STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157211	A. BUILDING 00 B. WING	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOME NURSING SERVICES	528 W WASHINGTON BLVD FORT WAYNE, IN 46802

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey Date: January 29, 2019 Facility Number: IN005372 Provider Number: 100265370 Census = 246 At this Emergency Preparedness survey, Home Nursing Services was found to be out of compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E 0000		
E 0001 Bldg. 00	Based on record review and interview, the agency failed to comply with all applicable Federal, State and local emergency preparedness requirements (Tag E0001); failed to develop an emergency plan that included facility-based and community-based risk assessment, utilizing an all-hazards approach, and that included strategies for addressing emergency events identified by the risk assessment (Tag E0006); failed to develop an emergency plan that adequately identified patients/client population at risk during an emergency event, the type of services the clinic had the ability to provide during an emergency, how the agency planned to continue to operate during an emergency, and the delegation of authority (Tag E0007); failed to develop a process	E 0001	The Governing Body and Administrator will immediately correct the deficiency by reorganizing our current Emergency Preparedness Plan by February 28, 2019. Governing Body and Administrator will prevent this deficiency from recurring in the future by educational coaching with ISDH Emergency Preparedness staff, Deborah Holbrook, Healthcare Emergency Preparedness Coordinator, Division of Emergency Preparedness, Indiana State Department of Health, by	04/30/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	for the cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the agency's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts (Tag E0009); failed to develop and implement emergency preparedness policies and procedures based on agency-based and community-based risk assessment, utilizing an all-hazards approach, and based on a communication plan that complies with Federal, State, and local laws (Tag E0013); failed to develop procedures to inform State and local emergency preparedness officials about home health agency (HHA) patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment (Tag E0019); failed to develop procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency and that the HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact (Tag E0021); failed to develop procedures to use volunteers in an emergency or other emergency staffing strategies, including the process and roll for integration of State or Federally designated health care professionals to address surge needs during an emergency (Tag 0024); failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws (Tag 0029); failed to develop a communication plan which would include names and contact information for staff, entities providing services under arrangement, patient's physicians, and		February 28, 2019. Our Administrator and Quality Management Committee will prevent and monitor 100% compliance with our Emergency Preparedness Plan every quarter by April 30, 2019. **UPDATE** E0001 – The agency failed to comply with all applicable Federal, State and local emergency preparedness requirements. See attachments and plans of action as listed E0006 – Failed to develop an emergency plan that included facility-based and community-based risk assessment, utilizing an all-hazards approach, and that included strategies for addressing emergency events identified by the risk assessment. See E0006 HVA with top five strategies E0007 - Failed to develop an emergency plan that adequately identified patients/client population at risk during an emergency event, the type of services the clinic had the ability to provide during an emergency, how the agency planned to continue to operate	

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	volunteers (Tag E0030); failed to develop and maintain an emergency preparedness plan that included contact information for Federal, State, tribal, regional, and local emergency preparedness staff and other sources of assistance (Tag 0031); failed to develop a communication plan that included primary and alternate means for communication with clinical staff and Federal, State, tribal, regional, and local emergency management agencies (Tag 0032); failed to develop and maintain an emergency preparedness communication plan that included a method for sharing medical information for patients under the agency's care with other health providers to maintain continuity of care (Tag 0033); failed to develop a means of providing information about the agency's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee (Tag 0034); failed to develop and maintain an emergency preparedness training and testing program (core element) based on the emergency plan set forth (Tag E0036); and failed to ensure they provided an initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role (Tag 0037). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 491.12, Establishment of the Emergency Program. In regards to the deficiencies identified above, findings include: 1. During an interview on 1/29/19 at 11:50 AM, the director of nursing (DON) was informed that the agency's emergency preparedness plan still		during an emergency, and the delegation of authority. See E0007 Identifying High Risk Clients in an Emergency E0009 - Failed to develop a process for the cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the agency's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. 2-15-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements with the Survey 1-29-19 results. 2-22-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements and Survey 1-29-19 results with Deborah Holbrook, ISDH Emergency Preparedness Coordinator for District 3. Governing Body, Administrator,	

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	needed to be reviewed, and therefor had been requested. 2. Durig an interview on 1/29/19 at 12:05 PM, the DON stated they've had a lot of turnover so they still needed to review the emergency preparedness plan with some staff, especially the new ones. 3. On 1/29/19 at 12:25 PM, the policies for the emergency preparedness plan were requested of the administrator who stated the agency did have an emergency preparedness plan. As of 1/29/19 at 2:40 PM, the policies had not been provided. 4. On 1/29/19 at 1:00 PM, the DON presented with a box of papers and a binder and stated this was "bits and pieces" of the emergency plan. The DON presented an undated packet titled "IAHHC [Indiana Association for Home and Hospice Care] Home Nursing Services Emergency Preparedness Plan." This packet had empty blanks to fill in, and appeared to be a template for an agency to use as a tool for guidance in preparing a plan. This packet failed to evidence it was an emergency preparedness plan, and failed to evidence the agency used it as a tool for a reference of developing a plan.		HR Director, and Clinical Director will develop a process for the cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the agency's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts by 2-28-2019 The Administrator will be responsible for the Emergency Preparedness Plan. E0013 - Failed to develop and implement emergency preparedness policies and procedures based on agency-based and community-based risk assessment, utilizing an all-hazards approach, and based on a communication plan that complies with Federal, State, and local laws. 2-15-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements with the Survey 1-29-19 results. 2-22-19 Governing Body,	

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			Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements and Survey 1-29-19 results with Deborah Holbrook, ISDH Emergency Preparedness Coordinator for District 3. Governing Body, Administrator, HR Director, and Clinical Director will develop and implement emergency preparedness policies and procedures based on agency-based and community-based risk assessment, utilizing an all-hazards approach, and based on a communication plan that complies with Federal, State, and local laws by 2-28-2019 The Administrator will be responsible for the Emergency Preparedness Plan. E0019 - Failed to develop procedures to inform State and local emergency preparedness officials about home health agency (HHA) patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment. 2-15-19 Governing Body, Administrator, HR Director, and	

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			Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements with the Survey 1-29-19 results. 2-22-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements and Survey 1-29-19 results with Deborah Holbrook, ISDH Emergency Preparedness Coordinator for District 3. Governing Body, Administrator, HR Director, and Clinical Director will develop and implement procedures to inform State and local emergency preparedness officials about home health agency (HHA) patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment by 2-28-2019. The Administrator will be responsible for the Emergency Preparedness Plan. E0021 - Failed to develop procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is	

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			an interruption in services during or due to an emergency and that the HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact. 2-15-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements with the Survey 1-29-19 results. 2-22-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements and Survey 1-29-19 results with Deborah Holbrook, ISDH Emergency Preparedness Coordinator for District 3. Governing Body, Administrator, HR Director, and Clinical Director will develop and implement procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency and that the HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact by 2-28-2019. The Administrator will be	

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			responsible for the Emergency Preparedness Plan. E0024 - Failed to develop procedures to use volunteers in an emergency or other emergency staffing strategies, including the process and roll for integration of State or Federally designated health care professionals to address surge needs during an emergency. See E0024 Volunteer Policy E0029 - Failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws. 2-15-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements with the Survey 1-29-19 results. 2-22-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements and Survey 1-29-19 results with Deborah Holbrook, ISDH Emergency Preparedness Coordinator for District 3.	

