	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
AND FLAN	or correction	15K070	A. BUILDING	00	06/17/2014
		100000	B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R		MAIN STREET STE 305	
TMG HO	ME HEALTH CARE	E INC	SOUTH	H BEND, IN 46601	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE COMPLETION DATE
G000000	regozinoni or		1110		3.112
	This visit was a	Home Health federal	G000000		
	recertification su	urvey. This was a			
	partially extende	-			
	1	•			
	Survey Dates: J 2014	Tune 12, 13, 16, and 17,			
	Facility Number	r: 011556			
	Medicaid Numb	per: 201022100			
	Surveyor: Tony	a Tucker, RN, PHNS			
	Total Census (un months) = 24	nduplicated last 12			
	Quality Review BSN, RN	: Joyce Elder, MSN,			
	-	e 19, 2014			
	0 0,11				
G000158	SUPER	OF PATIENTS, POC, MED			
	·	or care  periodically reviewed by a  e, osteopathy, or podiatric			
		review, clinical record	G000158	G-0158: Finding #	06/24/2014
	and document re	eview, and interview, the ensure home health aide		1: Correction: 06/20/2014; A. Immediately following the exit the surveyor on 06/20/2014 al	of
ĺ					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

011556

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		15K070	B. WIN			06/17/2014
		<u> </u>	D. 1111		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			MAIN STREET STE 305	
TMG HO	ME HEALTH CARE	EINC			I BEND, IN 46601	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	visits were made	e in accordance with the			home health Aides were notifie	∌d
	plan of care in 2	of 10 records reviewed			via phone that a mandatory	.,
	creating the pote	ential to affect all patients			in-service will be held Saturda 06/21/2014 at 3:00 PM and	y
	of the agency that	at receive home health			Sunday 06/22/2014 @ 3:00 Pl	М
	aide services. (#1 and #6)				and they must attend one. Aid	
	and services. ("1 and "0)				agreed by signature when pick	
	Findings include:				up their check on Friday	
					06/20/2014. Anyone who faile	
	1 771	4			meet this requirement received	
	" " "	olicy with a revision date			proper disciplinary action. Age policy was also revised to refle	-
		"Subject: Cancellation;			this change.	
	Missed visits; la	te or changed visit times"			B. Administrator, Alternate	
	states, "Policy:	When a client/CG			Administrator, or her designee	will
	[caregiver] calls	and cancels a visit, the			educate all staff members on	
	employee who re	eceived the call must			missed visits, cancelled visits,	
		it cancellation form.			calling the office when a client	
	_	staff members are to be			cancels or if they have missed scheduled visit, and completin	
	1	as possible unless the			the proper form for a	9
	client refuses ser	_			missed/cancelled	
	time/day/date				visit. Administrator advised sta	aff
	time/day/date	• •			to follow the policy that was	
	2 (1: : 1	1.111			instituted on 06/20/2014.C.	
		rd #1, start of care			If/when staff member calls off work, the Office Manager or he	or
		ed a physicians plan of			designee receiving the call wil	
		tion period 4/18 to			contact additional staff via pho	
		tates, "HH [home health]			for a replacement to prevent	
	AIDE visits 3hr	[hour] visits 3w8 [3			missed visits and provide patie	ent
	times per week f	for 8 weeks]; 1w1 [1 time			care as ordered by the	
	per week for 1 w	veek] starting wk [week]			physician's ordered POC. If no staff is available to pick up an	'
	of 4/20/14 O	N HOLD TILL PA [prior			additional client or the client/C	.G
	authorization] A				wishes to cancel, the newly	
	]				implemented form	
	A The reco	ord evidenced a document			"Missed/Cancelled visit form"	will
		led "Prior Authorization			be completed at that time and	
					must be faxed to the PCP for documentation and	
		"Status Approved			notification of change in service	٠_
	Start Date 05/05	5/2014" The record			Houncauon of change in Servic	·E.

