STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		157652	B. WIN			10/31/	2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				2ND STREET		
HOME HI	EALTH CARE ASS	OCIATES INC			N, IN 46952		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCE	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
N000000							
			N00	0000			
	This visit was for	r a state home health					
	relicensure surve						
	Teneensure surve	у.					
	Survey dates: O	ctober 29-31, 2013				ļ	
	Survey dates. O	200001 27 31, 2013				ļ	
	Facility #: 01216	69					
	Medicaid #: 200	969480				ļ	
	Surveyors: Tony	a Tucker, RN, PHNS					
	and Bridget Bost						
	and Bridget Bost	on, KN, Finns					
	Quality Review:	Joyce Elder, MSN,				ļ	
	BSN, RN	, , , , , , , , , , , , , , , , , , ,					
	*	ember 7, 2013					
	INOV	emoer 7, 2013					
N000442	410 IAC 17-12-1(b))					
	Home health agen	•					
	administration/mar						
	Rule 12 Sec. 1(b)	A governing body, or					
	designated person	n(s) so functioning, shall					
		authority and responsibility					
	·	f the home health agency.					
		dy shall do the following:					
		lified administrator.					
		iodically review written					
	bylaws or an acce						
		nanagement and fiscal					
	affairs of the home		NIOO	0442			12/13/2013
	-	nel file review, agency	1100	W44Z			12/13/2013
		, and interview, the					
	• •	ensure the governing					
	body appointed a	n administrator who					
	was qualified cre	ating the potential to					
	*						

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

TITLE (X6) DATE

Any defiency statement 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.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SU	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		157652	B. WIN	IG		10/31/20	013
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
HOMELI		OCIATES INC			2ND STREET		
	EALTH CARE ASS				N, IN 46952		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE '	COMPLETION DATE
1710		ents of the agency.		1710	·		DATE
	(employee C)	ents of the agency.					
	(employee c)						
	Findings include						
	1 mamgs merade	·•			Before an individual is offered		
	1 Personnel file	o for employee C			Boloro all'illaviadal lo olloroa		
	1. Personnel file for employee C, administrator, date of hire 4/18/11,				employment,		
	contained a job	· · · · · · · · · · · · · · · · · · ·			human resource personnel will	,	
	7/29/13 titled "Position: Administrator"				human resource personnel will vet an	"	
		UALIFICATIONS			101 0		
	Baccalaureate degree in nursing, health				individual's		
	service administration, business				qualifications to ensure they m	noot	
	administration or equivalent experience,				qualifications to ensure they if	icei	
	or related field.	• •			minimum		
		(5) years experience in					
	1 ^	easing responsibility in					
	_	bly in health care.			requirements for the position.	The	
		o (2) years experience in					
		dministrative positions.			agency's		
	Knowledge of	•			minimum requirements for a		
	1	the state, federal, and			qualified		
	_	wledge of business			•		
	management."				administrator		
	A. The docu	ment titled "Application					
		" dated 4/8/11 states,			are that they be either a licens	sed	
		ory COLLEGE [Name			mby raining		
	and location of s	-			physician,		
	ATTENDED 5	-			registered nurse, has training	and	
		May 2011 SUBJECTS					
		nish Pre-Med Former			experience		
	Employers (list b				in health service administration	n	
	employers, starting with last one first)				and at		
		O present [Name and					

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PRINTED: 01/22/2014 FORM APPROVED OMB NO. 0938-0391

		identification number: 157652	A. BUILDING B. WING	00 	COMPLETED 10/31/2013
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
	EALTH CARE ASS			V 2ND STREET ON, IN 46952	
(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
TAG	Address of Empl POSITION CNA assistant]." B. The unda "Pre-Employmer" "Position applied Assistant." 2. On 10/29/13 a	oyer] [salary] [certified nursing ted document titled at Application" states, for: Financial at 3:55 PM, employee C no supervisory or	TAG	least one year of supervisory or administrative experience in home health car or related health programs. The company CEO will monitor this	re

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 3 of 43

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157652		LDING	ONSTRUCTION 00	(X3) DATE : COMPL 10/31/	ETED
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE / 2ND STREET N, IN 46952		
(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
N000444	a home health age present full time at in order to qualify administrator, who supervising physic required by subse following: (1) Organize and agency's ongoing Based on personn observation, ager procedure and do interview, the ag the administrator documents were records could not employees who with agency, the at to personnel files management had record information reviewed creating all 81 patients of Findings include 1. On 10/29/13 a indicated being a home health agent.	nagement An individual need not be ency employee or be at the home health agency as its administrator. The ormay also be the cian or registered nurse ction (d), shall do the direct the home health functions. The ormay also be the cian or registered nurse ction (d), shall do the direct the home health functions. The ormay also be the cian or registered nurse ction (d), shall do the direct the home health functions. The ormay also be the cian or registered nurse ction (d), shall do the direct the nome health functions. The ormay also be the cian or registered nurse ction (d), shall do the direct the nome health functions. The ormay also be the cian or registered nurse ction (d), shall do the direct the nome health functions. The ormay also be the cian or registered nurse ction (d), shall do the direct the nome health functions. The ormay also be the cian or registered nurse ction (d), shall do the direct the nome health functions. The ormay also be the cian or registered nurse ction (d), shall do the direct the number of the number of the direct the number of the direct the number of the direct the number of the	N00	00444	N-444 1. The Board of Directors will review all Administrator applicants to ensure they meet minimum requirements for the position. agencies minimum requirements for the positions are that the applicant is either a licensed physician, RN, has training an experience in health service administration and at least one year of supervisory or administrative	The nts	12/16/2013

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 4 of 43

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 157652	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/31/2013
	PROVIDER OR SUPPLIER EALTH CARE ASSOCIATES INC	2038 W	ADDRESS, CITY, STATE, ZIP CODE / 2ND STREET N, IN 46952	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	dated 7/29/13 titled "Position: Administrator" which states, "ESSENTIAL FUNCTIONS 1. Identifies and implements the		experience in home health care or related health programs.	
	organizational structure. 2. Plans, organizes, and directs the Agency's ongoing functions. 3. Directs and coordinates the overall development and		The board of directors have orientated the new administrator	
	administration of the agency consistent with the agency mission and available resources, and the involvement of the agency staff and participation of the		to her role utilizing the "New Administrator Orientatio	
	professional advisory board 5. Provides direction in formulating the programs and policies 9. Assures the accuracy of public information materials		that she is aware and capable performing the supervisory	
	and promotional activities 14. Participates in the hiring, orientation, and development of management staff. 15. Directs daily business activities of		skills required for her job posi	ion.
	the agency and assures development of		She has shown understanding	9
	systems that support recruitment, hiring and the ongoing professional		of the job duties required.	
	development of agency staff"		The new administrator has be issued	en
	Agency document titled "Home Health Care Associates, Inc. Current		passwords and credentials	
	Organizational Chart" which evidenced physical therapy, occupational therapy,		to enter both the Devero (clini	cal
	physical therapy assistant, and occupational assistant in the		record) system, and the Generations	
	organizational structure.		(personnel, telephony) system she	1 80
	A. On 10/29/13 during survey			

