PRINTED: 08/21/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	(X2) MU A. BUII B. WIN	LDING	ONSTRUCTION 00	(X3) DATE COMPL 07/23	ETED
NAME OF PROVIDER OR SUPPLIER			1006 W	ADDRESS, CITY, STATE, ZIP CODE /EST MILL STREET SUITE B			
ואטועוטע	JAL SUPPORT HO	ME HEALTH AGENCY		MIDDLE	ETOWN, IN 47356		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT 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 APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
G000000		,					
	This visit was a complaint invest	home health federal tigation survey.	G00	00000			
	No deficiencies	700131673 Substantiated: realted to the allegation arelated deficiency is					
	Survey Dates: J	Tuly 23, 2013					
	Facility # 01110	60					
	Medicaid Vendo	or: 200836920					
	Surveyor: Susar Nurse Surveyor	n E. Sparks, RN, PH					
	Quality Review: RN	: Joyce Elder, MSN, BSN,					
	July 25,	, 2013					

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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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		15K025	B. WIN			07/23/	2013
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/EST MILL STREET SUITE B		
INDIVIDU	JAL SUPPORT HO	ME HEALTH AGENCY			ETOWN, IN 47356		
(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 APPROPRIATE	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
TAG G000158	484.18 ACCEPTANCE C SUPER Care follows a wr established and p doctor of medicine medicine. Based on clinical review and interventer ensure visits wer written plan of carecords reviewed affect all patients  1. Clinical record 3/15/13, with phynurse 1 extended 5 days a week and x 2 days a week and x 12/13.  A. The clinical revidence visits for 5/25, 5/26, 5/27, 6/23, 6/28, 7/8, 7/12/13.  B. On 7/23/	of PATIENTS, POC, MED  itten plan of care periodically reviewed by a e, osteopathy, or podiatric  I record and policy view, the agency failed to re made as ordered on the are in 2 of 5 clinical I with the potential to s. (1, 2 and 3)  dd 1, start of care (SOC) vysician orders for skilled I 8 hour visit a day x (for) red 1 extended 9 hour visit x 9 weeks for 5/14/13 to  cal record failed to or 5/21, 5/22, 5/23, 5/24, 5/29, 6/8, 6/9 6/22, 7/9, 7/10, 7/11, and  13 at 4 PM, the dicated the visits were	G00	TAG 00158	The Administrator and DON had inserviced nursing staff and he health aides on following mediplans of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist. The Administrator at DON has inserviced the nursing staff and home health aides or completion of the Missed Visit Form. The Missed Visit Form documents client name, date of missed visit, type of visit misser reason for missed visit, staff signature, staff discipline, date notification to physician, cc: original to client chart and copy billing. A missed visit form will completed by the clinical staff the time of the missed visit and submitted by the following Monday by 4pm or before to the office. All nursing staff will also document the reason the missed visit form was completed in the Nursing Note effective 7/24/13 and ongoing. The Nursing Assistant will record all service (including the missed visit report on a calendar worksheet for earlier individual client to track all visit	as as ame cal and g a fed, y of be at at at a fe collection and g at at at a feach as a	07/29/2013
		d 2, SOC 2/26/13, with for home health aides for			to ensure compliance with the Plan of Care. On Tuesday by 4pm the Nursing Assistant will		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED
15K025			B. WIN			07/23/2013
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				EST MILL STREET SUITE B	
	JAL SUPPORT HO	ME HEALTH AGENCY			ETOWN, IN 47356	
(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 APPROPRIAT	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1 extended 6 hou	ır visit and 1 - 1 hour			provide a completed tracking	
	visit x 7 days a v	veek for 9 weeks.			calendar worksheet to the nurs	•
					supervisor along with the clien	
	A The clini	ical record failed to			documentation, including Miss Visit Forms for review and	ea
		or the 1 hour evening			submission of all Missed Visit	
		•			Forms to Physician via fax. A	fax
		5/1, 5/2, 5/3, 5/4, 5/5,			confirmation will be obtained a	
		, 5/10, 5/13, 5/14, 5/15,			attached to Missed Visit Form	
	5/16/ 5/17, 5/21,	5/22, 5/23, 5/24, 5/27,			and filed in client clinical record	ds
	5/28, 5/29, 5/30,	5/31, 6/3, 6/4, 6/5, 6/7,			within 48 hours by the Nursing	
	6/9, 6/10, 6/11, 6	5/12, 6/14, 6/15, 6/18,			Assistant. To prevent this is the	
	6/19, and 6/21/1:				future all new staff will be orier	nted
					on following plans of care and	
	D On 7/22/	12 at 4.15 DM tha			completion and compliance regulations and policy and	
		13 at 4:15 PM, the			procedures on Missed Visit	
		dicated the visits were			Forms by Nursing Supervisor.	An
	missed or not do	cumented.			inservice has been developed	
					7/24/13 for an annual training	
	3. A policy title	d "Clinical			plans of care and the completi	on
	Documentation"	, Approved 7/10/12,			of Missed Visit Forms for all	
		al Support Home health			clinical staff to be administered	d by
		) will document each			Nursing Supervisor. This	
	1				deficiency and plan to correct	
		th the patient. This			implemented on 7/24/13 by the Administrator and DON. All	;
		vill be completed by the			Administrative Staff have been	
		and monitored by the			inserviced on returning all clier	
	skilled profession	nal responsible for			documentation to client record	
	managing the pa	tient's care."			by end of the day by	
					Administrator and DON effective	
					7/24/13 and ongoing. A sign of	
					sheet attached to the entrance	
					door of the clinical records file	:+0
					room will be utilized by all staff sign out client record	ıu
					documentation and sign back i	in
					All staff inserviced and	
					completion on 7/29/13. All nev	v
					staff will be oriented on policy	
					procedures of signing	