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			Governing Body, Administrator, HR Director, and Clinical Director will develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws by 2-28-2019. The Administrator will be responsible for the Emergency Preparedness Plan. E0030 - Failed to develop a communication plan which would include names and contact information for staff, entities providing services under arrangement, patient's physicians, and volunteers. See E0030 E0031 - Failed to develop and maintain an emergency preparedness plan that included contact information for Federal, State, tribal, regional, and local emergency preparedness staff and other sources of assistance. 2-15-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements with the Survey 1-29-19 results.	

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			2-22-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements and Survey 1-29-19 results with Deborah Holbrook, ISDH Emergency Preparedness Coordinator for District 3. Governing Body, Administrator, HR Director, and Clinical Director will develop and maintain an emergency preparedness plan that included contact information for Federal, State, tribal, regional, and local emergency preparedness staff and other sources of assistance by 2-28-2019. The Administrator will be responsible for the Emergency Preparedness Plan. E0032 - Failed to develop a communication plan that included primary and alternate means for communication with clinical staff and Federal, State, tribal, regional, and local emergency management agencies. 2-15-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements with the Survey	

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			1-29-19 results. 2-22-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements and Survey 1-29-19 results with Deborah Holbrook, ISDH Emergency Preparedness Coordinator for District 3. Governing Body, Administrator, HR Director, and Clinical Director will develop a communication plan that included primary and alternate means for communication with clinical staff and Federal, State, tribal, regional, and local emergency management agencies by 2-28-2019. The Administrator will be responsible for the Emergency Preparedness Plan. E0033 - Failed to develop and maintain an emergency preparedness communication plan that included a method for sharing medical information for patients under the agency's care with other health providers to maintain continuity of care. 2-15-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and	

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			local emergency preparedness requirements with the Survey 1-29-19 results. 2-22-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements and Survey 1-29-19 results with Deborah Holbrook, ISDH Emergency Preparedness Coordinator for District 3. Governing Body, Administrator, HR Director, and Clinical Director will develop and maintain an emergency preparedness communication plan that includes a method for sharing medical information for patients under the agency's care with other health providers to maintain continuity of care by 2-28-2019. The Administrator will be responsible for the Emergency Preparedness Plan. E0034 - Failed to develop a means of providing information about the agency's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. 2-15-19 Governing Body, Administrator, HR Director, and	

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			Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements with the Survey 1-29-19 results. 2-22-19 Governing Body, Administrator, HR Director, and Clinical Director met to review all applicable Federal, State, and local emergency preparedness requirements and Survey 1-29-19 results with Deborah Holbrook, ISDH Emergency Preparedness Coordinator for District 3. Governing Body, Administrator, HR Director, and Clinical Director will develop a means of providing information about the agency's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee by 2-28-2019. The Administrator will be responsible for the Emergency Preparedness Plan. E0036 - Failed to develop and maintain an emergency preparedness training and testing program (core element) based on the emergency plan set forth. See E0036 Training sign in and E0036 Training sign in 2	

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			E0037 - Failed to ensure they provided an initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. See E0037 Employee Orientation Training ***3/1/2019 UPDATE*** There was no attachment included for E0001. On 2/26/2019 Governing Body, Administrator, HR Director, and Clinical Director developed an emergency preparedness plan that complies with all applicable Federal, State and local emergency preparedness requirements. The plan has been uploaded for review. Documents will be reviewed quarterly by Governing Body, Administrator, HR Director, and Clinical Director and updated as needed. The Administrator will be responsible for the Emergency Preparedness Plan. Please put your attachment info of E0007, E0024, and E0030 into the plan of correction. You are not permitted to indicate to "see attachments."	

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			On 2/26/2019 Governing Body, Administrator, HR Director, and Clinical Director developed an emergency preparedness plan that complies with all applicable Federal, State and local emergency preparedness requirements. The plan has been uploaded for review. Documents will be reviewed quarterly by Governing Body, Administrator, HR Director, and Clinical Director and updated as needed. The Administrator will be responsible for the Emergency Preparedness Plan. E0024: Volunteer Policy: You must have a policy for the use of volunteers. You can turn away volunteers at your descretion during an emergency, but you must have a policy in place "just in case." On 2/26/2019 Governing Body, Administrator, HR Director, and Clinical Director developed an emergency preparedness plan that complies with all applicable Federal, State and local emergency preparedness requirements. The plan has been uploaded for review. Documents will be reviewed quarterly by Governing Body, Administrator, HR Director, and	

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			Clinical Director and updated as needed. The Administrator will be responsible for the Emergency Preparedness Plan. E0036 and E0037: The training attachments you provided was prior to the agency's survey. Please include any training attachments that has been conducted by your agency with your employees after the exit of the survey. If none has been conducted, please include specific dates within your plan of correction of when all table top exercises will be conducted with all staff. On 2/25/2019 the Clinical Director met with the RNCM staff to train the emergency preparedness plan, attendance logs are upload for review. On 2/27/2019 the management staff met and the Administrator and Clinical Director trained the staff on the components of the emergency preparedness plan. In March, the agency is planning a tabletop exercise called Twilight Twister with all staff. Documents will be reviewed quarterly by Governing Body, Administrator, HR Director, and Clinical Director and updated as needed. Updates will initiate new training with staff.	

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G 0000			The Administrator will be responsible for the Emergency Preparedness Plan. E0013, E0019, E0021, E0029, E0030, E0032, and E0033: Since your plan of correction indicated procedure documents will be completed by 2/28/19, please include all of the procedure documents by 3/2/19. Also include all of your contacts/ phone numbers for an emergency within District 3. On 2/26/2019 Governing Body, Administrator, HR Director, and Clinical Director developed an emergency preparedness plan that complies with all applicable Federal, State and local emergency preparedness requirements. The plan has been uploaded for review. Additionally, county EMAs have been contacted and correspondences are uploaded for review. Documents will be reviewed quarterly by Governing Body, Administrator, HR Director, and Clinical Director and updated as needed. The Administrator will be responsible for the Emergency Preparedness Plan.	