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SUI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLET	
		157652	B. WIN	G		10/31/20)13
NAME OF I	PROVIDER OR SUPPLIEF	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					2ND STREET		
HOME H	IEALTH CARE ASS	OCIATES INC		MARIO	N, IN 46952		
(X4) ID	SUMMARY S	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 C	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	<u> </u>	DATE
		nce, employee C			has access to all client charts,		
		ency did not provide or			staff flow sheets, and personn	el	
	contract for there	apy services.					
					records.		
		"Patient Handbook &					
	Orientation for home health care"				2. In the future The Board of		
	booklet states, "S	SCOPE OF SERVICE			Directors will utilized the "New		
	Home Health Ca	re Associates, Inc., is a					
	state licensed an	d medicaid certified			Administsrator Orientation		
	home health age	ncy Skilled nursing			Checklist"		
	Physical Therapy Occupational Therapy The scope of service for Home Health				to orientate the new		
					to offertiate the flew		
	-	includes part time or					
		ed nursing and therapy					
	services"	2 17			administrator. The Administrat	or	
					will		
	C. On 10/30	/13 at 9:38 AM,			be issued password		
		cated being unaware the			·		
		rt included therapy					
	_	icated being unaware the			credentials to be able to acces		
		on brochures included		all			
	this information						
		4. 5 0.			technical systems.		
	3 Agency polic	y with a review date of			3.The Board of Directors will		
		inical records/medical			monitor		
		PROTECTION OF			, merine.		
	RECORDS: 1.				the proficiency of of the new		
		l be safeguarded against					
		ized use. 2. Protected					
		on will be available only			administrator and conviene ev	ery	
		st use it. Procedures			90	´	
		to assure that this					
					days in the administrators		
	_	rotected, and consents or			first year of service to evaluate	,	
	authorizations ar	e signed before					

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 6 of 43

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157652		A. BUILDING B. WING		COMPLETED 10/31/2013			
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			2038 W	2ND STREET		
	EALTH CARE ASS			MARIO	N, IN 46952		
(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 APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710	information is re			mo	her		DATE
	information is re-	icused					
	A. On 10/29	0/13 at 9:40 AM,			job performance and proactive	:	
	employee J (offic	ce staff) indicated there			approchs.		
	was a new emplo	yee (non-employee #1)					
	but she did not k	now his job title.					
	B On 10/29	1/13 at 10 AM, employee					
		employee #1 was not					
	employed with the						
	C. On 10/29	7/13 at 4 PM,					
	non-employees #	² 1, #2, and #3 were					
	observed standin	g behind a desk at the					
	agency entrance,	next to the copier,					
	looking at unider	ntified paperwork.					
	D. On 10/29	9/13 at 4:10 PM,					
	employee C indi	cated that					
	non-employees #	1 has a contract with					
	the agency as a c	onsultant that entitles					
	him to review the	e patients' plans of care					
	after the registere	ed nurse prepares it and					
	returns it back to	the registered nurse if					
	corrections are no	eeded. The					
		licated non-employees					
	•	asswords and have					
	•	ent records through the					
		e medical record system					
		access since around the					
		when a meeting was					
	conducted by the						
		strator / director of					
	nursing (employe	ee A) informing the					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRU 00		(X3) DATE S	ETED
		157652	B. WING			10/31/	2013
	PROVIDER OR SUPPLIER		203		SS, CITY, STATE, ZIP CODE STREET 46952		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CRC	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	termination of ce	the new hires and of ertain agency staff. The licated she was unaware and termination of I this meeting.					
	employee C presorientation check confidentiality of consents from no 3. All document 10/29/13 (at time co-signed by the indicated she new before signing ar instructed her on orientation with	c lists, and f client information on-employees 1, 2, and s were signed and dated e of survey) and administrator who wer read the contracts and that employee A had 10/29/13 to complete the consultants.					
	documents provi administrator on employees #1 an	of undated agency ded by the 10/30/13 evidenced d #3 have access to the nic medical record					
	the administrator non-employee #1 electronic medic initially on 10/18 dates of 10/22 to non-employee has	had accessed the al record system 8/13 and between the					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		157652	B. WIN	G		10/31/	2013
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					2ND STREET		
HOME H	EALTH CARE ASS	OCIATES INC		MARIO	N, IN 46952		
(X4) ID	SUMMARY S	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	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	medical records.						
		policy with a review date					
		Contract Personnel"					
	· ·	L INSTRUCTIONS					
		ring services to agency					
	clients, all contra	act personnel shall					
	receive an orient	ation to the agency's					
	client care polici	es and procedures and					
	applicable person	nnel requirements. 4.					
	Professional pers	sonnel under contract					
	with the agency	to provide professional					
		ve complete personnel					
	files available fo	r the agency upon					
		uals who contract					
	_	the agency will have a					
	1	nel file in the agency					
	which includes r	• •					
		tions, mantoux/health					
		ther documentation					
	required by the a						
	required by the a	gency					
	On 10/2	9/13 at 4:21 PM, the					
		licated there was no					
		umes, or criminal					
	~	eks conducted for					
	non-employees 1	, 2, and 3.					
	4 0 10/20/22	4 4 05 PM 6 4					
	4. On 10/29/13 a	·					
		licated she did not know					
	_	access the agency's					
	personnel files sy	ystem.					
		. (15 D) (
	5. On 10/31/13 a	at 6:15 PM, employee					

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	DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CO	DRRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157652	B. WING		10/31/2013
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVII	DER OR SUPPLIER			2ND STREET	
HOME HEALT	TH CARE ASSO	OCIATES INC		N, IN 46952	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG I	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
ind	licated she and	etor of Nursing, the nurse managers			
	did not have assess to the aide visit notes				
		tion completed by the			
aid	les was in a tele	ephony system and			
mu	st be imported	by the office employee			
	o had the pass				
	•				
N000447 410) IAC 17-12-1(c)(4)			
	me health agen				
	ministration/mar				
		(4) The administrator,			
	, , ,	he supervising physician			
		e required by subsection			
(d),	, shall do the fol	lowing:			
· ,	Ensure the acc	• •			
info	ormation materia	als and activities.			
Bas	sed on agency	document review and	N000447		11/30/2013
inte	erview, the age	ency failed to ensure			
		ensured the accuracy			
		ation materials with the			
		t all current and future			
pat	ients of the ag	ency.			
 Fin	ndings include:				
	<i>G</i>				
1	Agency docum	nent titled "Home			
		ociates, Inc. Current			
	um Care ASSU	oraco, mo. Current			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157652	B. WIN	IG		10/31/	2013
NAME OF F	ROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					2ND STREET		
HOME H	EALTH CARE ASS	OCIATES INC		MARIO	N, IN 46952		
(X4) ID	SUMMARY S	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	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	Organizational C						
physical therapy, occupational therapy,							
	physical therapy						
	occupational therapy assistant in the						
	organizational structure.						
	2. On 10/29/13 during survey entrance						
	conference, employee C indicated the						
	agency did not provide or contract for				1 The current Administrator ha	IS	
	therapy services.						
		ent Handbook &					
		ome health care"			mandani all amamani muhlia		
		SCOPE OF SERVICE			review all agency public information		
		re Associates, Inc., is a			mormation		
	state licensed an	d medicaid certified					
	home health age	ncy Skilled nursing					
		y Occupational Therapy					
	The scope of s	service for Home Health			materials for accuracy. The		
	Care Associates	includes part time or			agency		
	intermittent skill	ed nursing and therapy					
	services"						
	4. Agency brock	nures evidenced physical					
	and occupationa	l therapy as services			brochures, organizational char	t,	
	provided by the	agency.					
	5. On 10/30/13	at 9:38 AM, employee					
	C indicated bein	g unaware the					
	organization cha	rt included therapy					
	services and indi	cated being unaware all					
	agency public in	formation brochures					
	included this info	ormation also.					
							l

