | N000000   |   |   |  |   |  |

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: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
| N000458  | <p>410 IAC 17-12-1(f)<br/>Home health agency administration/management<br/>Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:</p> <ol style="list-style-type: none"> <li>(1) Receipt of job description.</li> <li>(2) Qualifications.</li> <li>(3) A copy of limited criminal history pursuant to IC 16-27-2.</li> <li>(4) A copy of current license, certification, or registration.</li> <li>(5) Annual performance evaluations.</li> </ol> <p>Based on personnel record and policy review and interview, the agency failed to ensure all personnel files evidenced receipt of a job description for 1 of 8 records reviewed (L) with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file L, the alternate director of nursing, alternate administrator, and registered nurse, date of hire 3/1/13, failed to evidence a signed job descriptions.</li> <li>2. The undated policy titled "POLICY: HR.001 EMPLOYEE FILE" states, "B.</li> </ol> | N000458   | <p>N 458 Home Health Agency Administration/Management</p> <ol style="list-style-type: none"> <li>1. Employee L was notified that a signed job description was needed to complete her Personnel Record. Employee L came to the office and signed Job Description.</li> <li>2. Personnel Records for all employees were audited to ensure that each had a signed Job Description. The agency developed an internal audit form to ensure all new hires have a signed job description in their personnel files. The Agency will conduct an audit monthly for 3 months for submission to the QAS committee and quarterly thereafter if no deficiencies are found.</li> <li>3. The Human Resources manager will be responsible for correcting this deficiency and for conducting all required audits.</li> <li>4. The deficiency will be corrected by May 09, 2013</li> </ol> | 05/09/2013  |  |   |  |

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
|  | <p>The following information will be included in the personnel record: ... 2. Signed Job Description and Addendum"</p> <p>3. On 4/17/13 at 2:40 PM, the owner of the agency, employee J, indicated employee L did not have signed job descriptions.</p> |   |   |   |  |   |  |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
| N000462  | <p>410 IAC 17-12-1(h)<br/>Home health agency administration/management<br/>Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients.</p> <p>Based on personnel file review and interview, the agency failed to ensure all employees had a physical examination no more than one hundred eighty days prior to direct patient contact to ensure the employee would not spread infectious or communicable diseases in 3 of 8 files (C,K, and L) reviewed of employees who had direct patient contact with the potential to affect all the patients of the agency.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Personnel file C, date of hire 4/6/13 and first patient contact 4/8/13, failed to evidence a physical exam.</li> <li>2. Personnel file K, date of hire 2/22/13 and first patient contact 3/26/13, failed to evidence a physical exam.</li> </ol> | N000462   | <p>N 462 Home Health Agency Administration/Management1. Employees C, K, and L were notified that a physical exam was required. Employee C had a physical exam completed on 4.23.2013. Employee K had a physical exam completed on 5.1.2013. Employee L contacted her physician's office and the office faxed a copy of a physical exam that was dated and signed by the MD 12.11.20132. Personnel Records for all other staff were reviewed to ensure that a physical exam had been completed within 180 days prior to the first day of patient contact. The agency developed an internal audit tool which will be included in all new hire packets to ensure the deficiency will not reoccur. New hire packets will be audited by the Human Resource manager to ensure a physical exam has been completed prior to the first date of patient contact. This information will be submitted to the QA committee monthly for three</p> | 05/09/2013  |  |   |  |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
|  | <p>3. Personnel file L, date of hire 3/1/13 and first patient contact unknown, failed to evidence a physical exam.</p> <p>4. On 4/17/13 at 2:40 PM, the owner of the agency, employee J, indicated no evidence was available to verify employees C, K, and L had received a physical exam.</p> |   | <p>months and if no deficiencies are found quarterly thereafter.3. The Human Resources manager will be responsible for correcting this deficiency and conducting all required audits.4. The deficiency will be corrected by May 09,2013</p> |   |  |   |  |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                                  |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
| N000470  | <p>410 IAC 17-12-1(m)<br/>Home health agency administration/management<br/>Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.</p> <p>Based on observation, policy review, and interview, the agency failed to ensure all employees followed proper infection control technique for 1 of 2 (#3) home visit observations with a home health aide resulting in the potential to spread infectious diseases to other patients and staff.</p> <p>Findings include:</p> <p>1. On 4/17/13 at 9:40 AM, during a home visit to patient #3, the home health aide, employee F, was observed to don disposable gloves without washing her hands. Employee F then applied lotion to the patient's skin.</p> <p>2. The undated agency policy titled, "Policy: "QMI.019 INFECTION CONTROL MANAGEMENT &amp; ASSESSMENT" states, "5. All employees are responsible for adhering to established infection control policies and procedures during the provision of care which shall</p> | N000470   | <p>N 470 Home Health Agency Administration/Management1. A mandatory in service was held for direct care staff on Infection Control/Hand washing Practices.2. Upon employment all direct care staff will receive training on Infection Control/Hand washing policies prior to the first day of patient contact. The Agency has developed an internal audit form for monitoring to ensure the deficiency does not reoccur. This information will be submitted to the QA committee monthly for three months and quarterly thereafter if no deficiencies are found. The agency will hold an Infection Control/Hand washing in service quarterly for all direct care staff.3. The Administrator and or Director of the agency will be responsible for correcting this deficiency and will also be responsible for conducting quarterly in services.4. The deficiency will be corrected by May 09, 2013</p> | 05/09/2013  |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br>04/17/2013 |
|--|---|--|---|