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Bldg. 00		G 0000		
	This was a federal home health recertification survey. This was a partial extended survey. Survey Dates: January 17, 18, 28, and 29, 2019 Partial Extended Dates: January 28 and 29, 2019 Facility Number: IN005372 Medicaid Number: 100265370A Census Service Type: Skilled: 135 Home Health Aide Only: 111 Personal Care Only: 0 Total: 246 Sample: RR w/HV: 3 RR w/o HV: 4 Total: 7			
G 0580 Bldg. 00		G 0580	Clinical Director will meet with employee G by 2/28/19 to review the Skin Integrity Program and to ensure she follows the plan of care and provides wound care only as ordered by the physician. The meeting will include reviews of policies C-635 “Physician Orders” and C-580 “Plan of Care.” Clinical Director will monitor 100% of wound care documents until 30 days of 100% compliance achieved, then Clinical Director will	02/28/2019
	Based on record review, the agency failed to ensure nurses followed the plan of care and provided wound care only as ordered by the physician in 1 of 2 clinical records reviewed of patients receiving wound care (#1). Findings include The agency's undated policy, titled "Physician Orders," # C-635, stated "Policy ... All medications, treatments and services provided to clients must be ordered by a physician .... "			

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	The agency's undated policy, titled "Plan of Care," # C580 stated "Policy ...Home care services are furnished under the supervision and direction of the client's physician ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... Special Instructions ... 2. The Plan of Care shall be completed in full to include ... l. Medications, treatments, and procedures ...." The clinical record for patient # 1 was reviewed on 1/17/19. The start of care date was 12/11/19. The Certification Plan of Care dated 12/11/18-2/8/19 contained orders for skilled nursing (SN) 2 visits per day, 7 days a week The orders indicated for SN to do daily dressing changes on 7 pressure ulcers. Instructing included to remove old the dressings, cleanse each wound with soap and water, pack wounds with Gent Dakins soaked gauze, cover wound with abdominal (ABD) pad and secure with tape. Measure wounds weekly and monitor wound for changes in condition. This plan of care was signed by the physician on 12/17/18. The skilled nursing visit note by Employee G, dated 12/12/18, visit time 10:50-11:50 a.m., evidenced wound care was provided on 4 wounds. Wound #2: located on [left] ischium ... Wound cleaned [with] soap/H20. Vacufoam placed over wound. Secured [with] occlusive drape, activac tube attached and secured. Tube connected to activac. Vacuum successfully achieved. Wound #4: located on sacrum ... wound cleaned [with] soap/H20. Hydrophilic foam placed over sacrum for protection .... " The skilled nurse failed to follow the plan of care and provided new treatments absent of physician orders.		reassess monitoring as needed. **UPDATED** The Clinical Director will in service the RNCM staff of the Skin Integrity Program at the next RNCM meeting on 2/25/19 and will in service all other nurses by 3/29/19.	

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	The skilled nursing visit with Employee G dated 12/19/18, visit time 10:30-1 1:45 a.m., stated wound care was provided on 9 wounds. "Wound #1: located on [left] heel ... cleaned with chlorhexidine soap ...was able to debride a large amt of dead tissue ... wound covered [with] hydrophilic foam, wrapped in kerlix and secured [with] tape ... Wound #2: located on [right] shin in line [with] the tibial crest ... cleaned with chlorhexidine soap. Covered [with] hydrophilic foam and secured [with] tape ... Wound #3: located on [left] knee ... cleaned with chlorhexidine soap. Covered with hydrophilic foam and secured [with] an occlusive dressing ... Wound #4: located on [right] knee, lateral aspect ...cleaned with chlorhexidine soap. Wound covered [with] hydrophilic foam and secured [with] an occlusive dressing ... Wound #5: located on lateral aspect of [left] ankle ... cleaned with chlorhexidine soap. Covered with hydrophilic foam, wrapped in kerlix and secured [with] tape ... Wound #6: located on [left] hip ... wound flushed [with] sterile H20. Wound packed [with] gent/dakins soaked gauze, covered [with] ABD, secured [with] occlusive dressing ...Wound #7: located on [left] ischium. Wound cleaned with chlorhexidine soap, packed [with] gent/dakin's soaked gauze, covered [with] ABD, secured [with] occlusive dressing ... Wound #8: located on [right] ischium ... Wound cleaned [with] chlorhexidine soap. Packed [with] gent/dakins soaked gauze. Covered [with] ABD. Secured [with] occlusive dressing ... Wound #9: located on sacrum. Wound is healed but area covered [with] hydrophilic foam and covered [with] occlusive dressing to provide protection for bony prominence .... " The SN failed to ensure treatment was not provided absent of a physician's order.			

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G 0590 Bldg. 00	Based on record review and interview, the agency failed to ensure the physician was notified of additional wounds and that existing wound care orders were clarified in 1 of 2 clinical records reviewed of patients receiving wound care (#1). Findings include The agency's undated policy, titled "Physician Orders," # C-635, stated "Policy ... All medications, treatments, and services provided to clients must be ordered by a physician .... " The agency's undated policy, titled "Plan of Care," # C580 stated "Policy ...Home care services are furnished under the supervision and direction of the client's physician ... Planning for care is a dynamic process that addresses the care, treatment, and services to be provided ... Special Instructions ... 2. The Plan of Care shall be completed in full to include ... l. Medications, treatments, and procedures ...." The clinical record for patient # 1 was reviewed on 1/17/19. The patient was hospitalized for respiratory difficulties from 12/24/18 to 1/4/19. The Certification Plan of Care dated 12/11/18-2/8/19 contained orders for skilled nursing (SN) 2 visits per day, 7 days a week The orders indicated for SN to do daily dressing changes on 7 pressure ulcers. The skilled nursing visit with Employee G dated 12/19/18, visit time 10:30-1 1:45 a.m., stated wound care was provided on 9 wounds. The record failed to evidence the SN contacted the physician to	G 0590	Clinical Director will in service employees G and U by 2/28/19 to ensure physicians are notified of additional wounds and that existing wound care orders are clarified. Additionally, the Clinical Director will meet with all RNCMs in their by-weekly meeting before 2/28/19 to in service on above mentioned topics. In both in services, policies C-635 “Physician Orders” and C-580 “Plan of Care” will be reviewed. The Skin Integrity Program will also be reviewed/updated to include statements to ensure physicians are notified of additional wounds and that existing wound care orders are clarified. **UPDATED**Clinical Director will monitor 100% of wound care documents until 30 days of 100% compliance achieved, then Clinical Director will reassess monitoring as needed.	02/28/2019

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	notify of the additional wounds. Review of a skilled nursing (SN) resumption of care assessment dated 1/4/19, evidenced the patient had 8 wounds. The orders for wound care remained the same as prior to hospitalization and stated "SN 2 visits per day 7 days a week with daily dressing changes on 7 pressure ulcers. Remove old dressings, cleanse each wound with soap and water, pack wounds with Gent Dakins soaked gauze, cover wound with ABD pad and secure with tape ...." The record failed to evidence the SN contacted the physician to notify of the additional wound and the need for an order for the 8th wound identified in the resumption of care assessment. During an interview on 1/28/18 at 11:30 a.m., employee # U stated there were no new orders for wound care since 1/4/19.			
G 0684 Bldg. 00	Based on observation, record review, and interview, the agency failed to ensure all staff knew and followed infection control policies and procedures for 1 of 3 home visit observations (#6). Findings include 1. The agency's undated policy, titled "Handwashing/Hand Hygiene," # D-330, stated "Special Instructions ... 3. Indications for hand washing and hand antisepsis ... c. When there is prolonged or intense contact with the client (bathing the client) ... d. Between tasks on the same client ... f. After removing gloves ...Hand Hygiene Technique ... 2. When washing hands	G 0684	Clinical Director has met with employee H to retrain on infection control and hand hygiene. On 2/13/19, RNCM conducted a supervised visit on employee H to monitor hand hygiene and infection control. Agency will in service all employees on proper hand hygiene and infection control by 2/28/19. **UPDATE**During each present supervisory visit, the RNCM will observe and document hand hygiene of staff.	02/28/2019