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		157652	B. WING		10/31/2013	
NAME OF D	ROVIDER OR SUPPLIE		STREET	ADDRESS, CITY, STATE, ZIP CODE	-	
				V 2ND STREET		
HOME HE	EALTH CARE ASS	SOCIATES INC	MARIC	N, IN 46952		
(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	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
				client handbooks, and the Ho	me	
				Health Care Associates Web		
				site has all been amended an	d	
				approved by the administrate	_	
				approved by the administrator		
				for the appropriate scope of		
				lor the appropriate scope of		
				service being advertized.		
				23. 1100 23111g da 1011120d.		

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		IDENTIFICATION NUMBER: 157652	A. BUIL B. WINC	DING	00	COMPL 10/31/	ETED
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 2ND STREET		-
номе н	EALTH CARE ASS	OCIATES INC	MARION, IN 46952				
(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)	ΤE	(X5) COMPLETION DATE
		·			2 The administrator and the		
					board of directors will review		
					and approve any changes to tl	ne	
					public info material in the		
					future.		

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PRINTED: 01/22/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 157652	A. BUILDING B. WING		COMPLETED 10/31/2013	
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE		
HOME H	EALTH CARE ASS	OCIATES INC	MAR	ION, IN 46952		
(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 APPROPR DEFICIENCY)	сО	(X5) MPLETION DATE
				This will be monitored by the		
				administrator and board of		
				directors.		

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		IDENTIFICATION NUMBER: 157652	A. BUII B. WIN	LDING	00	COMPL 10/31/	ETED
	ROVIDER OR SUPPLIER			2038 W	ADDRESS, CITY, STATE, ZIP CODE ZND STREET N, IN 46952		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
N000460	records of the supunder subsection (1) Be kept currer (2) Include a copy (A) Limited crimir 16-27-2. (B) Nursing licens (C) Annual perfor (D) Documentation Performance evaluates subsection must be (9) to fifteen (15) in employment. Based on personnicy review, the ensure personnel documentation of in 1 of 9 personnics (employee C) Findings include 1. Personnel file of hire 4/18/11, of description dated "Position: Admirifailed to evidence 2. The agency personner (2) The agency personner (2) The agency personner (3/1/13 titled "Istates," POLICY	ragement As follows, personnel ervising nurse, appointed (d) of this rule, shall: In of the following: In history pursuant to IC Is e. Imance evaluations. In of orientation to the job. It is performed every nine months of active In el file review and e agency failed to records included for orientation to the job el files reviewed. In orientation to the job el files reviewed date el fil	N00	00460	1 The Board of Directors has orientated the new Administrator to her roand this will be the case in the future should need be. All personnel files has been reviewed for completeness, specifically checklist, and all are complete this time. 2 The	re ve	11/30/2013

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PRINTED: 01/22/2014 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		157652	B. WING		10/31/2013
	PROVIDER OR SUPPLIE		2038 V	ADDRESS, CITY, STATE, ZIP CODE V 2ND STREET NN, IN 46952	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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
	management of services, will participate in an orientation program specific to his/her educational background, experience, position in the agency, and the roles and responsibilities as an employee of the agency."		Board of Directors will utilize the New Administrator checklist to complete orientation. All		
			personnel are evaluated using an orienta	ation	
				checklist at this time. Each personnel	
				file will be audited for completeness	
				prior to the employee starting	
				employment. Monthly an audi	
				files to ensure completeness.	
				Board of Directors	

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AND PLAN	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		2038 W	ADDRESS, CITY, STATE, ZIP CODE V 2ND STREET N, IN 46952 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) TE (X5) COMPLETION DATE
N000484	services shall mair communications to appropriately comsupport the object. The means of corresults shall be do record or minutes. Based on clinical interview, the agpersonnel commaware of and inforcequired to meet of 11 clinical record the potential to a the agency. (#1 a Findings include 1. Clinical record physician's plan of certification periodication periodication periodication to ensure coordinated and care.	All personnel providing nation effective assure that their efforts plement one another and lives of the patient's care. Inmunication and the cumented in the clinical of case conferences. It record review and ency failed to ensure all unicated so they were ormed of the services the patient's needs in 2 ords reviewed creating effect all 81 patients of and #6) It included a for care for the fold 8/16 to 10/14/13 willed nursing and home eyes. The record failed the services maintained their efforts were supported in the plan of eal record contained a 8/15/13 from the	N000484	1 All RN Case Managers, and newly formed administions tea which consists of the DON, Administrator, ADON, the appropriate sched for the particular area, and the Administrative Secretary have been in-servicion coordination of care. The DON her designee will take the initial	am, uler ed

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157652		LDING	00	(X3) DATE SI COMPLE 10/31/2	TED	
	ROVIDER OR SUPPLIER		2038 W	ADDRESS, CITY, STATE, ZIP CODE 2 2ND STREET N, IN 46952	•	
(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
	evaluation for sk physical therapy	•		referral		
	employee B (altenursing) indicate	d she was unaware had been requested in		and meet with the adminisions team who will screen the potential of		
	C. On 10/30/13 at 11:20 AM, employee N (registered nurse-patient case manager) indicated she had never seen the written physician's order for physical therapy evaluation. 2. Clinical record #6 included a physician's plan of care for the certification period 10/2 to 11/30/13 with orders for skilled nursing and home health aide services. The record failed to evidence all the services maintained liaison to ensure their efforts were coordinated and supported in the plan of care.			their particular needs and the agencies ability to be able to meet those needs or	€	
				make a referral in a timely mato ensure coordination of care for the client. 2 Quality assuranse nurse will screen	r	
	document titled 'states, "Referral B. On 10/30	cal record contained a "Patient Profile" that Date: 09/26/2013."		new orders to ensure the ager meets the appropriate scope of service for the		
	staff) and reques services from the	ng to employee E (office ting home health care agency beginning in d not start receiving		client or the need for referral a the coordination of care with that	and	