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI III	LDING	00	COMPLETED	
		15K070	A. BUII B. WIN			06/17/2014	
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R			MAIN STREET STE 305		
TMG HO	ME HEALTH CARE	INC			I BEND, IN 46601		
		- 1140		30011			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	ON
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	evidenced a hom	ne health aide visit was			D. In-service also provided		
	conducted on 5/2	2/14 and 5/6/14 and not			education on reading and		
	again until 5/30/	14.			following the POC. Each POC must indicate services provide	۱	
					type of service, length, frequer		
	B On 6/17/	/1/Lat 11:19 AM			and duration of services. All	icy,	
	B. On 6/17/14 at 11:18 AM, employee A (administrator/director of nursing) indicated agency staff inquired about approval for payment of home				required information will be		
					available on the POC-485/487		
					and will be accessible in the		
					client's medical file/chart. Cha		
	health aide servi	ces on 5/19/14 at which			Audits to be completed on 10%	% of	
	time they realize	ed it had been approved to			all charts monthly by		
	start on 5/5/14. The employee indicated				Administrator or her designee	to	
		alth aide visit made on			monitor corrective actions are being completed and deficient	.,	
		gain until 5/30/14.			does not recur.	y	
	3/0/14 and not a	gain until 3/30/14.			G-0158: Finding #2 and		
					#3:Correction: 06/20/2014 A.	The	
		rd #6, start of care			Primary Nurse caring for the		
	4/25/14, contain	ed a physicians plan of			clients in Clinical Record #1 ar	nd	
	care for certifica	tion period 4/25 to			#6, was notified on 06/20/2014		
	6/23/14 which st	tates, "HH AIDE 3hr			that they did not want and cou		
		starting wk of 4/27/14			not receive services on Monda		
		L PA APPROVED"			Wednesday, and Friday due to		
	ON HOLD HE	ZIMMIKOVED			physical Therapy appointment for clinical record # 1 TMG ha		
	A 771	1 11 1			already scheduled services to		
		ord evidenced a			provided on M-W-F having sta		
		al order received by			availability for these days.		
	employee A date	ed 4/30/14 which states,			This presented TMG with staff	ing	
	"Proposed dates	of service 5/12/14 -			difficulties when the client		
	11/8/14"				requested a change in days, a		
					staff was assigned according t		
	R The reco	ord evidenced a document			client needs. Additional staff w	III	
					be hired to prevent this from		
		ating, "Status Approved			recurring.B.  Administrator educated all		
		2/14" The record			Office Personnel on missed vis	sits	
	evidenced the fir	rst home health aide visit			cancelled visits, and completing		
	was conducted o	on 6/3/14.			the proper form. All staff was	9	
					advised to review/follow the ne	ew	
	C. On 6/13/	14 at 11:28 AM,			instituted policy. Educated office	ce	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00		
		15K070	B. WINC	}		06/17/	2014
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
TMG HO	ME HEALTH CARE	INC			/AIN STREET STE 305 BEND, IN 46601		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES		ID	DDOVIDED'S DEAN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	employee A indi	cated agency staff			staff on contacting additional s		
		oproval for payment of			via phone call for placement to		
		e services on 5/28/14.			prevent missed visits and prov	ide	
		dicated the payment			patient care as ordered by physician/POC. A copy of police		
		s approved to start on			was distributed to staff	У	
		irst home health aide			members.C. When obtaining		
					Prior Authorization for services	3	
	visit was not con	risit was not conducted until 6/3/14.			Administrator or her designee		
					check the status every Monday	y	
					and Thursday and/or on any	4	
					additional day. This is to preve missed visits due to Medicaid	nt	
					authorizing visits prior to the da	ate	
					TMG received authorization. A		
					Inquiries will be printed at the		
					time was checked and filed in	the	
					chart. This is to provide		
					documentation of the inquiry; Approved, Denied, Suspended	Lin	
					Review. A New Policy will be	1, 111	
					written by 06/27/2014 to correct	ct	
					this and prevent the deficiency		
					from recurring. Administrator o	r	
					designee will audit 10 % of all		
					charts monthly to monitor		
G000159	484.18(a)						
5000103	PLAN OF CARE						
		eveloped in consultation					
	with the agency st	aff covers all pertinent					
		ng mental status, types of					
		oment required, frequency					
		s, rehabilitation potential, ns, activities permitted,					
		ns, activities permitted, nents, medications and					
		ifety measures to protect					
	against injury, inst						
	discharge or referr	<del>-</del>					
	appropriate items.						
	Based on agency	policy review, clinical	G00	0159	G- 159 FINDING		06/24/2014
	record review, ar	nd interview, the agency			The SOC date for clinical record #5,		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