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OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	COMPLETED
		15K025	B. WING		07/23/2013
	PROVIDER OR SUPPLIER	ME HEALTH AGENCY	1006 W	ADDRESS, CITY, STATE, ZIP CODE VEST MILL STREET SUITE B ETOWN, IN 47356	
(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 APPROPRI DEFICIENCY)	
				client documentation in and of effective 7/24/13 and ongoing nursing supervisor. The on conversing supervisor will ensure daily that all clinical records signed out are returned by day and effective 7/24/13 and ongoing. The on call nursing supervisor will retrieve al clinical records within 24 hours if not signed back in to the records room effective 7/24/13 and ongoing. 25% of all clinical records will be audited quarter for evidence that medical plan care, documentation sheets (physician review not required and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optomet or podiatrist auditing team. 1 of clinical records will be audited semi-annually for evidence the medical plans of care, documentation sheets (physic review not required) and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor optometrist or podiatrist by Compliance Officer - this provides a triple check in our system. Effective 7/24/13 The DON and Administrator will be responsifor monitoring this corrective action to ensure that this deficiency is corrected ar will not recur by auditing a 10 random sample. Effective 7/2 The Administrator has	but g by sall e ay ical e ay ical erly ns of d) trist 00% ited nat cian sed he or, e ible and 1%