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

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|--|---------------------|--|----------------------------|
|                          | <p>include: a. Hand washing. "</p> <p>3. On 3/17/13 at 3:30 PM, the registered nurse / alternate administrator, employee M, present during the home visit, indicated the home health aide did not wash her hands prior to patient contact.</p> |                     |  |                            |

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                                  |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
| N000486  | <p>410 IAC 17-12-2(h)<br/>Q A and performance improvement<br/>Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.</p> <p>Based on observation, clinical record review, policy review, and interview, the agency failed to ensure coordination of care occurred with other providers providing services for 1 of 2 home visit observations (#2) of patients receiving services from other providers with the potential to affect all the patients of the agency receiving services from other entities.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. During the home visit on 4/16/13 at 9:40 AM with patient #2, a representative from another agency visited the patient. The representative interviewed the patient to assist with care of the patient. The registered nurse / alternate administrator, employee M, present during the home visit, indicated the representative was a case manager from another home health agency.</li> <li>2. Clinical record #2, start of care 3/26/13, failed to evidence any communication / case conferences to</li> </ol> | N000486   | <p>N 486 QA and performance1. Patient #2 Clinical record was updated to reflect that care is being coordinated with other other providers. Clinical records for all remaining patients were reviewed to ensure that care is being coordinated with other providers.2. Upon admission and with recertification, a case conference will be held for each patient to ensure all other providers are included in coordination of care. The agency will use an internal audit form to monitor this. This information will be presented to the QA committee monthly for three months and quarterly thereafter if no deficiencies are found. care coordinators were in serviced on coordination of care.3. The administrator and or Director of the agency will be responsible for correcting this deficiency and for future audits.4.The deficiency will be corrected by May 09, 2013.</p> | 05/09/2013  |  |   |  |

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                                  |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
|  | <p>coordinate the patient care with the other agency providing services to the patient.</p> <p>3. The undated policy titled "Policy: CLN.014 COORDINATION OF CARE" states, "Policy: It shall be the policy of this agency to ensure effective interchange, reporting, and coordination of care and information provided by agency staff, contractors and other providers of care. The interchange of information will be documented in the patient's medical record. "</p> <p>4. On 4/17/13 at 3:30 PM, the registered nurse / alternate administrator, employee M, and the owner of the agency, employee J, indicated there was no further documentation to evidence coordination of care with the other agency providing services for patient #2.</p> |   |   |   |  |   |  |