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		157652	A. BUILDING B. WING		10/31/2013
NAME OF I	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	•
	EALTH CARE ASS			V 2ND STREET DN, IN 46952	
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	services until Oc	tober 2013.		additional	
	C. On 10/31 employee B indithe date of the in agree there was on the D. On 10/31 employee E indicates	2/13 at 10:05 AM, cated being unsure of itial referral but does one. 1/13 at 11:36 AM, cated taking the first over the summer but		additional referral source. The individual client RN Case Managers will every 3 days or if a change occurs hold a care conference with all care givers of the client and will also case conference with the DON or his/her designee. The DON will oversee the coordination of care program.	o e ent

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		157652	B. WIN	G		10/31/	2013
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HOME H	EALTH CARE ASS	OCIATES INC			/ 2ND STREET N, IN 46952		
					14, 114 40002		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
N000508	410 IAC 17-12-3(b	LSC IDENTIFYING INFORMATION)		TAG	BEI ICIENCI)		DATE
11000300	Patient Rights)(Z)(L)					
	Rule 12 Sec. 3(b))(2)(E)					
	(b) The patient h	as the right to exercise his					
	or her rights as a patient of the home health agency as follows: (2) The patient has the right to the						
	following:	as the right to the					
	(E) Confidentiality of the clinical records						
maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and							
	procedures regarding disclosure of clinical records. Based on observation, agency document						
			N00	00508			11/30/2013
		v, and interview, the					
	agency failed to						
		f the clinical records					
	-	n 33 patient records					
		ntial to affect all 81					
		gency. (#1, 4-7, 9-11,			1 Credentials are required to v	view .	
	13-37)	(iii, 4 7, 5 11,			protected health information		
	13-37)				protected health information. Upon		
	Findings include						
	r manigs merade.	•			hire or contracted individiuals	are	
		y with a review date of			issued credentials with the		
	3/1/13 titled "Cli	nical records / medical					
	record retention	PROTECTION OF					
	RECORDS: 1. (Clinical record			appropriated level of access. I	n	
	information shall	be safeguarded against			order		
	loss or unauthoris	zed use. 2. Protected					
	health information	on will be available only			to get credentials, the		
	to those who mus	st use it. Procedures			Administrator		
	will be followed	to assure that this			or his/her designee must fill ou	ut	
	information is pr	otected, and consents or			and		
	authorizations are	e signed before					
	information is rel	•			sign a user request form, givin	ıg	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157652	B. WIN	G		10/31/	2013
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUFFLIER			2038 W	2ND STREET		
	EALTH CARE ASS	OCIATES INC		MARIO	N, IN 46952		
(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' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	·		DATE
					the		
		9/13 at 9:40 AM,			employee or contracted individ	lual	
	employee J (office staff) indicated there						
was a new employee (non-employee #1),				authorization to view protected	I		
	but she did not know his job title.				health		
					information. The user request		
	B. On 10/29	0/13 at 10 AM, employee			form is		
	C indicated non-	employee #1 was not					
	employed with the agency.				then forwarded to the IT Direct	tor;	
	C. On 10/29/13 at 4 PM,				credentials are generated and given		
	non-employees #1, #2, and #3 were				given		
	observed standing behind a desk at the				to the authorized individual wh	0	
		next to the copier,			may		
	"	ntified paperwork.					
	<i>y</i>	r or			need to view protected health		
	D. On 10/29	9/13 at 4:10 PM,					
		cated that non-employee					
		with the agency as a	information.				
		bb entitles him to review			2 The Director of IT will perform	~	
	_	s of care after the			2 The Director of H will perion	11	
	1 -	prepares it and returns it			monthly audits of credentials		
	back to the regis	• •			-		
	corrections are n				master list and remove any		
					individuals who are no longer		
		licated non-employees			individuals who are no longer		
		passwords and have			contracted.		
		ent records through the					
		c medical record system			Administrator will review the		
	and has had this access since around the				master list audit and will		
	18th of October when a meeting was				master hat addit and will		
	conducted by the agency owner /						
	alternate administrator / director of						
		ee A) informing the			present the findings at the		
	administrator of	the new hires and of					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	(X3) DATE SI COMPLE	
		157652	A. BUILDI B. WING	NG		10/31/2	2013
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			2ND STREET		
HOME H	EALTH CARE ASS	OCIATES INC			I, IN 46952		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	1	ΓAG	DEFICIENCY)		DATE
		ertain agency staff. The					
		licated she was unaware			quarterly PAC meeting.		
		and termination of					
	agency staff unti	I this meeting.					
	On 10/2	9/13 at 4:21 PM,					
		ented with contracts,					
	orientation check	· ·					
	confidentiality of client information consents from non-employees 1, 2, and				Administrator will be responsib	ole	
	3. All documents were signed and dated						
	10/29/13 (at time of survey) and						
	co-signed by the administrator whom						
		ver read the contracts					
		nd that employee A had					
		10/29/13 to complete					
	orientation with	•					
	orientation with	the consultants.					
		ion on 10/30/13 at 9:12					
		computer in the office					
	I	ction with the agency					
	login page on the						
	contained non-er	nployee #1's sign-in					
	credentials.						
	F. Review of	of agency documents					
	provided by the	• •					
	1 -	ced non-employees #1					
		ess to the agency's					
		al record system.					
		1					
		documents presented by					
	the administrator						
	non-employee #	l had accessed the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 157652		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/31/2013	
	PROVIDER OR SUPPLIER		STREET 2 2038 W	ADDRESS, CITY, STATE, ZIP CODE / 2ND STREET N, IN 46952	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	dates of 10/22 to non-employee ha 4, 5, 6, 7, 9, 10, 1 medical records.	1/13 and between the 10/28/13. The ad accessed patient's #1, 11, and 13-37 electronic			
	packet contained titled"Patient Har for home health of of Rights and Re patient has the fo The patient has the confidentiality of	ndbook & Orientation care" states, "Client Bill sponsibilities The llowing rights: 17.			
N000520	health needs can l home health agen	Patients shall be			
	review, and inter	record review, policy view, the agency failed r services were able to	N000520	All RN Case Managers, an the newly formed admissions team, which consists of the D Administrator, ADON, the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157652		(X2) MUL A. BUILD		NSTRUCTION 00	(X3) DATE S	ETED	
		157652	B. WING			10/31/	2013