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY  COMPLETED
		15K025	B. WING		07/23/2013
	ROVIDER OR SUPPLIER	ME HEALTH AGENCY	1006 W	ADDRESS, CITY, STATE, ZIP CODE /EST MILL STREET SUITE B ETOWN, IN 47356	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  inserviced the DON, nursing s	DATE
				inserviced the DON, nursing and all administrative staff on missed visit reports and filing charts timely and signing in a out client records. Nursing stawill document in nursing note reason for all missed visits effective 7/24/13 and ongoing Missed visit reports were separated from the chart durit the billing process. For clinical record #1 the clinical record von 5/21, 5/22, 5/23, 5/24, 5/25, 5/26, 5/27 - client was in hospital and a missed visit rewas separated from chart durit the billing process - Missed V Form Attached. 5/29 client hamedical appointment and mis visit report was separated from chart during billing process - Missed Visit Form Attached. 6/9 client requested no service and missed visit report was separated from chart during billing process - Missed Visit Form Attached. 6/22 & 6/23 or requested no services and missed visit report was separated from chart during billing process - Missed Visit Form Attached. 6/28 client had medical appointment and missed visit report was separated from chart during billing process - Missed Visit Form Attached. 6/28 client had medical appointment and missed visit report was separated from chart during billing process - Missed Visit Form Attached. 6/28 client had medical appointment and missed visit report was separated from chart during billing process - Missed Visit Form Attached 7/8, 7/9, 7/10, 7/11, 7/12 documentation sheets were separated from chart during billing process. The Financial Coordinator was on vacation during the survey and the Agency failed to look in	in and aff so the solution of

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	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/23/2013
	ROVIDER OR SUPPLIER	ME HEALTH AGENCY	STREET A	ADDRESS, CITY, STATE, ZIP CODE /EST MILL STREET SUITE B ETOWN, IN 47356	<b>.</b>
(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 APPROPR DEFICIENCY)	DATE DATE
				the department for missed vireports and missing documentation. Upon her re on 7/29/13 missing documentation was retrieved filed in clinical records and submitted to ISDH for review prevent the deficiency from recurring in the future all Administrative Staff including Financial Coordinator have be inserviced on returning all cli documentation to client record by end of the day by Administrator and DON effect 7/24/13 and completed 7/29/ and ongoing. A sign out she attached to the entrance dood the clinical records file room be utilized by all staff to sign out client record documentation and sign back in. All staff inserviced and completion 7/29/13. All new staff will oriented on policy and proces of signing client documentation and out effective 7/24/13 and ongoing by nursing supervisor The on call nursing supervisor will retrieve all clinical records signed out are return by day end effective 7/24/13 ongoing. The on call nursing supervisor will retrieve all clir records within 24 hours if not signed back in to the records room effective 7/24/13 and ongoing. 25% of all clinical records will be audited quarte for evidence that medical pla care, documentation sheets (physician review not	turn I and I. To I the seen ent rds Stive 13 et r of will ion on be dures on in dor. or will ned and I hical is I erly

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/23/2013
	ROVIDER OR SUPPLIER	L ME HEALTH AGENCY	STREET A	ADDRESS, CITY, STATE, ZIP CODE /EST MILL STREET SUITE B ETOWN, IN 47356	
(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 APPROPRI DEFICIENCY)	DATE
				required) and Missed Visit Fo are completed, submitted and reviewed by the physician, dentist, chiropractor, optomet or podiatrist auditing team. 1 of clinical records will be audi semi-annually for evidence the medical plans of care, documentation sheets (physic review not required) and Misse Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractic optometrist or podiatrist by Compliance Officer - this provides a triple check in our system. Effective 7/24/13 The DON and Administrator will be responsifor monitoring this corrective action to ensure that this deficiency is corrected an will not recur by auditing a 10 random sample. Effective 7/2 The Administrator requested documentation sheets be pull for client #2. All documentation sheets was found and the missing documents are attached. Client #2 had been given a 30 day notice, the Administrative Assistant had pulled May thru July 2013 documents to compile a report the Board of Directors reporting indicating that we were provided adequate care with staffing the home health aides (one at the agencies expense - a non bill unit) at the same time and providing additional time to ensure adequate care, as you	rist 00% ted at cian ed e or,  e ble d % 4/13 l ed on  3 rt for ng ling //o e able