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
| N000504  | <p>410 IAC 17-12-3(b)(2)(D)(i)<br/>Patient Rights<br/>Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows:<br/>(2) The patient has the right to the following:<br/>(D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows:<br/>(i) The home health agency shall advise the patient in advance of the:<br/>(AA) disciplines that will furnish care; and<br/>(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 the change in the frequency of skilled nurse visits for 1 of 7 (#4) clinical records reviewed with the potential to affect all new patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #4, Start of Care 3/26/13, included a consent form, signed by the patient's power of attorney on 3/26/13 for skilled nursing every 2 weeks. The plan of care for the certification period 3/26/13-5/24/13 had orders for skilled nurse admission visit, then every 4 weeks times 9 weeks. The record failed to evidence any documentation the patient or power of attorney had been informed of the change of frequency of skilled</p> | N000504   | N 504 Patient Rights1. Patient #4, POA and the physician were notified of adjustment in frequency of visits and the clinical record was updated.2. All remaining patient charts were audited to ensure the frequency of ordered visits and actual visits correlate. All care coordinators were in serviced on Patient Rights.3. The patient's care coordinator will be responsible for ensuring that patients, POA and physicians are notified when an adjustment in frequency of visits is warranted.4. The deficiency will be corrected by May 09, 2013 | 05/09/2013  |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
|--|---|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
|  | <p>nurse visits.</p> <p>2. The undated policy titled "Policy: CLN.009 " Patient Plan of Care" states, "8. Changes to the Care Plan to reduce service or a referral of service will be communicated to the patient prior to initiation of the change ...."</p> <p>3. On 4/17/13 at 11:45 PM, the registered nurse / alternate administrator, employee M, and the owner of the agency, employee L, indicated there was no further documentation to evidence patient #4 had been notified of the change of frequency of skilled nurse visits after the consent was signed.</p> |   |   |   |  |   |  |

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
| N000524  | <p>410 IAC 17-13-1(a)(1)<br/>Patient Care<br/>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:</p> <ul style="list-style-type: none"> <li>(A) Be developed in consultation with the home health agency staff.</li> <li>(B) Include all services to be provided if a skilled service is being provided.</li> <li>(B) Cover all pertinent diagnoses.</li> <li>(C) Include the following: <ul style="list-style-type: none"> <li>(i) Mental status.</li> <li>(ii) Types of services and equipment required.</li> <li>(iii) Frequency and duration of visits.</li> <li>(iv) Prognosis.</li> <li>(v) Rehabilitation potential.</li> <li>(vi) Functional limitations.</li> <li>(vii) Activities permitted.</li> <li>(viii) Nutritional requirements.</li> <li>(ix) Medications and treatments.</li> <li>(x) Any safety measures to protect against injury.</li> <li>(xi) Instructions for timely discharge or referral.</li> <li>(xii) Therapy modalities specifying length of treatment.</li> <li>(xiii) Any other appropriate items.</li> </ul> </li> </ul> <p>Based on clinical record and policy review, the agency failed to ensure the start of care / start of services was accurate on the plan of care for 7 or 7 clinical records reviewed of patients receiving home health aide services (#1, 2, 3, 4, 5, 6 and 7) with the potential to affect all the patients of the agency receiving services.</p> <p>Findings include:</p> | N000524   | N 524 Patient Care 1. Clinical records for patients 1, 2, 3, 4, 5, 6, and 7 were reviewed and respective MD's were notified of the lapse in time between start of care date and start of service date. All remaining patients' clinical records were audited to ensure that services were started according to the Agency policy. 2. Upon admission, the patient's care coordinator will notify the agency scheduler of the patients ordered hours. Services will be started within 48 hours of | 05/09/2013  |  |   |  |