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	with soap and water ... rub hands together vigorously for at least 40-60 seconds .... " 2. During a home visit observation on 1/18/19 at 10:00 AM, employee H was observed providing care for patient #6. Upon arrival to the home, employee H already had gloves on. When she removed the gloves, employee H washed her hands at the sink for less than 10 seconds. Employee H then donned new gloves and proceeded to prepare the patient's medications. Employee H then removed her gloves and washed hands at the sink for less than 10 seconds, finished preparing medications and then administered the medications via tube. Employee H then removed her gloves and began providing oral care to the patient. Employee H failed to wash her hands per agency policy and failed to wash her hands when removing gloves prior to providing mouth care and failed to wear gloves while providing oral care. During an interview on 1/18/19 at 10:50 AM, employee H stated she did not usually wear gloves while providing oral care. During an interview on 1/28/19 at 10:00 AM, the director of nursing (DON) stated the hand washing policy is 20 to 40 seconds duration upon entering the patients' homes, when going from dirty to clean during tasks, and in between glove changes. The DON stated staff are expected to wear gloves during oral care.			
G 0708 Bldg. 00	Based on record review, the agency failed to ensure the nurse developing the plan of care	G 0708	Clinical Director will in service the RNCM to ensure that when developing the plan of care, to	02/28/2019

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	identified specific locations of wounds for 1 of 2 clinical records reviewed of patients receiving wound care (#1). Findings include The agency's undated policy, titled "Plan of Care," # C580 stated "Policy ...Home care services are furnished under the supervision and direction of the client's physician ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... Special Instructions ... 2. The Plan of Care shall be completed in full to include ... l. Medications, treatments, and procedures ...." Clinical record for patient # 1 was reviewed on 1/17/19. The start of care date was 12/11/19. The Certification Plan of Care dated 12/11/18-2/8/19 contained orders for skilled nursing (SN) 2 visits per day, 7 days a week The orders indicated for SN to do daily dressing changes on 7 pressure ulcers. The skilled initiating the plan of care failed to include specific locations for each wound in the plan of care.		identify the specific location of wounds. The in service will review policy C-580 “Plan of Care.” **UPDATE**The Clinical Director will also in service all RNCM on wound identification and location on the plan of care. The Clinical Director will observe each RNCM develop one plan of care at point of care annually. Clinical Director will monitor and report issues to Administrator.	
G 0710 Bldg. 00	Based on observation, record review, and interview, the agency failed to ensure nurses followed the plan of care and provided wound care as ordered by the physician in 1 of 2 clinical records reviewed of patients receiving wound care (#1). Findings include The agency's undated policy, titled "Physician	G 0710	Clinical Director will in service employee G to provide wound care as ordered by the physician. The in service with include the review of policies C-635 “Physician Orders” and C-580 “Plan of Care.” **UPDATE**The Clinical Director will in service all nurses on following physician’s orders by 3/29/19. Case conferences,	02/28/2019

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	Orders," # C-635, stated "Policy ... All medications, treatments and services provided to clients must be ordered by a physician .... " The agency's undated policy, titled "Plan of Care," # C580 stated "Policy ...Home care services are furnished under the supervision and direction of the client's physician ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... Special Instructions ... 2. The Plan of Care shall be completed in full to include ... l. Medications, treatments, and procedures ...." The clinical record for patient # 1 was reviewed on 1/17/19. The start of care date was 12/11/19. The Certification Plan of Care dated 12/11/18-2/8/19 contained orders for skilled nursing (SN) 2 visits per day, 7 days a week The orders indicated for SN to do daily dressing changes on 7 pressure ulcers. Instructing included to remove old the dressings, cleanse each wound with soap and water, pack wounds with Gent Dakins soaked gauze, cover wound with abdominal (ABD) pad and secure with tape. Measure wounds weekly and monitor wound for changes in condition. This plan of care was signed by the physician on 12/17/18. The SN failed to follow physician orders for wound care for all 7 pressure ulcers, added in non-ordered wound care, and failed to consistently identify each wound location from week to week, and or day to day. The skilled nursing visit note by Employee G, dated 12/12/18, visit time 10:50-11:50 a.m., evidenced wound care was provided on 4 wounds. The skilled nursing visit note indicated "Wound #1: located on L hip ... wound flushed [with] 10 ml sterile H2O [water]. Packed with gent/dakins soaked gauze, covered [with] ABD,		overseen by the Clinical Director, will include a wound documentation review. Clinical Director will monitor and report issues to Administrator.	

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	secured [with] tape. Wound #2: located on [left] ischium ... Wound cleaned [with] soap/H20. Vacufoam placed over wound. Secured [with] occlusive drape, activac tube attached and secured. Tube connected to activac. Vacuum successfully achieved. Wound #3: located on [right] ischium ... Wound cleaned [with] soap/H20. Packed with gent/ dakins soaked gauze covered [with] ABD, secured [with] tape. Wound #4: located on sacrum ... wound cleaned [with] soap/H20. Hydrophilic foam placed over sacrum for protection .... " The SN failed to address the other 3 wounds and failed to follow the plan of care. The skilled nursing visit Note by Employee G, dated 12/17/18, visit time 10:30 - 11:15 a.m., evidenced wound care was provided on 4 wounds. "Wound #1: located on [left] hip ... wound flushed [with] 10 ml sterile H20. Packed [with] gent/dakins soaked gauze. Covered [with] ABD secured [with] tegaderm. Wound #2" located on [left] ischium ... Wound cleaned with soap/H20. Packed [with] gent/ dakins soaked gauze - covered [with] ABD. Secured [with] occlusive dressing. This wound is no longer being treated [with] wound vac as client is out of supplies ... due to see wound care on Wed 12/19 ... wound #3: located on [right] ischium ... Wound cleaned [with] soap/H20. Packed with gent/dakins soaked gauze, covered [with] ABD, secured [with] occlusive dressing ...Wound #4: located on clients sacrum. Wound is healed but a piece of hydrophilic foam is placed over the bony prominence for protection. Client states foot, ankle, leg and knee wounds were dressed yesterday so he is deferring bandage changes on those until Wednesday .... " The SN failed to address the other 3 wounds and failed to follow the plan of care.			

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G 0716 Bldg. 00	During a home visit on 1/18/19 at 10:00 am with patient #1, employee G was observed performing wound care on 4 wounds consisting of: right knee, and 3 wounds on patient's back side (right and left ischium and sacrum). Each of the wounds were cleansed with soap and water, packed with Dakins soaked gauze, covered with ABD pad and secured with tape. No other wounds were addressed. During an interview on 1/18/19 at 10:30 am, employee G stated the patient directs which wounds they want dressed and when. Based on clinical record review, the agency failed to ensure nurse visit notes were consistent in identifying the locations of wounds being treated in 1 of 2 clinical records reviewed of patients receiving wound care (#1). Findings include: The clinical record for patient # 1 was reviewed on 1/17/19. The start of care date was 12/11/18. The Certification Plan of Care dated 12/11/18 - 2/8/19 contained orders for SN to do daily dressing changes on 7 pressure ulcers. The skilled nursing visit note for patient by Employee G, dated 12/12/18, visit time 10:50-11:50 a.m., evidenced wound care was provided on 4 wounds. The skilled nursing visit note indicated "Wound #1 ...located on L hip ... Wound #2 ...located on [left] ischium ... wound #3: located on [right] ischium ... wound #4: located on	G 0716	Clinical Director will in service employee G and RNCM to ensure nurse visit notes were consistent in identifying the locations of would being treated. **UPDATE**All nurses will be in serviced on proper identification of wound treatment by 3/29/19. The case conference, overseen by the Clinical Director, will include a wound documentation review. Clinical Director will monitor and report issues to Administrator.	02/28/2019