MFNM11 Facility ID: 011556

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		15K070	B. WIN			06/17/	2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	t .			MAIN STREET STE 305		
TMC HO	ME HEALTH CARE	INC			H BEND, IN 46601		
TIVIG HO	IVIE HEALTH CARE	INC		30011	1 BEND, IN 40001		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	failed to ensure	the plan of care included			was changed to the date the patien	t	
	accurate informa	ation in 1 of 10 clinical			was admitted into skilled services.		
	records reviewed	1 (#5)			Starting skilled services requires the	е	
	10001ds 10 110 Wes	. (113)			OASIS Assessment to be entered		
	F: 1: : 1 1				into HAVEN. A new SOC date was		
	Findings include	):			indicated on the POC/485 along wit	h	
					a new certification period.		
	1. The undated agency policy titled				Correction: On 06/20/2014 the		
	"Clinical records	s/medical record			Administrator Deleted the HAVEN		
	retention" states	, "POLICY A clinical			ASSESSMENT on the SOC and		
		aintained for every client			Re-certification OASIS ASSESSMENT	S	
		•			for clinical record #5. This was		
	1	health services			completed to correct the deficiency	,	
		are legal documents			(G-159) and to change the SOC date	!	
	containing accur	rate, and organized			back to original date that		
	information P	URPOSE To maintain			NON-SKILLED services started		
	an accurate reco	rd of the services			(05/06/2011) Upon Re-entering the		
		agency for each client			admission assessment into HAVEN,		
	"	agency for each enem			the system would not allow the		
	•				assessment to be entered on the		
					date ( 05/06/2011), not even with		
		rd #5 evidenced a			accepting the warning then		
	document signed	d by the registered nurse,			continuing. When attempting to		
	dated 5/6/11, and	d titled "Adult Nursing			"complete" the assessment and		
	Assessment" wh	ich states, "REASON			export it, HAVEN will not allow this		
		ENT: Start of Care"			to occur.		
	T OIL TISSESSIVE	Erri Start of Care			The Administrator called HAVEN for		
	A The	ord evidenced a home			assistance in this, it was determined that entering the original SOC date	ı	
					of 05/06/2011 was impossible. It		
		on and plan of care for			does not accept dates from an		
	certification peri	od 3/20 to 5/18/14 that			extended time frame. Example SOC		
	states, "Start of 0	Care Date 03/20/2014."			entered 05/06/2011 and the initial		
					assessment date 03/20/2014. Rich,		
	B. On 6/12/	14 at 1:25 PM, employee			the assistant from HAVEN, then		
		/ director of nursing)			placed a three way call to Joyce		
	,	•			Elder,MSN,BSN,RN, QUALITY		
		ient was admitted to the			REVIEW. After determining that		
	1 0 1	6, 2011, with home			OASIS-C, entry for HAVEN had a		
	health aide servi	ces only. The employee			changed in March 2014, Again, this		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
	15K070	B. WING		06/17/2014
NAME OF F	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
	NO FIELD ON SOLVE ELEM		MAIN STREET STE 305	
TMG HO	ME HEALTH CARE INC	SOUTH	H BEND, IN 46601	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	indicated skilled nursing services were		will not allow the original SOC date	
	ordered in March, 2014 and was under		to be used. Joyce Elder, MSN, BSN, RI	N
	the impression the start of care date		stated this will be addressed with Kelley,BSN,RN PHNSS-Program	
	needed to be changed to the date the new		Director ISDH/Acute Care Division.	
	service was added.		OASIS re-entered with new SOC	
			date. The Administrator will follow	
			up on this discrepancy with Joyce	
			Elder,MSN,BSN,RN and	
			Kelley,BSN,RN PHNSS-Program	
			Director ISDH/Acute Care Division	
			one week after this plan of	
			correction is submitted. A new	
			policy to be instituted when a decision on this matter has been	
			approved.	
G000224	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME			
	HEALTH AIDE			
	Written patient care instructions for the			
	home health aide must be prepared by the			
	registered nurse or other appropriate professional who is responsible for the			
	supervision of the home health aide under			
	paragraph (d) of this section.			
		G000224	G-224 Correction: On	06/20/2014
	Based on agency policy review, clinical		06/20/2014 The Administrato	or
	record review, and interview, the agency		has instructed the Registered	
	failed to ensure the home health aide plan		Nurses verbally on following/reviewing P&P The	
	of care was updated at least every 60 days		Administrator instructed Nursi	
	as required by agency policy in 1 of 8		staff on updating the Aide Car	e
	clinical records reviewed of patients		Plan at least every 60 days ar	
	•		as needed. Registered Nurses	
	•			&
	receiving nome nearin aide services. (#/)		DUTIES OF HOME HEALTH	
			AIDE). The Administrator has	a
	Findings include:		checklist for the nurse to	
	receiving home health aide services with the potential to affect all patients receiving home health aide services. (#7)  Findings include:		were given a copy of (42 CFF 484.36 - Condition of participation) (ASSIGNMENT DUTIES OF HOME HEALTH AIDE). The Administrator has	&