|  |   |   |  |   |  |   |  |
|--|---|---|--|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
|  | <p>1. Clinical record #1, start of care (SOC) 3/26/13, with a plan of care (POC) for the certification period 3/26/13-5/24/13 had orders for home health aide 2 hours day times 3 days a week times 9 weeks. The record evidenced a comprehensive assessment by the registered nurse on 3/26/13. The home health aide began providing services on 4/2/13.</p> <p>2. Clinical record #2, SOC 3/26/13, with a POC for the certification period 3/26/13-5/24/13 had orders for home health aide services 2 hours a day times 4 days a week times 9 weeks. The record evidenced a comprehensive assessment by the registered nurse on 3/26/13. The home health aide began providing services on 4/2/13.</p> <p>3. Clinical record #3, SOC 3/28/13, with a POC for the certification period 3/28/13-5/26/13 had orders for home health aide services 1 hour a day times 5 days a week times 9 weeks. The record evidenced a comprehensive assessment by the registered nurse on 3/28/13. The home health aide began providing services on 4/1/13.</p> <p>4. Clinical record #4, SOC 3/26/13, with a POC for certification period 3/26/13-5/24/14 had orders for the home</p> |   | <p>admission unless otherwise ordered by MD or requested by the patient. The Agency will use an internal audit form to ensure the policy regarding Patient Care is being followed. This information will be submitted to the QA committee monthly for three months and quarterly thereafter if no deficiencies are found. All care coordinators were in serviced regarding Patient Care. 3. The Agency scheduler will be responsible for ensuring that ordered hours will be covered timely. 4. The deficiency will be corrected by May 09, 2013</p> |   |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING | X3) DATE SURVEY COMPLETED<br>04/17/2013 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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 |
|--------------------|--|---------------|---|----------------------|
|                    | <p>health aide 2 hours a day time 3 days a week times 9 weeks. The record evidenced a comprehensive assessment by the registered nurse on 3/26/13. The home health aide began providing services on 4/1/13.</p> <p>5. Clinical record #5, SOC 3/27/13, with a POC for the certification period 3/27/13-5/25/13 had orders for the home health aide 1 hour a day times 5 days a week times 9 weeks. The record evidenced a comprehensive assessment by the registered nurse on 3/27/13. The home health aide began providing services on 4/8/13.</p> <p>6. Clinical record #6, SOC 3/26/13, with a POC for the certification period 3/26/13-5/24/13 had orders for the home health aide 2 hours a day times 3 days a week times 9 weeks. The record evidenced "Home Care Aide Care Plan / Assignment Daily Visit" document dated 3/26/13. The home health aide began providing services on 4/1/13.</p> <p>7. Clinical record #7, SOC 3/28/13, with a POC for the certification period 3/28/13-5/26/13 with orders for home health aide 2 hours a day times 3 days a week times 9 weeks. A monthly planner document evidenced the home health aide began services on 4/1/13.</p> |               |   |                      |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
|  | 8. The undated policy titled "Policy: CLN.009 PATIENT PLAN OF CARE" states, "Policy: It shall be the policy of this Agency to develop and implement an individualized Plan of Care for each patient admitted for service, which is established and periodically reviewed by a physician to insure appropriate application of services to the patient's condition." |   |   |   |  |   |  |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
| N000540  | <p>410 IAC 17-14-1(a)(1)(A)<br/>Scope of Services<br/>Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:<br/>(A) Make the initial evaluation visit.</p> <p>Based on clinical record, policy review, and interview, the agency failed to ensure the registered nurse completed an initial assessment visit within 48 hours of referral for 3 of 7 patient records reviewed (#4, 5, and 6) with the potential to affect all new patients of the agency.</p> <p>Findings include:</p> <p>1. Clinical record #4, start of care 3/26/13, evidenced a physician's order dated 3/20/13 to evaluate and treat for home services. The comprehensive assessment was completed on 3/26/13. The record failed to evidence an initial assessment was completed within 48 hours of the referral.</p> <p>2. Clinical record #5, start of care 3/27/13, evidenced a physician's order dated 3/22/12 to evaluate and treat for home services. The comprehensive assessment was completed on 3/27/13. The record failed to evidence an initial assessment was completed within 48</p> | N000540   | <p>1. Physicians for patients #1, 4, 5 and 6 were notified of the lapse in time between the actual admission order and the actual start of care date. All other patients clinical records were audited to ensure that services were started within the 48 hour time frame from the date of the referral.2. When a referral is received from a physician the agency will ensure the patient will have a comprehensive assessment completed within 48 hours. The agency will use an internal audit form to ensure the policy is being followed. This information will be submitted to the QA committee on a monthly basis for 3 months and quarterly thereafter if no deficiencies are found. All care coordinators were inserviced on Scope of Services policy.3. The care coordinator assigned to the referral will be responsible for ensuring the comprehensive assessment is completed within 48 hours of the referral.4. The deficiency will be corrected by May 9, 2013.</p> | 05/09/2013  |  |   |  |