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15K025	B. WING		07/23/2013
	PROVIDER OR SUPPLIER	ME HEALTH AGENCY	1006 W	ADDRESS, CITY, STATE, ZIP CODE /EST MILL STREET SUITE B ETOWN, IN 47356	-
(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)	2.112
				note in the documentation sh attached. The Administrator f to ask the Administrative Assistant if they had client #2 documentation sheets (as it cont cross her mind). To preve the deficiency from recurring the future all Administrative Sincluding the Administrative Assistant have been inservice on returning all client documentation to client record by end of the day by Administrator and DON effect 7/24/13 and completed 7/29/2 and ongoing. A sign out sheet attached to the entrance door the clinical records file room to be utilized by all staff to sign out client record documentation and sign back in. All staff inserviced and completion 7/29/13 by DON and Administrator. All new staff to be oriented on policy and procedures of signing client documentation in and offective 7/24/13 and ongoing nursing supervisor. The onconursing supervisor will ensured daily that all clinical records signed out are returned by day and effective 7/24/13 and ongoing. The on call nursing supervisor will retrieve all clinical records within 24 hours if not signed back in to the records room effective 7/24/13 and ongoing. 25% of all clinical records will be audited quarter for evidence that medical plat care, documentation sheets	ailed did ent in staff ed ds tive 13 et of will on on on yill dy all ee ay ical

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:  15K025	A. BUILDING	00	O7/23/2013
		TUNUZU	B. WING		0112312013
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP CODE	
וחו/וחמו	JAL SUPPORT HO	ME HEALTH AGENCY		/EST MILL STREET SUITE B ETOWN, IN 47356	
				I	(775)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG				CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	(physician review not required) and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optome or podiatrist auditing team. of clinical records will be audisemi-annually for evidence to medical plans of care, documentation sheets (physician, dentist, chiropraction optometrist or podiatrist by Compliance Officer - this provides a triple check in our system. Effection 7/24/13 The DON and Administrator will be responsion for monitoring this corrective action to ensure that this deficiency is corrected a will not recur by auditing a 10 random sample. Effective 7/2 The policy title "Clinical Documentation" now include missed visit report will be completed by the staff scheol for the services and submitted Mondays by 4 pm when servare not delivered. All service will be monitored by supervisinurse responsible for manage the client's care. The Nursin Assistant will provide the nur supervisor and the billing department a utilization report based on the plan of care for missing documentation even Tuesday by 4pm and report the supervising nurse responsing nurs	etrist 100% litted hat ician sed he or, eve sible  nd 0% 24/13 es: A duled ed on vices s sing jing g gring g gring g gring g gring g g g rt or any y tto

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NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL SUPPORT HOME HEALTH AGENCY  STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE COMPLET	A. BUILDING COMPLETED
NAME OF PROVIDER OR SUPPLIER  INDIVIDUAL SUPPORT HOME HEALTH AGENCY  ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (COMPLET)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356  ID PROVIDER'S PLAN OF CORRECTION (X5)
	PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE
for managing the client's care, the DON and the Administrator any discrepancies. The billing department will make contact with staff responsible for submitting documentation, if applicable. To prevent the deficiency from recurring in the future the Compliance Officer will update all policies effective 7724/13 and present to Administrator and DON to present to the Board for approval. The Administrator received verbal approval from Board on change of policy and implemented policy with inservice to all staff on 7/29/13. A new Compliance Officer was hired on 6/25/13 to ensure that all policies meet requirements and will review annually with the Administrator and DON and present to Board.	for managing the client's care, the DON and the Administrator any discrepancies. The billing department will make contact with staff responsible for submitting documentation, if applicable. To prevent the deficiency from recurring in the future the Compliance Officer will update all policies effective 7/24/13 and present to Administrator and DON to present to the Board for approval. The Administrator received verbal approval from Board on change of policy and implemented policy with inservice to all staff on 7/29/13. A new Compliance Officer was hired on 6/25/13 to ensure that all policies meet requirements and will review annually with the Administrator and DON and