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If continuation sheet

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STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15K070	B. WIN			06/17/	2014
NAME OF B	AD CAMPED OD GARDA IED		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			108 N M	IAIN STREET STE 305		
	ME HEALTH CARE			l	BEND, IN 46601		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	complete for an admission,		DATE
	January 20, 2014 Care" states, "The care shall be reviewed by sician and personnel as ofter patient's condition once every sixty  2. Clinical recort 1/14/14, contained care for certificate 7/12/14. The record registered number of the registered number of the registered for certificate the registered number of the re	d #7, start of care ed a physician's plan of tion period 5/14 to cord evidenced an aide e last review/update by			recertification, and resumption and nurses are to utilize this for This will assist in providing assurance the required information/duties have been completed. The Administrator audit 10% of incoming forms monthly to monitor if corrective actions are being completed at to prevent deficiency from recurring. During the home head hade staff meeting held on 06/21/2014 and 06/22/2014, at staff members were instructed call the Primary Nurse when a change/update is needed for a client. If unable to contact the Primary Nurse call the office at report to the Administrator or designee. Administrator or designee is to complete chart audits on 10% of all charts monthly to monitor if corrective actions are being completed at to prevent deficiency from recurring.	will alth Ito	
G000225	HEALTH AIDE The home health a				-		
	review, and inter	review, clinical record view, the agency failed ne health aide provided e ordered by the	G00	00225	G-225: Correction: 06/20/2014 A. Immediately following the e of the surveyor on 06/20/2014 home health Aides were notifie via phone call, a mandatory sta meeting will beheld Saturday 06/21/2014 at 3:00 PM and	exit all ed	06/21/2014

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Event ID:

MFNM11 Facility ID: 011556

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPLETED	
		15K070	B. WIN			06/17/2014	
					ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF F	PROVIDER OR SUPPLIE	R			MAIN STREET STE 305		
TMG HO	ME HEALTH CAR	EINC			I BEND, IN 46601		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		1
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	1 ^ -	plan of care in 2 of 8			Sunday 06/22/2014 @ 3:00 P	M	
	patient records i	reviewed of patients			they must attend one. Aides agreed by signature when pic	kina	
	receiving home	health aide services			up their check on 06/20/2014.	_	
	creating the potential to affect all patients				Anyone who failed to meet thi		
	receiving home	health aide services. (#1			requirement received proper		
	and #6)				disciplinary action. G-225 E	i.	
					During the In-service on 06/21/2014 and 06/22/2014, s	toff	
	Findings include	a·			members were re-educated o		
					following the POC per physici		
	1 The agency r	oolicy titled "Home			orders and following Agency		
		cumentation" with a			policy. All staff instructed on o		
					provided must be concurrent	with	
		5/15/14 states, "Policy:			the Care Plan and staff is to		
		ides are to document			monitor for changes every vis the RN may update at any tim		
		ovided on the visit record			and they are responsible for		
		rrence with the Care Plan.			following this POC. Staff also		
	Purpose: 1. Pro	ovides documentation of			in-serviced on correct visit not	e to	
	care/services pro	ovided during the home			complete,time, date, client		
	health aide visit	. 2. Provides			signature, and staff credential	S	
	documentation of	of the home health aide's			must all be completed before turning in. All visit notes to be		
	observations du	ring the visit and			turned in on Friday of current		
	evidence of clie	nt's progress or demise			week,visit note is a legal		
	."	1 0			document and per policy mus		
					filed in the chart within 14 day	s of	
	2 Clinical reco	rd #1, start of care			the visit. Administrator or		
	4/18/14, include				designee is to audit 10% of all charts monthly to monitor if		
	established by the	•			corrective actions are being		
					completed and to prevent		
	_	iod 4/18 to 6/16/14 with			deficiency from recurring.		
		health aide services and					
	_	onal care to assist with					
		ath; hair care; shampoo;					
		are; check pressure areas					
	I =	regarding problem skin					
	area. Assist wit	h medication reminders;					
	assist with mobi	lity; perform PROM					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15K070	B. WIN			06/17	2014
NAME OF I	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
TMC HO		INC			MAIN STREET STE 305		
TIVIG HO	ME HEALTH CARE	INC		300111	BEND, IN 46601		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		,		TAG	BHIGHACL		DATE
		f motion] to BLE					
	_	extremities]. Assist with					
	nutrition, light housekeeping in patient bedroom; bathroom; kitchen; living						
		_					
	room; change be	d linen					
	Λ The rese	ard avidanced an eide vieit					
	A. The record evidenced an aide visit dated 6/3/14 with task of "light						
		n task of light bedroom / bathroom /					
	1 0	d bed linen" being the					
		•					
	only task comple	eteu at the visit.					
	B On 6/12/	14 at 2:25 PM, employee					
		/ director of nursing)					
	`	ne health aides are					
		owing the care plan and					
		tation and was not aware					
		l were not completed at					
	this visit.	i were not completed at					
	this visit.						
	3 Clinical reco	d #6, start of care					
	4/25/14, included						
	established by th	•					
	I	od 4/25 to 6/23/14 with					
	_	health aide services and					
		onal care to assist with					
		ath; hair care; shampoo;					
		are; nail care; oral care;					
		reas and notify nurse					
	_	m skin area. Assist with					
		nders; assist with					
		· ·					
		n PROM to BLE. Assist					
		ght meal preparation,					
	set-up meals and	i iiuias. wasn					

AND PLAN OF CORRECTION IDENTIFICATION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUC 00	CTION		(X3) DATE : COMPL	ETED
		15K070	B. WING				06/17/	2014
	ROVIDER OR SUPPLIER		108		S, CITY, STATE, ZIP TREET STE 305 , IN 46601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC CROSS	PROVIDER'S PLAN OF CO CH CORRECTIVE ACTION S-REFERENCED TO THE DEFICIENCY)	SHOULD BE	Ē	(X5) COMPLETION DATE
		erform light patient bedroom; en; living room; change						
	dated 6/3/14 with housekeeping / b kitchen / changed only task comple B. On 6/13/ employee A india	d bed linen" being the sted at the visit.  14 at 11:18 AM, cated being unaware the form all tasks as ordered						
N000000								
	This visit was a l licensure survey.	Home Health state	N000000					
	Survey Dates: Ju 2014	une 12, 13, 16, and 17,						
	Facility Number:	011556						
	Medicaid Number	er: 201022100						
	Surveyor: Tonya	a Tucker, RN, PHNS						
	Total Census (un	duplicated last 12						

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY  COMPLETED
		15K070	B. WING		06/17/2014
	ROVIDER OR SUPPLIER ME HEALTH CARE		108 N I	ADDRESS, CITY, STATE, ZIP CODE MAIN STREET STE 305 H BEND, IN 46601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
N000522	BSN, RN  June  410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) a written medical pand periodically redentist, chiropracte podiatrist, as follow  Based on policy and document reagency failed to visits were made plan of care in 2 creating the pote of the agency that aide services. (#  Findings include  1. The agency portion of 5/15/14 titled Missed visits; latt states, "Policy: Vicaregiver] calls employee who recomplete the visit Missed visits by	Medical care shall follow blan of care established viewed by the physician, or, optometrist or ws:  review, clinical record view, and interview, the ensure home health aide in accordance with the of 10 records reviewed ntial to affect all patients at receive home health 1 and #6)  :  blicy with a revision date "Subject: Cancellation; we or changed visit times" when a client/CG and cancels a visit, the exceived the call must at cancellation form. staff members are to be	N000522	N-522: Finding #  1: Correction: 06/20/2014; Immediately following the exit the surveyor on 06/20/2014 al home health Aides were notifivia phone call, a mandatory structure will be held Saturday 06/21/2014 at 3:00 PM and Sunday 06/22/2014 @ 3:00 Pthey must attend one. Aides agreed by signature when pictup their check on 06/20/2014. Anyone who failed to meet thirequirement received proper disciplinary action. Agency powas also revised to reflect this change. B. Administrator, Alternate Administrator, or held designee will educate all staff members on missed visits, cancelled visits, calling the of when a client cancels or if the have missed a scheduled visit and completing the proper for missed/cancelled visits.	l ed
	made up as soon	as possible unless the		visits. Administrator advised s	татт