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	sacrum ...." The SN failed to address the other 3 wounds. The skilled nursing visit note with Employee G dated 12/19/18, visit time 10:30-1 1:45 AM, stated wound care was provided on 9 wounds. "Wound #1: located on [left] heel ... wound #2: located on [right] shin in line [with] the tibial crest ... wound #3: located on [left] knee ... Wound #4: located on [right] knee, lateral aspect ... Wound #5: located on lateral aspect of [left] ankle ... wound #6: located on [left] hip ... wound #7: located on [left] ischium ... wound #8: located on [right] ischium ... wound #9: located on sacrum ...." The SN failed to identify wound #1 as the left hip as per previous visits, failed to identify wound #2 as left ischium as per previous visits; failed to identify wound #3 as the right ischium, as per previous visits, and failed to evidence she notified the physician of 2 more wounds after she dressed them without orders. The skilled nursing visit note by employee G dated 1/14/19 visit time 10:30 - 11:45 AM stated 8 wounds were addressed. "Wound #1..[Right] heel ... wound #2 ... [left] heel ... wound #3 ... lateral aspect of [left] ankle ... wound #4 ... lateral aspect of [right] knee ... wound #5 ... medial aspect of [right] knee ... wound #6 ... [left] hip ... wound #7 ... [left] ischium ... wound #8 .... [right] ischium ... " The SN failed to identify wound #1 as the left hip as per previous visits, failed to identify wound #2 as left ischium as per previous visits; failed to identify wound #3 as the right ischium, as per previous visits.			
G 0808 Bldg. 00		G 0808	Clinical Director will in service	02/28/2019

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	Based on record review and interview, the agency failed to ensure clinical documentation of home health aide (HHA) supervisory visits had been placed into patient records within 14 days for 1 of 2 clinical records reviewed of patients receiving HHA services with a skilled service. (#2). Findings include:\ 1. The agency's undated policy titled "Home Health Aide Supervision," # C-340, stated "Special Instructions ... 3. Supervisory visits of Home Health Aides shall be according to the following frequency ... a. When skilled service are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client's residence at least every two (2) weeks (either when the Home Health Aide is present to observe and assess care delivery, or when the Home Health Aide is absent) to assess relationships and determine whether goals are being met ... b. Home Health Aide services only: When Home Health Aide services are being furnished to a client, who does not require the skilled service of a nurse or therapist, a Registered Nurse or qualified therapist must make a supervisory visit to the client's residence at least once every thirty (30) days ... 4. Supervisory visits are to be documented in the client's chart on the Home Health Aide Supervision Form ..." 2. The agency's undated policy titled "Clinical Documentation," # C680 stated "Policy ... Home Nursing Services will document each direct contact with the client ... Special Instructions ...5. Documentation of services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within fourteen (14) days after the care has been provided ...."		employees U, W and all RNCM to make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Clinical Director will review 100% of daily productivity of RNCM to ensure all supervisory visits are documented in the computer tracking system until 100% compliance achieved, then 10% will be reviewed.	

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	157211	A. BUILDING 00 B. WING	01/29/2019

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	3. The clinical record for patient # 2 was reviewed on 1/17/19 and 1/28/19. The plan of care for the certification period 1/4/19 - 3/4/9 contained orders for HHA 2 hours day, 1 day a week for 1 week, then 2 hours a day for 3 days a week for 8 weeks and skilled nursing (SN) visit every 2 weeks. The clinical record failed to evidence documentation of supervisory visits on 12/12/18, 12/26/18, 1/9/19, and 1/23/19. During an interview on 1/28/19 at 1:00 PM employee U indicated she called the supervising nurse (employee W) to ask where the supervisory visits had been documented. Upon returning to the electronic record, the aide supervisory visits suddenly appeared, and were time stamped as follows: 12/12/18 was time stamped as entered on 1/28/19 at 11:14 AM; 12/26/18 as time stamped as entered on 1/28/19 at 12:23 PM; 1/9/19 was time stamped as entered on 1/28/19 at 12:29 PM; and 1/23/19 was time stamped as entered on 1/28/19 at 12:45 PM. During an interview on 1/28/19 at 1:43 PM, with the administrator and director of nursing regarding marking of visits as complete in scheduling software, both stated the "C" on the calendar in front of the visits stated the visit was completed, and would have been entered after time sheet review, or through billing. They both stated the agency's scheduling software and documentation software did not communicate to mark visits as complete when documentation had been completed.			
G 1012 Bldg. 00		G 1012	Clinical Director will in service	02/28/2019

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	Based on record review and interview, the agency failed to ensure clinical documentation of home health aide (HHA) supervisory visits had been placed into patient records and not created after request for 1 of 2 clinical records reviewed of patients receiving HHA services with skilled service (#2). Findings include 1. The agency's undated policy titled "Home Health Aide Supervision," # C-340, stated "Special Instructions ... 3. Supervisory visits of Home Health Aides shall be according to the following frequency ... a. When skilled service are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client's residence at least every two (2) weeks (either when the Home Health Aide is present to observe and assess care delivery, or when the Home Health Aide is absent) to assess relationships and determine whether goals are being met ... b. Home Health Aide services only: When Home Health Aide services are being furnished to a client, who does not require the skilled service of a nurse or therapist, a Registered Nurse or qualified therapist must make a supervisory visit to the client's residence at least once every thirty (30) days ... 4. Supervisory visits are to be documented in the client's chart on the Home Health Aide Supervision Form ..." 2. The agency's undated policy titled "Clinical Documentation," # C680 stated "Policy ... Home Nursing Services will document each direct contact with the client ... Special Instructions ...5. Documentation of services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within fourteen (14) days after the care has been		employees U, W and all RNCM to make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Clinical Director will review 100% of daily productivity of RNCM to ensure all supervisory visits are documented in the computer tracking system until 100% compliance achieved, then 10% will be reviewed.	

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	provided ...." 3. The clinical record for patient # 2 was reviewed on 1/17/19 and 1/28/19. The plan of care for the certification period 1/4/19 - 3/4/19 contained orders for HHA 2 hours day, 1 day a week for 1 week, then 2 hours a day for 3 days a week for 8 weeks and skilled nursing (SN) visit every 2 weeks. The paper and electronic portions of the clinical record failed to evidence HHA supervisory visits had been completed on 12/12/18, 12/26/18, 1/9/19, and 1/23/19. During an interview on 1/28/19 at 1:00 PM employee U indicated she called the supervising nurse (employee W) to ask where the supervisory visits had been documented. Upon returning to the electronic record, the aide supervisory visits suddenly appeared, and were time stamped as follows: 12/12/18 was time stamped as entered on 1/28/19 at 11:14 AM; 12/26/18 as time stamped as entered on 1/28/19 at 12:23 PM; 1/9/19 was time stamped as entered on 1/28/19 at 12:29 PM; and 1/23/19 was time stamped as entered on 1/28/19 at 12:45 PM. During an interview on 1/28/19 at 1:43 PM with the administrator and director of nursing regarding marking of visits as complete in scheduling software, both stated the "C" on the calendar in front of the visits stated the visit was completed, and would have been entered after time sheet review, or through billing. They both stated the agency's scheduling software and documentation software did not communicate to mark visits as complete when documentation had been completed.			
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Bldg. 00	This was a home health state licensure survey. Survey Dates: January 17, 18, 28, and 29, 2019 Facility Number: IN005372 Medicaid Number: 100265370A Census Service Type: Skilled: 135 Home Health Aide Only: 111 Personal Care Only: 0 Total: 246 Sample: RR w/HV: 3 RR w/o HV: 4 Total: 7	N 0000		
N 0460 Bldg. 00	410 IAC 17-12-1(g) Home health agency administration/management Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment. Based on record review and interview, the agency failed to ensure annual home health aide (HHA) employee evaluations had been completed for 2 of	N 0460	Director of HR will conduct at 100% audit of personnel files to ensure that all employees have timely performance evaluations.	02/28/2019

