

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVOCATES HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9135 N MERIDIAN ST STE B4 INDIANAPOLIS, IN 46260
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G000000	This was a partial extended federal home health recertification survey. Survey Dates: September 24, 25, 26, and 29, 2014 Facility #: 012167 Medicaid Vendor #: 200982750 Surveyor: Tonya Tucker, RN, PHNS Unduplicated Census Last 12 Months: 79 Quality Review: Joyce Elder, MSN, BSN, RN October 2, 2012	G000000		
G000158	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 skilled nursing visits were made as ordered on the plan of care for 1 of 7 active records reviewed of patients receiving skilled nursing services	G000158	On 10/3/14 the Director of Nursing conducted an inservice and education to remind all skilled and non-skilled staff to notify the office of any missed visit so the doctor can be notified if warranted and a missed visit can be notated	10/06/2014

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: 157636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVOCATES HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9135 N MERIDIAN ST STE B4 INDIANAPOLIS, IN 46260
--	--

(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>creating the potential to affect all the agency's patients receiving skilled nursing services. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 9/2/14, contained a plan of care for certification period 9/2 to 10/31/14 with orders for skilled nursing services 2 times per week. The record failed to evidence a second skilled nursing visit was made for week 3.</p> <p>On 9/29/14 at 11:25 AM, employee A (administrator/director of nursing) indicated being unable to locate documentation of the skilled nursing visit.</p> <p>2. The agency policy with an effective date as 2/12/14 titled "Confirmation of Physician Orders" states, "OBJECTIVES: To ensure that treatments/interventions are given only as ordered by the patient's physician. ... POLICY: All treatments/interventions provided to the patient by agency staff are provided under the orders of a physician. ... "</p>		<p>in the patient record. By 10/6/14 100% of current patient medical records we audited by the Director of Nursing to ensure all visits were accounted for and any missed visits were documented and notified to MD if warranted. No other issues were found. Going forward, at the time of recertification or discharge, the Director of Nursing will review all visits in the previous certification period to ensure all visits are documented or if a missed visit, it has been noted and notified to MD if warranted. In addition, 10% of the clinical records will be audited quarterly to ensure visit frequency is established by the physician orders is being met. The Director of Nursing will be responsible for implementing these actions to ensure the deficiency does not recur.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVOCATES HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9135 N MERIDIAN ST STE B4 INDIANAPOLIS, IN 46260
--	--

(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
G000159	<p>484.18(a) PLAN OF CARE</p> <p>The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on clinical record and policy review, observation, and interview, the agency failed to ensure the plan of care included all the patient's equipment in 1 of 4 home visit observations creating the potential to affect all the agency's patients. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 9/2/14, included a plan of care for the certification period 9/2 to 10/31/14 that failed to include all patient equipment.</p> <p>A. On 9/25/14 at 12:10 PM, a home visit was conducted at which time a cane was observed. The patient indicated using the cane often to assist with ambulation.</p>	G000159	<p>On 10/3/14 the Director of Nursing conducted an inservice and education to all skilled staff members to not only make a complete inventory of all DME present at admission and recertification but also to create a physician's interim order if a patient acquires additional DME after the most recent assessment for plan of care creation. RN case managers have reviewed DME needs for all patients to ensure they were noted on the patient's current plan of care. No further discrepancies were found. A physician's interim order has been created and sent to the physician for signature for the patient who acquired a cane after most recent plan of care had been created. Going forward, the Director of Nursing will be responsible for ensuring all staff reports any changes in DME equipment so that it can be added as an addendum to the plan of</p>	10/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVOCATES HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9135 N MERIDIAN ST STE B4 INDIANAPOLIS, IN 46260
--	--