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		15K070	B. WIN			06/17/2014	
NAME OF E	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	_
NAME OF F	NOVIDER OR SUPPLIER	<u>.</u>		108 N N	MAIN STREET STE 305		
	ME HEALTH CARE				BEND, IN 46601		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	·	DATE	—
	client refuses ser				to follow the new policy that winstituted on 06/20/2014. C.	as	
	time/day/date	."			If/when staff member calls off		
					work, the Office Manager or he	er	
	2. Clinical record #1, start of care				designee who receive the call		
	4/18/15, containe	ed a physicians plan of			contact additional staff via pho		
	care for certifica	tion period 4/18 to			call for a replacement to preve		
	6/16/14 which st	ates, "HH [home health]			missed visits and provide pation care as ordered by the	<del>s</del> iil	
		[hour] visits 3w8 [3			physician/POC. If no staff is		
	l '	for 8 weeks]; 1w1 [1 time			available to pick up additional		
	_	eek] starting wk [week]			client or the client/CG wishes	to	
	_	N HOLD TILL PA [prior			cancel the implemented form		
	authorization] A				"Missed/Cancelled"visit form v		
	aumonzanonj A	TIROVED			be complete at that time. Each POC must indicate services	)	
	A 701	1 11 1 1			provided type of service, lengt	h	
		rd evidenced a document			frequency, and duration of	,	
		led "Prior Authorization			services. All information will be	e	
	1	"Status Approved			available on the POC-485/487	'	
	Start Date 05/05	5/2014" The record			and will be accessible in the		
	evidenced a hom	ne health aide visit was			client's medical file/chart. POC will be faxed to PCP	,	
	conducted on 5/2	2/14 and 5/6/14 and not			for documentation of notification	on.	
	again until 5/30/	14.			and his records. Chart Audits		
					be completed on 10% of all		
	B. On 6/17/	14 at 11:18 AM,			charts monthly by Administrate	or	
		ninistrator/director of			or her designee to monitor		
	· ·	ed agency staff inquired			corrective actions are being completed and deficiency doe	,	
	l • •	or payment of home			not recur. N-522: Finding		
	1 1	ces on 5/19/14 at which			and #3: Correction: 06/20/201		
		d it had been approved to			A. It was advised that clients for		
	1	The employee indicated			Clinical Record #1 and #6 had		
		1 2			told the Primary nurse they did		
		alth aide visit made on			not want and could not receive visits on Monday, Wednesday		
	5/6/14 and not ag	gain until 5/30/14.			and Friday due to physical		
	2 Clinical recor	ed #6 start of agra			Therapy appointments for clini	ical	
		d #6, start of care			record # 1 TMG had already		
		ed a physicians plan of			scheduled services for M-W-F		
	care for certifica	tion period 4/25 to			having staff availability for the	se	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY  COMPLETED	
ANDILAN	OI CORRECTION	15K070	A. BUILDING	00	06/17/2014
		1011010	B. WING	ADDRESS CITY STATE OF CORE	00/11/2017
NAME OF P	PROVIDER OR SUPPLIER	R		ADDRESS, CITY, STATE, ZIP CODE MAIN STREET STE 305	
TMG HO	ME HEALTH CARE	EINC		H BEND, IN 46601	<u>,</u>
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	COMPLETION DATE
TAG		<u> </u>	IAG	days. This presented TMG w	
		states, "HH AIDE 3hr starting wk of 4/27/14		staffing difficulties when the	
		L PA APPROVED"		requested a change in days,	
	ONTIOLD TILI	Z FA AFFROVED		staff was assigned according	ı to
	A The rese	ord evidenced a		client needs. B. Administrator educated	
		al order received by		Office Personnel on missed	visits,
		ed 4/30/14 which states,		cancelled visits, and complet	ing
		of service 5/12/14 -		the proper form for missed/cancelled visits. All s	taff
	11/8/14"	01 001 V100 3/12/17 -		was advised to review/follow	
	11/0/11			new instituted policy.Educate	
	B The reco	rd evidenced a document		office staff on contacting	
		ating, "Status Approved		additional staff via phone call are placement to prevent mis	
		2/14" The record		visits and provide patient car	
		rst home health aide visit		ordered by the physician/PO	
	was conducted o			copy of policy was distributed	d to
	was conducted o	11 0/3/11.		staff members C. When obtaining Prior Authorization	for
	C. On 6/13/	14 at 11:28 AM,		services Administrator or her	
		cated agency staff		designee will check status ev	very
		pproval for payment of		Monday and Thursday and/o	r on
		e services on 5/28/14.		any additional day. This is to prevent missed visits due to	
	The employee in	ndicated the payment		Medicaid authorizing visits pr	ior to
	authorization wa	is approved to start on		date authorization was received	
	5/12/14 but the f	first home health aide		All Inquiries will be printed at time it was checked to note s	
	visit was not con	nducted until 6/3/14.		of the inquiry; Approved,	sialus
				Denied, Suspended,in Revie	w. A
				New Policy will be written by	
				06/27/2014 to correct this an prevent deficiency from recui	
				prevent denote noy nom recul	illig.
N000524	410 IAC 17-13-1(a	a)(1)			
	Patient Care	· // /			
		(1) As follows, the medical			
	plan of care shall:	in consultation with the			
	home health agen				
	_	vices to be provided if a			