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
|  | <p>hours of the referral.</p> <p>3. Clinical record #6, start of care 3/26/13, evidenced a physician's order dated 3/21/13 to evaluate and treat for home services. The comprehensive assessment was completed on 3/16/13. The record failed to evidence an initial assessment was completed within 48 hours of the referral.</p> <p>4. The undated policy titled "Policy: CLN.001 ADMISSION COURSE OF ACTION" states, "A comprehensive assessment will be conducted by a Registered Nurse within 48 hours of receiving the referral ... or on the physician's order start of care date."</p> <p>5. On 4/17/13 at 3:30 PM, the alternate administrator / registered nurse, employee M, and the owner of the agency, employee J, indicated there was no further documentation to evidence the reason for the assessment not being completed within the 48 hours of the referral.</p> |   |   |   |  |   |  |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                            |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
| N000545  | <p>410 IAC 17-14-1(a)(1)(F)<br/>Scope of Services<br/>Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:<br/>(F) Coordinate services.</p> <p>Based on observation, clinical record review, policy review, and interview, the agency failed to ensure the registered nurse coordinated services with other entities providing services for 1 of 2 home visit observations of patients who received services from other providers (#2) with the potential to affect all the agency's patients.</p> <p>Findings include:</p> <p>1. During the home visit on 4/16/13 at 9:40 AM with patient #2, a representative from another agency visited the patient. The representative interviewed the patient to assist with care of the patient. The registered nurse / alternate administrator, employee M, present during the home visit, indicated the representative was a case manager from another home health agency.</p> <p>2. Clinical record #2, start of care 3/26/13, failed to evidence any communication / case conferences to</p> | N000545   | <p>1. Patient #2 clinical records were audited, the physician was notified and the Plan of Care was updated to reflect the coordination of care with other providers. All other patient clinical records were audited to ensure patient care is being coordinated with other providers.2. When a referral is received, the agency will inquire of the patient and or POA as to other providers that will be participating in the coordination of care. The agency will use an internal audit form to ensure the deficiency will not recur. This information will be submitted to the QA committee monthly for three months and quarterly thereafter if no deficiencies are found. All care coordinators were inserviced to on Scope of Services policy. 3. The agency Administrator and or the Director will be responsible for ensuring coordination of care with other providers.4.The deficiency will be corrected by May 09,2013.</p> | 05/09/2013  |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING                                  |  | X3) DATE SURVEY COMPLETED<br>04/17/2013 |  |
|--|---|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>MISSION IN HOME HEALTH CARE, LLC |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>190 W BECKS MILL ROAD STE F<br>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  |  |   |  |
|  | <p>coordinate the patient care with the other agency providing services to the patient.</p> <p>3. The undated policy titled "Policy: CLN.014 COORDINATION OF CARE" states, "Policy: It shall be the policy of this agency to ensure effective interchange, reporting, and coordination of care and information provided by agency staff, contractors and other providers of care. The interchange of information will be documented in the patient's medical record. "</p> <p>4. On 4/17/13 at 3:30 PM, the registered nurse / alternate administrator, employee M, and the owner of the agency, employee J, indicated there was no further documentation to evidence coordination of care with the other agency providing services for patient #2.</p> |   |   |   |  |   |  |