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	10 HHA files reviewed (N and T) Findings include 1. The agency's undated policy titled "Performance Evaluations," Policy # D-260, stated "A competency-based performance evaluation will be conducted for all employees ... at one (1) year of employment ... Special Instructions ... 2. A criteria-based performance evaluation ... will be conducted ... at least annually by the appropriate supervisor ...." 2. Employee N's file was reviewed on 1/28/19. Employee N's date of hire and first patient contact dates were 6/7/17. The file failed to evidence an annual evaluation had been conducted in 2018. During an interview on 1/28/19 at 2:55 PM, employee C stated she found a note dated 7/18 about employee N not turning in her paperwork, and that was when employee N knew she would not be receiving a raise. A requested was made for the annual evaluation be delayed because she did not want any bad marks. Employee C stated the evaluation was not done. 3. Employee T's file was reviewed on 1/29/19. Employee T's date of hire was 11/13/15 and first patient contact was 11/18/15. The file failed to evidence an annual evaluation had been conducted in 2016. During an interview on 1/29/19 at 10:30 AM, employee C stated the agency's policy is to do an evaluation at one year even though regulations say can be 3 months before or after. Employee C stated that employee T was promoted from on-call to full time, but she could not recall why the annual evaluation had not been completed for		Director of HR will do a monthly audit of all active employee evaluation due dates to ensure timely completion of evaluations. Agency policy will be revised by Director of HR to match the state regulations requiring evaluations to be given every nine (9) to fifteen (15) months of active employment. Performance evaluations will be conducted regardless of employee's request for deferment. **UPDATE**HR Director and HR support staff will utilize reminders and scheduled events within the scheduling/HR tracking software to perform evaluation in a timely manner. The HR Director will monitor the monthly annual evaluation calendar and make sure all evaluations are performed within the new policy guidelines.	

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	2016.			
N 0470 Bldg. 00	410 IAC 17-12-1(m) Home health agency administration/management Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and interview, the agency failed to ensure all staff knew and followed infection control policies and procedures for 1 of 3 home visit observations (#6). Findings include 1. The agency's undated policy, titled "Handwashing/Hand Hygiene," # D-330, stated "Special Instructions ... 3. Indications for hand washing and hand antisepsis ... c. When there is prolonged or intense contact with the client (bathing the client) ... d. Between tasks on the same client ... f. After removing gloves ...Hand Hygiene Technique ... 2. When washing hands with soap and water ... rub hands together vigorously for at least 40-60 seconds .... " 2. During a home visit observation on 1/18/19 at 10:00 AM, employee H was observed providing care for patient #6. Upon arrival to the home, employee H already had gloves on. When she removed the gloves, employee H washed her hands at the sink for less than 10 seconds. Employee H then donned new gloves and proceeded to prepare the patient's medications. Employee H then removed her gloves and washed hands at the sink for less than 10 seconds, finished preparing medications and then	N 0470	Clinical Director has met with employee H to retrain on infection control and hand hygiene. On 2/13/19, RNCM conducted a supervised visit on employee H to monitor hand hygiene and infection control. Agency will in service all employees on proper hand hygiene and infection control by 2/28/19. **UPDATE**During each present supervisory visit, the RNCM will observe and document hand hygiene of staff.	02/28/2019

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	administered the medications via tube. Employee H then removed her gloves and began providing oral care to the patient. Employee H failed to wash her hands per agency policy and failed to wash her hands when removing gloves prior to providing mouth care and failed to wear gloves while providing oral care. During an interview on 1/18/19 at 10:50 AM, employee H stated she did not usually wear gloves while providing oral care. During an interview on 1/28/19 at 10:00 AM, the director of nursing (DON) stated the hand washing policy is 20 to 40 seconds duration upon entering the patients' homes, when going from dirty to clean during tasks, and in between glove changes. The DON stated staff are expected to wear gloves during oral care.			
N 0527 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review and interview, the agency failed to ensure the physician was notified of additional wounds and that existing wound care orders were clarified in 1 of 2 clinical records reviewed of patients receiving wound care (#1). Findings include The agency's undated policy, titled "Physician Orders," # C-635, stated "Policy ... All medications, treatments, and services provided to	N 0527	Clinical Director will in service employees G and U by 2/28/19 to ensure physicians are notified of additional wounds and that existing wound care orders are clarified. Additionally, the Clinical Director will meet with all RNCMs in their by-weekly meeting before 2/28/19 to in service on above mentioned topics. In both in services, policies C-635 “Physician Orders” and C-580	02/28/2019

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	clients must be ordered by a physician .... " The agency's undated policy, titled "Plan of Care," # C580 stated "Policy ...Home care services are furnished under the supervision and direction of the client's physician ... Planning for care is a dynamic process that addresses the care, treatment, and services to be provided ... Special Instructions ... 2. The Plan of Care shall be completed in full to include ... l. Medications, treatments, and procedures ...." The clinical record for patient # 1 was reviewed on 1/17/19. The patient was hospitalized for respiratory difficulties from 12/24/18 to 1/4/19. The Certification Plan of Care dated 12/11/18-2/8/19 contained orders for skilled nursing (SN) 2 visits per day, 7 days a week The orders indicated for SN to do daily dressing changes on 7 pressure ulcers. The skilled nursing visit with Employee G dated 12/19/18, visit time 10:30-1 1:45 a.m., stated wound care was provided on 9 wounds. The record failed to evidence the SN contacted the physician to notify of the additional wounds. Review of a skilled nursing (SN) resumption of care assessment dated 1/4/19, evidenced the patient had 8 wounds. The orders for wound care remained the same as prior to hospitalization and stated "SN 2 visits per day 7 days a week with daily dressing changes on 7 pressure ulcers. Remove old dressings, cleanse each wound with soap and water, pack wounds with Gent Dakins soaked gauze, cover wound with ABD pad and secure with tape ...." The record failed to evidence the SN contacted the physician to notify of the additional wound and the need for an order for the 8th wound identified in the		"Plan of Care" will be reviewed. The Skin Integrity Program will also be reviewed/updated to include statements to ensure physicians are notified of additional wounds and that existing wound care orders are clarified. **UPDATED**Clinical Director will monitor 100% of wound care documents until 30 days of 100% compliance achieved, then Clinical Director will reassess monitoring as needed.	