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	LIA (X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE	TE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		15K070	B. WIN			06/17/	/2014
NAME OF I	DOWNER OF CLIDALIE			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				108 N N	MAIN STREET STE 305		
TMG HOME HEALTH CARE INC				SOUTH	HBEND, IN 46601		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	skilled service is b (B) Cover all pert						
	(C) Include the fo						
	(i) Mental statu	•					
	(ii) Types of ser	vices and equipment					
	required.						
		nd duration of visits.					
	<ul><li>(iv) Prognosis.</li><li>(v) Rehabilitation</li></ul>	n notential					
	(vi) Functional li						
	(vii) Activities per						
	(viii) Nutritional re						
	` '	and treatments.					
	(x) Any safety measures to protect						
	against injury. (xi) Instructions	for timely discharge or					
	referral.	ioi umoly disentings of					
	(xii) Therapy mod	dalities specifying length of					
	treatment.						
	(xiii) Any other ap						0.5/2.1/2.01.1
		policy review, clinical	N00	00524	N-524 FINDING		06/24/2014
	•	nd interview, the agency			The SOC date for clinical record #5,		
		the plan of care included			was changed to the date the patient	t	
		ation in 1 of 10 clinical			was admitted into skilled services.		
	records reviewed. (#5)				Starting skilled services requires the	9	
					OASIS Assessment to be entered		
	Findings include	t:			into HAVEN. A new SOC date was		
					indicated on the POC/485 along with	h	
	1. The undated	agency policy titled			a new certification period.		
	"Clinical records	s/medical record			Correction: On 06/20/2014 the Administrator Deleted the HAVEN		
	retention" states.	"POLICY A clinical			ASSESSMENT on the SOC and		
	· · · · · · · · · · · · · · · · · · ·	aintained for every client			Re-certification OASIS ASSESSMENT	S	
		health services			for clinical record #5. This was		
	_	are legal documents			completed to correct the deficiency		
		rate, and organized			(G-159) and to change the SOC date		
	_	URPOSE To maintain			back to original date that		
		rd of the services			NON-SKILLED services started		
					(05/06/2011) Upon Re-entering the		
	provided by the	agency for each client	1		admission assessment into HAVEN,		

State Form Event ID: MFNM11 Facility ID: 011556 If continuation sheet Page 14 of 17