	PROVIDER OR SUPPLIER			2038 W	DDRESS, CITY, STATE, ZIP CODE 2ND STREET I, IN 46952		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	records reviewed to affect all 81 pa (#1) Findings include 1. Clinical recorphysician's plan of the certification pwith orders for slinealth aide service contained a document from the patient's evaluation for skiphysical therapy 2. On 10/30/13 and B (alternate directing indicated she was therapy had been physicians order. 3. On 10/30/13 and N (registered numenager) indicate the written physitherapy evaluation 4. On 10/29/13 and entrance conference.	d #1 included a of care established for period 8/16 to 10/14/13 killed nursing and home ces. The clinical record ment dated 8/15/13 s primary physician for illed nursing and services. at 10:10 AM, employee ctor of nursing) s unaware physical a requested in the at 11:20 AM, employee rese-patient case ed she had never seen cians order for physical on. at 9 AM during survey nce, employee C ncy did not provide or			appropriate scheduler for the particular client area, and the Administrative Secretary have been in-serviced on coordination of care. The DON or her/his designee will take the initial referral and meet with admissing team who will screen the poter client for their particular needs and the agencies ability to be to meet those needs or make referral in a timely manor to ensure coordination of care for the client and that the client get the appropriate service ordered the appropriate service ordered the agency meets the appropriscope of service for the client the need for referral and the coordination of care with that additional referral source. The individual client RN Case Managers will every 30 days, a change occurs, hold a care conference with all care givers the client and will also case conference with the DON or his/her designee.3. DON	ons ons ntial able a r ets d.2. vill re iate or	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157652			LDING G	ONSTRUCTION 00 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE : COMPL 10/31/	ETED	
	PROVIDER OR SUPPLIER EALTH CARE ASS		2038 W 2ND STREET MARION, IN 46952				
(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)	ATE	(X5) COMPLETION DATE
N000522	a written medical pand periodically redentist, chiropracto podiatrist, as follows Based on clinical review, and interto ensure visits won the plan of carecords reviewed to affect all 81 pate (#4-8) Findings include 1. Clinical recording the cordinal	Medical care shall follow blan of care established viewed by the physician, or, optometrist or ws: record review, policy view, the agency failed were provided as ordered re in 5 of 11 clinical creating the potential atients of the agency.	NOO	00522	The RN Case Managers habeen in-serviced on missed visit shand how to fill them out and report the	neet	11/30/2013
	states, "21. Order treatments: HHA visit Frequency. day] x 5days/wk weeks + 5hrs/day to assist w/per [activities of dail record failed to ehealth aide visit to 10/18/13). On 10/31/13 employee B (alternal treatments of the state of the	ers for discipline and A [home health aide] 5hrs/day [hours per [days per week] x 8 v x 4 days/wk x 1week sonal care/ADLs y living]" The vidence a fifth home for week 4 (10/13 to			missed visit to the MD. 2.The quality assurance staff audit patient schedules against the POC on a weekly basis to ensure vare completed according to the POC.	isits	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		157652	B. WIN			10/31/	2013
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	EALTH CARE ASS		2038 W 2ND STREET MARION, IN 46952				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		I		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	home health aide	visit on 10/17/13 but					
	was unable to locate documentation of				The audit well be completed w	vith .	
	why the visit was				а		
	,				schedule auditing tool develop	ned	
	2 Clinical recor	d #5, start of care			by	,cu	
	7/11/13, included a plan of care for the						
	· ·	od 9/9/13 to 11/7/13			the agency.		
	that states, "21 HHA visit frequency				The DN case managers have		
	4hrs/day x 7 days/wk x 9 weeks to				The RN case managers have been		
	assist w/personal care/ADLs" The						
	record failed to evidence home health				instructed to notify the the DO	N of	
	aide visits were made for week 4						
					any change in services.		
	(10/2/13), week 5 (10/10/13), and week				The ADON will also be receivi	na	
	6 (10/13/13).				а	5	
	Om 10/21/12	at 12:04 DM applayed					
		at 12:04 PM, employee were missed home					
					copy of all new MD orders for		
	health aide visits				review.		
	2 Clinical recor	d #6, start of care			T. 450M		
		d #0, start of care d a plan of care for the			The ADON will provide the DC	Ν	
		-			with monthly report.		
	-	od 10/2 to 11/30/13 that			,		
		ers for discipline and A visit frequency			The Administrator also recieve	es a	
		2 2			weekly report on missed visits		
		/wk x 9weeks " The lone home health aide			weekly report on missed visits		
	visit for week 1.	one nome nearth aige			from the previous week.		
	visit for week 1.						
	On 10/21/12	at 10:50 AM ammlayes					
		at 10:50 AM, employee					
		was only one visit					
	made for week 1	•					
	4 (21: 1	1 1/7			Administrator 20		
		d #7, start of care			Administrator will ensure monitoring		
	10/11/13, include	ed a plan of care for the			monitoring		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	
		157652	B. WING		10/31/	2013
NAME OF I	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COD	Е	
NAME OF I	KOVIDEK OK SOIT EIEF		2038 W	/ 2ND STREET		
HOME H	EALTH CARE ASS	OCIATES INC	MARIO	N, IN 46952		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		od 10/11 to 12/9/13 that				
	-	ers for discipline and				
	treatments: SN [skilled nursing] visit					
	frequency 1 x 2	wks x 9wks for med set				
	up and sup visits	, monthly for diabetic				
	foot care, and q [every] 60 days for					
	recerts HHA visit frequency 2					
hrs/day x 3 days/wk x 9 weeks " The						
record evidenced a skilled nursing visit						
on 10/11/13 and 17 days later on						
10/28/13. The record evidenced no						
	home health aide visits for week 1, one					
		and one visit for week				
	3.					
	On 10/31/13	at 11:38 AM, employee				
	B indicated these	e visits were not made				
	according to the	plan of care.				
	Clinical recor	d #8, start of care				
	10/21/13, include	ed a plan of care for the				
	certification peri	od 10/21 to 12/19/13				
	that states, "21.	Orders for discipline				
	and treatments:	HHA visit frequency				
	2hrs/day x 3 d	ays/wk x 9 weeks "				
	_	enced a missed home				
	health aide visit	for week one.				
	On 10/31/13	at 4:45 PM, employee				
	B indicated docu	mentation of the missed				
	visit could not be	e located.				
	(A					
		y with a review date of				
	3/1/13 titled "Mi	ssed Visit Policy"				

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 27 of 43

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		157652	B. WING		10/31/2013	
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
	NO TIDEN ON SOLI EIEN		2038	W 2ND STREET		
HOME H	EALTH CARE ASS	OCIATES INC	MAR	RION, IN 46952		
(X4) ID	SUMMARY ST	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	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	states, "Policy Ca	are provided to client by				
	all disciplines wi	ll follow established				
	plan of care."					
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				
	skilled service is b	~ .				
(B) Cover all pertinent diagnoses.						
(C) Include the following: (i) Mental status.						
	` '	s. vices and equipment				
	required.	vioce and equipment				
	-	nd duration of visits.				
	(iv) Prognosis.					
	(v) Rehabilitatio					
	(vi) Functional lir(vii) Activities per					
	(viii) Nutritional re					
	· '	and treatments.				
	(x) Any safety r	measures to protect				
	against injury.					
	(xi) Instructions referral.	for timely discharge or				
		dalities specifying length of				
	treatment.	admice opeonying length of				
	(xiii) Any other ap	propriate items.				
	Based on clinical	record review, policy	N000524		11/30/2013	
	review, and inter	view, the agency failed				
	· ·	n of care included any				
	diagnoses, any di	-				
		oplies needed, the				
	patient's functional limitations and					
	activities permitted in the home,					
	allergies, any safety measures in the			All BOO have the service of the serv		
		sciplines ordered to		All POC have been audited a this	IL	
	mome, and me dis	scipinies oracica to		4110		