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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. BUII	DING	00	COMPL	ETED
		15K025	A. BUII B. WIN			07/23/	2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.					
INDIVIDI	IAL CURRORT HO	ME LIEALTH A CENCY			/EST MILL STREET SUITE B		
טטועוטעוו	IAL SUPPORT HO	ME HEALTH AGENCY		MIDDL	ETOWN, IN 47356		
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
N000000							
	This visit was a l	home health state	N00	00000			
	complaint invest	igation survey					
	complaint invest	igation survey.					
	Commission # DV	00121672 S-b-tttt					
	•	00131673 Substantiated:					
		realted to the allegation					
	are cited. An un	related deficiency is					
	cited.						
	Survey Dates: J	uly 23 2013					
	Survey Dates. 3	ury 23, 2013					
	<b>7</b>						
	Facility # 01116	50					
	Medicaid Vendo	or: 200836920					
	Curveyor: Cucar	n E. Sparks, RN, PH					
		i E. Sparks, KN, FII					
	Nurse Surveyor						
	•	Joyce Elder, MSN, BSN,					
	RN						
	July 25,	2013					
	,						

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION 00	COMPLETED
I I I I I I I I I I I I I I I I I I I		15K025	A. BUILDING	<del></del>	07/23/2013
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			WEST MILL STREET SUITE B	
INDIVIDU	JAL SUPPORT HOI	ME HEALTH AGENCY		ETOWN, IN 47356	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE
		·	IAG	DEFICIENC!)	DATE
TAG N000522	410 IAC 17-13-1( Patient Care Rule 13 Sec. 1(a) a written medical and periodically re	Medical care shall follow plan of care established eviewed by the physician, tor, optometrist or	N000522	N 522 The Administrator ar DON has inserviced nursing and home health aides on following medical plans of caestablished and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist. The Administrato DON has inserviced the nurs staff and home health aides completion of the Missed Visit Form. The Missed Visit Form documents client name, date missed visit, type of visit mis reason for missed visit, staff signature, staff discipline, da notification to physician, cc: original to client chart and co billing. A missed visit form v completed by the clinical stath the time of the missed visit a submitted by the following Monday by 4pm or before to	ond of staff  are of seed, ate, oppy of will be fif at and
				office. All nursing staff will document in the nursing note reason a missed visit form w	
				completed. The Nursing Assistant will record all servi (including the missed visit fo on a calendar worksheet for individual client to track all vi to ensure compliance with th Plan of Care. On Tuesday b	rm) each isits ne
				4pm the Nursing Assistant w	/111

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		COMPLETED		
		15K025	B. WING		07/23/2013		
	PROVIDER OR SUPPLIER	ME HEALTH AGENCY	STREET ADDRESS, CITY, STATE, ZIP CODE  1006 WEST MILL STREET SUITE B  MIDDLETOWN, IN 47356				
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
				provide a completed tracking calendar worksheet to the nu supervisor along with the clied documentation, including Mis Visit Forms for review and submission of all Missed Visit Forms to Physician for review fax. A fax confirmation will be obtained and attached to Mis Visit Form and filed in client clinical records within 48 houthen Nursing Assistant. To provide the Nursing Assistant of the Nursing Supervisor of the Nursing Supervisor of the Nursing Supervisor of the Supervisor of the Assistant of the Nursing Supervisor of the Assistant of the Assi	arsing ent essed it w via be essed ars by event eswill as of policy (isit er. An ed on ention ed by en eccord estate esta		

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		IDENTIFICATION NUMBER:  15K025	A. BUILDING  B. WING		COMPLETED 07/23/2013		
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
INDIVIDU	JAL SUPPORT HON	ME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(X5) COMPLETION DATE			
				team. 100% of clinical records will be audited semi-annually fevidence that medical plans, documentation sheets (Physic review not required) of care and Missed Visit Forms are completed, submitted and reviewed by the physician, dentist, chiropractor, optometror podiatrist by Compliance Officer - this provides a triple check in our system. Effective 7/24/13 The DON and Administrator will be responsite for monitoring this corrective action to ensure that this deficiency is corrected and will not recur by review and auditing a 10% random samplinguarterly. Effective 7/24/13 an ongoing.	ian ind ist e		

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