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K070	A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/17/	ETED
		151(07)	B. WIN			00/17/	2017
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  108 N MAIN STREET STE 305				
TMG HOME HEALTH CARE INC				SOUTH	BEND, IN 46601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
N000550	document signed dated 5/6/11, and Assessment" wh FOR ASSESSM  A. The reconstruction period in the impression the impression of the impress				the system would not allow the assessment to be entered on the date ( 05/06/2011), not even with accepting the warning then continuing. When attempting to "complete" the assessment and export it, HAVEN will not allow this to occur.  The Administrator called HAVEN for assistance in this, it was determined that entering the original SOC date of 05/06/2011 was impossible. It does not accept dates from an extended time frame. Example SOC entered 05/06/2011 and the initial assessment date 03/20/2014. Rich, the assistant from HAVEN, then placed a three way call to Joyce Elder,MSN,BSN,RN, QUALITY REVIEW. After determining that OASIS-C, entry for HAVEN had a changed in March 2014, Again, this will not allow the original SOC date to be used. Joyce Elder,MSN,BSN,RN stated this will be addressed with Kelley,BSN,RN PHNSS-Program Director ISDH/Acute Care Division. OASIS re-entered with new SOC date. The Administrator will follow up on this discrepancy with Joyce Elder,MSN,BSN,RN and Kelley,BSN,RN PHNSS-Program Director ISDH/Acute Care Division one week after this plan of correction is submitted. A new policy is to be instituted when a decision on this matter has been approved.	I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		15K070	B. WIN			06/17/2014	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		108 N N	MAIN STREET STE 305		
TMG HOME HEALTH CARE INC				SOUTH	BEND, IN 46601		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		N
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
	Scope of Services	(1)(K) Except where					
		ed to therapy only, for					
		ice in the home health					
	setting, the registe	ered nurse shall do the					
	following:						
		es and tasks to licensed					
	practical nurses and other individuals as appropriate.  Based on agency policy review, clinical						
			NO	N000550	N-550 Correction: The	06/20/2014	4
		nd interview, the agency	1,00		Registered Nurses have been	00,20,201	•
		the home health aide plan			instructed verbally on		
		ated at least every 60 days			following/reviewing P&P and		
		gency policy in 1 of 8			updating the POC at least eve 60 days as required by agency		
					policy. A copy of policy was g		
		reviewed of patients			to all Registered Nurses. Nurs		
	_	health aide services with			also instructed to use the		
	-		checklist available to ensure a				
	receiving home	health aide services. (#7)			requirements are completed. A copy of the checklist was give		
	Findings include	<b>:</b> :	all Registered Nurses. During home health Aide staff meetin		the		
					held on 06/21/2014 and	"	
	1. The policy w	ith a revision date as			06/22/2014, all staff members		
		4 titled "Medical Plan of			were instructed to call the Prin		
	Care" states, "Th	ne total medical plan of			Nurse when a change/update needed for a client. If unable to	l l	
	· · · · · · · · · · · · · · · · · · ·	iewed by the attending			contact the Primary Nurse call		
		home health agency			office and report to the		
		en as the severity of the			Administrator or her		
	-	on requires, but at least			designee. Administrator or		
	once every sixty	-			designee is to complete chart audits on 10% of all charts		
	Silve every blaty	(00) aujo			monthly to monitor if corrective	<u>,</u>	
	2 Clinical reco	rd #7, start of care			actions are being completed a		
		ed a physician's plan of			to prevent deficiency from		
	· ·	tion period 5/14 to			recurring.		
		cord evidenced an aide					
	_	ne last review / update by					
	the registered nu	irse as 2/14/14.					

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/27/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  TMG HOME HEALTH CARE		108 N	ONSTRUCTION  00  ADDRESS, CITY, STATE, ZIP CODE  MAIN STREET STE 305  H BEND, IN 46601	(X3) DATE SURVEY COMPLETED 06/17/2014
(X4) ID SUMMARY S' PREFIX (EACH DEFICIEN TAG REGULATORY OR  3. On 6/13/14 at (administrator / c) indicated the aid	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  11:55 AM, employee A director of nursing) e care plan should have by the registered nurse in	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	

State Form Event ID: MFNM11 Facility ID: 011556 If continuation sheet Page 17 of 17