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 28 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		157652	B. WIN			10/31/2013		
NAME OF B	DOLUDED OD GLIDDLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIEF	C		2038 W 2ND STREET				
	EALTH CARE ASS		_		N, IN 46952			
(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' DEFICIENCY)			
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE		
	*	ealth services with						
	frequency and duration in 1 of 11							
		reviewed creating the			time for completeness. All Cas	ie e		
	potential to affect all 81 patients of the							
	agency. (#2)				Managers			
	Findings include: 1. Clinical record 2, start of care 2/27/13, included a plan of care dated 10/25/13 through 12/23/13 signed by the				have been in-serviced on the			
					completeness			
					and timeliness of all POCs.			
					2.Quality assurance staff will			
	director of nursing and dated 10/23/13				audit			
		e any diagnoses, any			addit			
		equipment or supplies			every plan of care before it is s	sent		
	needed, the patie				to			
		ctivities permitted in						
		ies, any safety measures						
		the disciplines ordered			the physician for a signature to	,		
	•	•			ensure			
	-	health services with						
	frequency and du	uration.			the plan of care covers all			
	, mi				pertinent			
		ord evidenced employee			diagnosis, mental status, requi	ired		
	-	ices on $10/25/13$ and the						
	agency's aide sch				equipment, frequency of visits	,		
		to provide services on			progranic robob notontial			
	October 29, 30, 3	31, 2013.			prognosis, rehab potential, nutritional			
	_							
		9/13 at 1:30 PM, during			requirements, medications, an	d		
		view with the patient on						
	10/29/13 at 1:30	•						
	indicated employee K provided aide services, including bathing assistance,				treatments, safety measures,			
					a saumonto, outory moudairos,			
	Monday through	Friday 9 AM to 4 PM.			instruction			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157652	(X2) MUL A. BUILD B. WING		00	(X3) DATE S COMPL 10/31/	ETED
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
HOME H	EALTH CARE ASS	OCIATES INC	2038 W 2ND STREET MARION, IN 46952				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) /13 at 6:15 PM,		ID REFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) for discharge, and other appria		(X5) COMPLETION DATE
employee B indicated the record did not include orders for aide services and the current plan of care was not complete.				items. Quality assuranse staff be trained, and audit tool will be			
	3/1/13 titled "Pla" "SPECIAL INST plan of care shall include: a. all per principle and sec of onset. b. men frequency, and divisits/services. cand modalities for functional limitary. activities perm m. medical supported in any protect against in	I. specific procedures or therapy services i. tions and precautions. iitted or restrictions lies and equipment safety measures to ajury u. all of the t always be address on			developed. The training and audit tool will give quality assurance staff the abil to assist agency efforts in developing complete plans of care. The DON will monitor and present the findings at the quarterly PA	ity	
N000540	services are limite purposes of practi setting, the registe following:						

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 30 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURV	EY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		157652	B. WIN			10/31/2013	3
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L.			/ 2ND STREET		
HOME H	EALTH CARE ASS	OCIATES INC	MARION, IN 46952				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		MPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	Based on clinical record review, policy		N00	0540		11/	/30/2013
	review, and interview, the agency failed						
	to ensure the reg	istered nurse completed					
	the initial assessi	ment visit within 48					
	hours of referral	as required by agency					
	policy in 3 of 11 clinical records reviewed creating the potential to affect all new patients. (#6, 8, and 11) Findings include: 1. Clinical record #6, start of care						
					1. The admission RN's have been		
					educated on the timeliness of		
					making the initial client		
					assessment.		
					They have been instructed that	t if	
		evidenced a referral to			it		
	home care dated						
		ssessment on 10/2/13.			necessary to put off the		
	•	to evidence an initial			assessment		
					neet 40 hours, thou are to mal		
		completed within 48			past 48 hours, they are to make	e a	
	hours of the refer	-			note on the client profile page	as	
	immediate care r	needs.					
					to why this is.		
	On 10/31/13	at 10:05 AM, employee					
	B indicated the p	physician was notified					
	on 9/30/13 for or	ders and the initial			2. The quality assurance		
	assessment was i	not completed within 48			2. The quality assurance		
	hours of the refe	-			staff will review all new		
					admissions		
	2 Clinical recor	rd #8, SOC 10/21/13					
		rral to home care dated			for timeliness of assessment a	nd	
	10/9/13 and a co						
		•					
		0/21/13. The record			will forward the results on to the	ie	
		e an initial assessment					
	•	vithin 48 hours of the			DON or his/her designee. If the	e	
		fy immediate care					
	needs.				assessments are not done tim	aly	

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 31 of 43

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157652	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/31/2013		
	PROVIDER OR SUPPLIER HEALTH CARE ASSOCIATES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2038 W 2ND STREET MARION, IN 46952				
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	On 10/31/13 at 12:07 PM, employee B indicated the agency did not complete		and no reason is listed why, the DON will give disciplinary acti			
	the initial assessment within 48 hours of the referral.		The DON will present the find			
	3. Clinical record #11, SOC 9/12/13		the PAC quarterly.			
	evidenced a referral to home care dated 9/6/13 and a comprehensive assessment on 9/12/13. The record failed to evidence an initial assessment was completed within 48 hours of the referral to identify immediate care needs.		DON			
	On 10/31/13 at 5:30 PM, employee B indicated the agency was waiting on physician orders for services and did not complete the initial assessment within 48 hours of the referral.					
	4. Agency policy with a review date of 3/1/13 titled "Client Admission Process" states, "SPECIAL INSTRUCTIONS 7. Each client referred to the agency shall be evaluated by a registered nurse/therapist to determine the immediate care and support needs of the client The initial assessment will be completed within forty-eight (48) hours of referral or within forty eight (48) hours of the client's return home, or on the physician ordered/client requested					
	nurse/therapist to determine the immediate care and support needs of the client The initial assessment will be completed within forty-eight (48) hours of referral or within forty eight (48) hours of the client's return home, or on					