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	resumption of care assessment. During an interview on 1/28/18 at 11:30 a.m., employee # U stated there were no new orders for wound care since 1/4/19.			
N 0530 Bldg. 00	410 IAC 17-13-1(b) Patient Care Rule 13 Sec. 1(b) A home health agency may accept written orders for home health services from a physician, a dentist, a chiropractor, a podiatrist, or an optometrist licensed in Indiana or in any other state. If the home health agency receives an order from a physician, dentist, chiropractor, podiatrist, or optometrist who is licensed in another state, the home health agency shall take reasonable immediate steps to determine the following: (1) The order complies with the laws of the state where the order originated. (2) The individual who issued the order: (A) examined the patient; and (B) is licensed to practice in that state. Based on record review, the agency failed to ensure nurses followed the plan of care and provided wound care only as ordered by the physician in 1 of 2 clinical records reviewed of patients receiving wound care (#1). Findings include The agency's undated policy, titled "Physician Orders," # C-635, stated "Policy ... All medications, treatments and services provided to clients must be ordered by a physician .... " The agency's undated policy, titled "Plan of Care," # C580 stated "Policy ...Home care services	N 0530	Clinical Director will meet with employee G by 2/28/19 to review the Skin Integrity Program and to ensure she follows the plan of care and provides wound care only as ordered by the physician. The meeting will include reviews of policies C-635 “Physician Orders” and C-580 “Plan of Care.” Clinical Director will monitor 100% of wound care documents until 30 days of 100% compliance achieved, then Clinical Director will reassess monitoring as needed. **UPDATED** The Clinical Director will in service the RNCM	02/28/2019

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	are furnished under the supervision and direction of the client's physician ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... Special Instructions ... 2. The Plan of Care shall be completed in full to include ... l. Medications, treatments, and procedures ...." The clinical record for patient # 1 was reviewed on 1/17/19. The start of care date was 12/11/19. The Certification Plan of Care dated 12/11/18-2/8/19 contained orders for skilled nursing (SN) 2 visits per day, 7 days a week The orders indicated for SN to do daily dressing changes on 7 pressure ulcers. Instructing included to remove old the dressings, cleanse each wound with soap and water, pack wounds with Gent Dakins soaked gauze, cover wound with abdominal (ABD) pad and secure with tape. Measure wounds weekly and monitor wound for changes in condition. This plan of care was signed by the physician on 12/17/18. The skilled nursing visit note by Employee G, dated 12/12/18, visit time 10:50-11:50 a.m., evidenced wound care was provided on 4 wounds. Wound #2: located on [left] ischium ... Wound cleaned [with] soap/H20. Vacufoam placed over wound. Secured [with] occlusive drape, activac tube attached and secured. Tube connected to activac. Vacuum successfully achieved. Wound #4: located on sacrum ... wound cleaned [with] soap/H20. Hydrophilic foam placed over sacrum for protection .... " The skilled nurse failed to follow the plan of care and provided new treatments absent of physician orders. The skilled nursing visit with Employee G dated 12/19/18, visit time 10:30-1 1:45 a.m., stated wound		staff of the Skin Integrity Program at the next RNCM meeting on 2/25/19 and will in service all other nurses by 3/29/19.	

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	care was provided on 9 wounds. "Wound #1: located on [left] heel ... cleaned with chlorhexidine soap ...was able to debride a large amt of dead tissue ... wound covered [with] hydrophilic foam, wrapped in kerlix and secured [with] tape ... Wound #2: located on [right] shin in line [with] the tibial crest ... cleaned with chlorhexidine soap. Covered [with] hydrophilic foam and secured [with] tape ... Wound #3: located on [left] knee ... cleaned with chlorhexidine soap. Covered with hydrophilic foam and secured [with] an occlusive dressing ... Wound #4: located on [right] knee, lateral aspect ...cleaned with chlorhexidine soap. Wound covered [with] hydrophilic foam and secured [with] an occlusive dressing ... Wound #5: located on lateral aspect of [left] ankle ... cleaned with chlorhexidine soap. Covered with hydrophilic foam, wrapped in kerlix and secured [with] tape ... Wound #6: located on [left] hip ... wound flushed [with] sterile H20. Wound packed [with] gent/dakins soaked gauze, covered [with] ABD, secured [with] occlusive dressing ...Wound #7: located on [left] ischium. Wound cleaned with chlorhexidine soap, packed [with] gent/dakin's soaked gauze, covered [with] ABD, secured [with] occlusive dressing ... Wound #8: located on [right] ischium ... Wound cleaned [with] chlorhexidine soap. Packed [with] gent/dakins soaked gauze. Covered [with] ABD. Secured [with] occlusive dressing ... Wound #9: located on sacrum. Wound is healed but area covered [with] hydrophilic foam and covered [with] occlusive dressing to provide protection for bony prominence .... " The SN failed to ensure treatment was not provided absent of a physician's order.			
N 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency			

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	shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on observation, record review, and interview, the agency failed to ensure nurses followed the plan of care and provided wound care as ordered by the physician in 1 of 2 clinical records reviewed of patients receiving wound care (#1). Findings include The agency's undated policy, titled "Physician Orders," # C-635, stated "Policy ... All medications, treatments and services provided to clients must be ordered by a physician .... " The agency's undated policy, titled "Plan of Care," # C580 stated "Policy ...Home care services are furnished under the supervision and direction of the client's physician ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... Special Instructions ... 2. The Plan of Care shall be completed in full to include ... l. Medications, treatments, and procedures ...." The clinical record for patient # 1 was reviewed on 1/17/19. The start of care date was 12/11/19. The Certification Plan of Care dated 12/11/18-2/8/19 contained orders for skilled nursing (SN) 2 visits per day, 7 days a week The orders indicated for SN to do daily dressing changes on 7 pressure ulcers. Instructing included to remove old the dressings, cleanse each wound with soap and water, pack wounds with Gent Dakins soaked gauze, cover wound with abdominal (ABD) pad and secure with tape. Measure wounds weekly	N 0537	Clinical Director will in service employee G to provide wound care as ordered by the physician. The in service with include the review of policies C-635 “Physician Orders” and C-580 “Plan of Care.” **UPDATE**The Clinical Director will in service all nurses on following physician’s orders by 3/29/19. Case conferences, overseen by the Clinical Director, will include a wound documentation review. Clinical Director will monitor and report issues to Administrator.	02/28/2019

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	157211	A. BUILDING 00 B. WING	01/29/2019