(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>B. On 9/29/14 at 11:29 AM, employee A (administrator/director of nursing) indicated the cane was not listed on the plan of care.</p> <p>2. The agency policy with an effective date of 2/12/14 titled "Establishment and Review of the Plan of Care" states, "Information reported on the plan of care will include but not be limited to the following: ... medical supplies and durable medical equipment (DME)"</p>	N000000	care and sent to the physician for signature. The Director of Nursing will be responsible for implementing these actions to ensure the deficiency does not recur.	
N000522	<p>This was a State Home Health re-licensure survey.</p> <p>Survey Dates: September 24, 25, 26, and 29, 2014</p> <p>Facility #: 012167</p> <p>Medicaid Vendor #: 200982750</p> <p>Surveyor: Tonya Tucker, RN, PHNS</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN October 2, 2012</p> <p>410 IAC 17-13-1(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVOCATES HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9135 N MERIDIAN ST STE B4 INDIANAPOLIS, IN 46260
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Patient Care</p> <p>Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:</p> <p>Based on clinical record review, policy review, and interview, the agency failed to ensure skilled nursing visits were made as ordered on the plan of care for 1 of 7 active records reviewed of patients receiving skilled nursing services creating the potential to affect all the agency's patients receiving skilled nursing services. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 9/2/14, contained a plan of care for certification period 9/2 to 10/31/14 with orders for skilled nursing services 2 times per week. The record failed to evidence a second skilled nursing visit was made for week 3.</p> <p>On 9/29/14 at 11:25 AM, employee A (administrator/director of nursing) indicated being unable to locate documentation of the skilled nursing visit.</p> <p>2. The agency policy with an effective date as 2/12/14 titled "Confirmation of Physician Orders" states, "OBJECTIVES:</p>	N000522	<p>On 10/3/14 the Director of Nursing conducted an inservice and education to remind all skilled and non-skilled staff to notify the office of any missed visit so the doctor can be notified if warranted and a missed visit can be notated in the patient record. By 10/6/14 100% of current patient medical records we audited by the Director of Nursing to ensure all visits were accounted for and any missed visits were documented and notified to MD if warranted. No other issues were found. Going forward, at the time of recertification or discharge, the Director of Nursing will review all visits in the previous certification period to ensure all visits are documented or if a missed visit, it has been noted and notified to MD if warranted. In addition, 10% of the clinical records will be audited quarterly to ensure visit frequency is established by the physician orders is being met. The Director of Nursing will be responsible for implementing these actions to ensure the deficiency does not recur.</p>	10/06/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVOCATES HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9135 N MERIDIAN ST STE B4 INDIANAPOLIS, IN 46260
--	--

(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>To ensure that treatments/interventions are given only as ordered by the patient's physician. ... POLICY: All treatments/interventions provided to the patient by agency staff are provided under the orders of a physician. ... "</p> <p>410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/29/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ADVOCATES HOME HEALTH CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 9135 N MERIDIAN ST STE B4 INDIANAPOLIS, IN 46260
--	--

(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>treatment. (xiii) Any other appropriate items.</p> <p>Based on clinical record and policy review, observation, and interview, the agency failed to ensure the plan of care included all the patient's equipment in 1 of 4 home visit observations creating the potential to affect all the agency's patients. (#2)</p> <p>Findings include:</p> <p>1. Clinical record #2, start of care 9/2/14, included a plan of care for the certification period 9/2 to 10/31/14 that failed to include all patient equipment.</p> <p style="padding-left: 40px;">A. On 9/25/14 at 12:10 PM, a home visit was conducted at which time a cane was observed. The patient indicated using the cane often to assist with ambulation.</p> <p style="padding-left: 40px;">B. On 9/29/14 at 11:29 AM, employee A (administrator/director of nursing) indicated the cane was not listed on the plan of care.</p> <p>2. The agency policy with an effective date of 2/12/14 titled "Establishment and Review of the Plan of Care" states, "Information reported on the plan of care will include but not be limited to the</p>	N000524	<p>On 10/3/14 the Director of Nursing conducted an inservice and education to all skilled staff members to not only make a complete inventory of all DME present at admission and recertification but also to create a physician's interim order if a patient acquires additional DME after the most recent assessment for plan of care creation. RN case managers have reviewed DME needs for all patients to ensure they were noted on the patient's current plan of care. No further discrepancies were found. A physician's interim order has been created and sent to the physician for signature for the patient who acquired a cane after most recent plan of care had been created. Going forward, the Director of Nursing will be responsible for ensuring all staff reports any changes in DME equipment so that it can be added as an addendum to the plan of care and sent to the physician for signature. The Director of Nursing will be responsible for implementing these actions to ensure the deficiency does not recur</p>	10/03/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157636	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/29/2014
NAME OF PROVIDER OR SUPPLIER ADVOCATES HOME HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 9135 N MERIDIAN ST STE B4 INDIANAPOLIS, IN 46260		
(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	
	following: ... medical supplies and durable medical equipment (DME)"				