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 32 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		157652	B. WIN			10/31/	2013
			D. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	2ND STREET		
HOME HI	EALTH CARE ASS	OCIATES INC		l	N, IN 46952		
	LALTIT CARL AGO	OCIATES INC		WAINO	N, IN 40932		
(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 APPROPRIAT	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N000606	410 IAC 17-14-1(r	•					
	Scope of Services						
		A registered nurse, or y only cases, shall make					
		ne patient's residence and					
		ry visit at least every thirty					
		hen the home health aide					
	is present or abse	nt, to observe the care, to					
assess relationships, and to determine whether goals are being met. Based on clinical record review, policy							
		_					
		l record review, policy	N00	00606	1 All PN case managers have		11/30/2013
	review, and inter	view, the agency failed			All RN case managers have	;	
	to ensure the reg	istered nurse made an			been inserviced on the		
	on-site visit to the patient's home no less frequently than every 2 weeks as				supervisory		
		cy policy for patients			visit policy. All supervisory visi	ts	
		and home heath aide					
					are being monitored on a weel	kly	
	services in 2 of 9	-			schedual.		
	•	ent receiving skilled			Scriedual.		
	•	e health aide services					
	-	y 30 days in 1 of 1					
	record reviewed	of patients receiving			2 The quality assurance nurse	will	
	home health aide	only services creating					
	the potential to a	ffect all 74 patients of			do a weekly audit for the previ	ous	
	-	ving home health aide					
	services. (#2, 7, a	•			weeks supervisory visits to		
	Ser vices. (112, 1, t	and 11)			ensure		
	E' 1' ' 1 1				they are done timely. If any		
	Findings include	•			and the series amony. It dily		
					violation of the policy is found		
		d #7, start of care					
	•	ed a plan of care with			the DON will be notified and		
	physician orders	for skilled nursing				_	
	services and hom	ne health aide services			disciplinary action will be giver	1.	
	for certification period 10/11 to 12/9/13.						
	•	enced a skilled nursing					
		on 10/11/13 and 17					
	supervisory visit	011 10/11/13 allu 1/					

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 33 of 43

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION		A. BUILDING	00	COMPLETED		
		157652	B. WING		10/31/2013		
NAME OF I	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP CODE			
LIOMETI	EALTH CARE AGO	OCIATEO INO	2038 W 2ND STREET				
HOME H	EALTH CARE ASS	OCIATES INC	MARIO	ON, IN 46952			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION			
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE		
	1 -	28/13. The record					
		e a supervisory visit					
	was made by the registered nurse within			DON			
	14 days.						
	On 10/31/13 at 11:38 AM, employee						
B indicated there should have been a							
supervisory visit made on or before							
	October 25, 2013.						
	2. The agency p	olicy with a review date					
	of 3/1/13 titled "Clinical Supervision"						
	states, "SPECIA"	L INSTRUCTIONS					
	3. A registered 1	nurse is available					
	whenever home	health aide services are					
	provided. Home	Health aide services					
	•	very two weeks or as					
	_	/federal regulations."					
	3. Clinical recor	d 11, Start of Care					
		ed a plan of care dated					
		11/10/13 with orders					
		ng and home health aide					
		cord indicated aide					
		ovided and began on					
	_	cord failed to evidence a					
	-	pervisory visit was made					
		period of more than 14					
	days.						
	4 01: 1	10.00000000000					
		rd 2, SOC 2/27/13,					
	_	of care dated 8/24/13					
	_	3 with orders for home					
	health aide servi	ces only. The record					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 157652		A. BUILDING B. WING	00	COMPLETED 10/31/2013				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2038 W 2ND STREET MARION, IN 46952					
(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)	(X5) COMPLETION DATE			
	conducted a supe thirty days. The supervisory visits	e a registered nurse ervisory visit every record evidenced is were made on 9/10/13 eriod of more than 30						

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 35 of 43

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			nstruction 00	(X3) DATE : COMPL	
		157652	A. BUILI			10/31/	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				2ND STREET		
HOME H	EALTH CARE ASS	OCIATES INC			N, IN 46952		
(X4) ID	SUMMARY ST	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 APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
N000608	findings in accordar professional stand for every patient at (1) The medical appropriate identifical (2) Name of the chiropractor, podia (3) Drug, dietary orders. (4) Signed and docontributed to by a Clinical notes shall is rendered and in (14) days. (5) Copies of surperson responsible component of the (6) A discharge shased on clinical review and intervito ensure clinical incorporated into within 7 days as a policy in 5 of 11 reviewed and all signed by the per assessment in 1 ocreating the potential agency's patients Findings included 1. Clinical records	Clinical records Int past and current Ince with accepted Ince Ince Ince Ince Ince Ince Ince Ince	N000	0608	1 All staff have been in-service on timely charting and signing of documentation. All documer are currently caught up in the system and the office manage has been made responsible to make	nts r	11/30/2013

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		(X2) MULTIPLE CO		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 157652	A. BUILDING	00	COMPLETED 10/31/2013			
		101002	B. WING					
NAME OF F	ROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP CODE	į			
HOME HEALTH CARE ASSOCIATES INC				V 2ND STREET DN, IN 46952				
				/ I I TOOJA				
(X4) ID PREFIX	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL				
TAG			PREFIX TAG	CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE COMPLETION DATE			
		t available for review on		sure that all flow sheets ha				
	the electronic medical record.			been				
	the electronic in	curcui record.						
	The physicia	an's plan of care for		up loaded and signed time	ely.			
		od 8/16 to 10/14/13		2 An audit has been put in	n place			
	-	for home health aide			·			
		per day times 2 days per		monthly to make sure all				
		s and 7 hours per day		documentation				
		week times 8 weeks.		has been placed in the clie	ent			
				chart				
	2. Clinical recor	rd #5, on 10/31/13 at		timely				
		visit notes from 9/9/13		timely.				
	· · · · · · · · · · · · · · · · · · ·	le for review on the						
	electronic medic	eal record.						
	The physicia	an's plan of care for						
	certification peri	fod 9/9 to 11/7/13						
	_	for home health aide		Administrator				
	services 4 hours	per day times 7 days per						
	week.							
	3. Clinical recor	rd #9, on 10/30/13 at						
	4:30 PM, aide vi	isit notes from						
	_	od 8/19/13 through						
	10/15/13 were no	ot available for review						
	on the electronic	e medical record.						
		an's plan of care for						
	_	od 8/19 to 10/15/13						
		for home health aide						
		per day times 7 days per						
	week.							
	4. Clinical recor	rd #10, on 10/30/13 at						

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
		IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		157652	B. WING			10/31/	2013
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
HOME HEALTH CARE ASSOCIATES INC					2ND STREET N, IN 46952		
					N, IIN 40902		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG				TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
		sit notes from start of					
	· ·	present were not					
		iew on the electronic					
	medical record.						
	The physicia	an's plan of care for					
	certification peri	od 10/13 to 12/1/13					
	contained orders	for home health aide					
	services 8 hours	per day times 5 days per					
	week.						
		d #11, on 10/30/13 at					
	· ·	sit notes from start of					
	care 9/12/13 to p						
	available for review on the electronic						
	medical record.						
	The physicis	an's plan of care for					
		od 9/12/13 to 11/10/13					
	_	for home health aide					
		per day times 3 days per					
	week.	per day times 3 days per					
	6. On 10/30/13	at 9:15 AM, employee F					
	(office staff), inc	licated the home health					
	aide visit notes a	re done by an					
	automated teleph	none system when the					
	aide is at the patient's home at which						
	time the visits become available for						
	viewing on the c	omputer and then can					
	be uploaded into	patient charts. The					
	employee indica	ted not having enough					
	time to upload al	Il documents into the					
	patient charts an	d is aware some visits					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		157652				10/31/	2013
			B. WIN		DDDEGG CITY GTATE TID CODE		
NAME OF F	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
					2ND STREET		
HOME H	EALTH CARE ASS	OCIATES INC		MARIO	N, IN 46952		
(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
	notes are over 30	days.					
		3					
	7. The agency p	olicy with a review date					
	of 3/1/13 titled '	-					
		' states, " SPECIAL					
		S 5. Documentation					
		ed on the plan of care					
	will be complete	d the day service is					
	rendered and inc	orporated into the					
		ithin seven (7) days					
		been provided. "					
	arter the care has	s been provided.					
	8. Clinical recor						
	recertification as	sessment dated 8/22/13.					
	The assessment	filed to evidence the					
		person completing the					
	assessment.						
			1				

State Form Event ID: VP1Q11 Facility ID: 012169 If continuation sheet Page 39 of 43

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00 COMP		COMPL	ETED	
		157652				10/31/	2013
			B. WINC		DDDFGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
	- A - T - L - A - D - A - A - A	0014750 1110			2ND STREET		
HOME H	EALTH CARE ASS	OCIATES INC		MARIO	N, IN 46952		
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
N000614	410 IAC 17-15-1(c	()				•	
	Clinical Records	,					
	Rule 15 Sec. 1(c)	Clinical record					
	information shall b	e safeguarded against					
	loss or unauthorize	ed use. Written					
		govern use and removal of					
		tions for release of					
		nt's written consent shall					
	-	ease of information not					
	_	Current service files shall					
		he parent or branch office rvices are provided until					
		narged from service.					
		ne stored away from the					
	•	office provided they can be					
	_ ·	turned to the office within seventy-two (72)					
		s do not become current					
	service files if the	patient is readmitted to					
	service.	•					
	Based on observa	ation, agency document	N00	0614			11/30/2013
		w, and interview, the					
	agency failed to						
		f the clinical records					
	_	n 33 patient records					
		ntial to affect all 81					
					1 Credentials are required to v	riew	
		ngency. (#1, 4-7, 9-11,					
	and 13-37)				protected health information.		
					Upon		
	Findings include	:			hire or contracted individiuals	oro	
					Time of contracted individuals a	aı C	
	1. Agency policy	y with a review date of			issued credentials with the		
		nical records / medical			Tiere of out and that are		
		PROTECTION OF					
	RECORDS: 1.				appropriated level of access. In order		
		be safeguarded against					
	loss or unauthori	zed use. 2. Protected					
	health information	on will be available only			to get credentials, the		
					Administrator		
		on will be available only st use it. Procedures			to get credentials, the Administrator		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION . DUM DIVIS . DOWN DIVIS . D		(X3) DATE SURVEY COMPLETED			
157652				LDING		10/31/	
		.3.35	B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SUPPLIER				/ 2ND STREET		
HOME H	EALTH CARE ASS	OCIATES INC			N, IN 46952		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		to assure that this	+	TAG			DATE
		otected, and consents or			or his/her designee must fill or	ut	
	authorizations ar	-		and			
	information is re	•	sign a user request form, giving the			ng	
	A On 10/20	9/13 at 9:40 AM,			uic		
		ce staff) indicated there			employee or contracted individ	dual	
	1 5	oyee (non-employee #1),			authorization to view protected health		
	but she did not k	2 2 7					
	B. On 10/29	1/13 at 10 AM, employee employee #1 was not			information. The user request form is		
	employed with the agency.				then forwarded to the IT Direct	tor;	
		1/13 at 4 PM, 1, #2, and #3 were g behind a desk at the			credentials are generated and given to the authorized individual wh		
		next to the copier,		may			
	looking at unider	ntified paperwork.			need to view protected health		
	employee C indi #1 has a contract	0/13 at 4:10 PM, cated that non-employee with the agency as a			information.		
		bb entitles him to review			2 The Director of IT will perfor	m	
	registered nurse	s of care after the prepares it and returns it			monthly audits of credentials		
	back to the regist corrections are n				master list and remove any		
		licated non-employees			individuals who are no longer		
	_	asswords and have ent records through the			contracted.		
		e medical record system			Administrator will review the		
		access since around the when a meeting was			master list audit and will		

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· · · · · · · · · · · · · · · · · · ·		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED
		157652	B. WIN			10/31/2	2013
NAME OF I	DROVIDED OD GLIDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF PROVIDER OR SUPPLIER			2038 W 2ND STREET				
HOME HEALTH CARE ASSOCIATES INC				MARIO	N, IN 46952		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5)
PREFIX				PREFIX			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	1	DATE
	1	e agency owner /					
		strator / director of					
		ee A) informing the			present the findings at the		
		the new hires and of					
		ertain agency staff. The					
		licated she was unaware			quarterly PAC meeting.		
		and termination of					
	agency staff unti	l this meeting.					
	0 10/0	0/40 4.04 . 77 . 5					
		9/13 at 4:21 PM,					
	1 1 1	sented with contracts,					
	orientation check lists, and						
		f client information			Administrator will be responsible	ole	
		on-employees 1, 2, and					
		ts were signed and dated					
	10/29/13 (at time						
		administrator whom					
		ver read the contracts					
		nd that employee A had					
		10/29/13 to complete					
	orientation with	the consultants.					
	·	C 1					
		of agency documents					
	provided by the						
		ced non-employees #1					
		ess to the agency's					
	electronic medic	al record system.					
	Ageney	documents presented by					
	the administrator	_					
		1 had accessed the					
	electronic medic						
		8/13 and between the					
	dates of 10/22 to						
	uates of 10/22 to	10/48/13. THE					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		157652	B. WING		10/31/2013
	PROVIDER OR SUPPLIE		STREET 2038 W	ADDRESS, CITY, STATE, ZIP CODE / 2ND STREET N, IN 46952	1
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
PREFIX	non-employee h 4, 5, 6, 7, 9, 10, medical records 2. The agency p packet contained titled"Patient Ha for home health of Rights and Re patient has the f The patient has confidentiality of	ncy Must be preceded by full R LSC IDENTIFYING INFORMATION) and accessed patient's #1, 11, and 13-37 electronic outlient's admission d a handbook andbook & Orientation care" states, "Client Bill esponsibilities The following rights: 17.	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E COMPLETION

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