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	and monitor wound for changes in condition. This plan of care was signed by the physician on 12/17/18. The SN failed to follow physician orders for wound care for all 7 pressure ulcers, added in non-ordered wound care, and failed to consistently identify each wound location from week to week, and or day to day. The skilled nursing visit note by Employee G, dated 12/12/18, visit time 10:50-11:50 a.m., evidenced wound care was provided on 4 wounds. The skilled nursing visit note indicated "Wound #1: located on L hip ... wound flushed [with] 10 ml sterile H2O [water]. Packed with gent/dakins soaked gauze, covered [with] ABD, secured [with] tape. Wound #2: located on [left] ischium ... Wound cleaned [with] soap/H20. Vacufoam placed over wound. Secured [with] occlusive drape, activac tube attached and secured. Tube connected to activac. Vacuum successfully achieved. Wound #3: located on [right] ischium ... Wound cleaned [with] soap/H20. Packed with gent/ dakins soaked gauze covered [with] ABD, secured [with] tape. Wound #4: located on sacrum ... wound cleaned [with] soap/H20. Hydrophilic foam placed over sacrum for protection .... " The SN failed to address the other 3 wounds and failed to follow the plan of care. The skilled nursing visit Note by Employee G, dated 12/17/18, visit time 10:30 - 11:15 a.m., evidenced wound care was provided on 4 wounds. "Wound #1: located on [left] hip ... wound flushed [with] 10 ml sterile H20. Packed [with] gent/dakins soaked gauze. Covered [with] ABD secured [with] tegaderm. Wound #2" located on [left] ischium ... Wound cleaned with soap/H20. Packed [with] gent/ dakins soaked gauze - covered [with] ABD. Secured [with]			

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	occlusive dressing. This wound is no longer being treated [with] wound vac as client is out of supplies ... due to see wound care on Wed 12/19 ... wound #3: located on [right] ischium ... Wound cleaned [with] soap/H20. Packed with gent/dakins soaked gauze, covered [with] ABD, secured [with] occlusive dressing ...Wound #4: located on clients sacrum. Wound is healed but a piece of hydrophilic foam is placed over the bony prominence for protection. Client states foot, ankle, leg and knee wounds were dressed yesterday so he is deferring bandage changes on those until Wednesday .... " The SN failed to address the other 3 wounds and failed to follow the plan of care. During a home visit on 1/18/19 at 10:00 am with patient #1, employee G was observed performing wound care on 4 wounds consisting of: right knee, and 3 wounds on patient's back side (right and left ischium and sacrum). Each of the wounds were cleansed with soap and water, packed with Dakins soaked gauze, covered with ABD pad and secured with tape. No other wounds were addressed. During an interview on 1/18/19 at 10:30 am, employee G stated the patient directs which wounds they want dressed and when. During an interview on 1/28/18 at 11:30 am with employee # U, she stated there were no new orders for wound care since 1/4/19.			
N 0542 Bldg. 00	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the			

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	following: (C) Initiate the plan of care and necessary revisions. Based on record review, the agency failed to ensure the nurse developing the plan of care identified specific locations of wounds for 1 of 2 clinical records reviewed of patients receiving wound care (#1). Findings include The agency's undated policy, titled "Plan of Care," # C580 stated "Policy ...Home care services are furnished under the supervision and direction of the client's physician ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... Special Instructions ... 2. The Plan of Care shall be completed in full to include ... l. Medications, treatments, and procedures ...." Clinical record for patient # 1 was reviewed on 1/17/19. The start of care date was 12/11/19. The Certification Plan of Care dated 12/11/18-2/8/19 contained orders for skilled nursing (SN) 2 visits per day, 7 days a week The orders indicated for SN to do daily dressing changes on 7 pressure ulcers. The skilled initiating the plan of care failed to include specific locations for each wound in the plan of care.	N 0542	Clinical Director will in service the RNCM to ensure that when developing the plan of care, to identify the specific location of wounds. The in service will review policy C-580 “Plan of Care.” **UPDATE**The Clinical Director will also in service all RNCM on wound identification and location on the plan of care. The Clinical Director will observe each RNCM develop one plan of care at point of care annually. Clinical Director will monitor and report issues to Administrator.	02/28/2019
N 0554 Bldg. 00	410 IAC 17-14-1(a)(2)(B) Scope of Services Rule 14 Sec. 1(a) (2) (B) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (B) Prepare clinical notes.	N 0554	Clinical Director will in service	02/28/2019

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	Based on clinical record review, the agency failed to ensure nurse visit notes were consistent in identifying the locations of wounds being treated in 1 of 2 clinical records reviewed of patients receiving wound care (#1). Findings include: The clinical record for patient # 1 was reviewed on 1/17/19. The start of care date was 12/11/18. The Certification Plan of Care dated 12/11/18 - 2/8/19 contained orders for SN to do daily dressing changes on 7 pressure ulcers. The skilled nursing visit note for patient by Employee G, dated 12/12/18, visit time 10:50-11:50 a.m., evidenced wound care was provided on 4 wounds. The skilled nursing visit note indicated "Wound #1 ...located on L hip ... Wound #2 ...located on [left] ischium ... wound #3: located on [right] ischium ... wound #4: located on sacrum ...." The SN failed to address the other 3 wounds. The skilled nursing visit note with Employee G dated 12/19/18, visit time 10:30-1 1:45 AM, stated wound care was provided on 9 wounds. "Wound #1: located on [left] heel ... wound #2: located on [right] shin in line [with] the tibial crest ... wound #3: located on [left] knee ... Wound #4: located on [right] knee, lateral aspect ... Wound #5: located on lateral aspect of [left] ankle ... wound #6: located on [left] hip ... wound #7: located on [left] ischium ... wound #8: located on [right] ischium ... wound #9: located on sacrum ...." The SN failed to identify wound #1 as the left hip as per previous visits, failed to identify wound #2 as left ischium as per previous visits; failed to identify wound #3 as the right ischium, as per previous visits, and failed to evidence she notified		employee G and RNCM to ensure nurse visit notes were consistent in identifying the locations of would being treated. **UPDATE**All nurses will be in serviced on proper identification of wound treatment by 3/29/19. The case conference, overseen by the Clinical Director, will include a wound documentation review. Clinical Director will monitor and report issues to Administrator.	

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	the physician of 2 more wounds after she dressed them without orders. The skilled nursing visit note by employee G dated 1/14/19 visit time 10:30 - 11:45 AM stated 8 wounds were addressed. "Wound #1..[Right] heel ... wound #2 ... [left] heel ... wound #3 ... lateral aspect of [left] ankle ... wound #4 ... lateral aspect of [right] knee ... wound #5 ... medial aspect of [right] knee ... wound #6 ... [left] hip ... wound #7 ... [left] ischium ... wound #8 .... [right] ischium ... " The SN failed to identify wound #1 as the left hip as per previous visits, failed to identify wound #2 as left ischium as per previous visits; failed to identify wound #3 as the right ischium, as per previous visits.			
N 0606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on record review, and interview, the agency failed to ensure the skilled nurse (SN) conducted home health aide (HHA) supervisory visits had been conducted every 30 days for 2 of 2 clinical records receiving HHA services (# 2 and 5). Findings include 1. The agency's undated policy titled "Home Health Aide Supervision," # C-340 stated "Special Instructions ... 3. Supervisory visits of Home	N 0606	Clinical Director will in service employees U, W and all RNCM to make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Clinical Director will review 100% of daily productivity of RNCM to ensure all supervisory visits are documented in the computer tracking system until	02/28/2019

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	Health Aides shall be according to the following frequency ... a. When skilled service are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client's residence at least every two (2) weeks (either when the Home Health Aide is present to observe and assess care delivery, or when the Home Health Aide is absent) to assess relationships and determine whether goals are being met ... b. Home Health Aide services only: When Home Health Aide services are being furnished to a client, who does not require the skilled service of a nurse or therapist, a Registered Nurse or qualified therapist must make a supervisory visit to the client's residence at least once every thirty (30) days ... 4. Supervisory visits are to be documented in the client's chart on the Home Health Aide Supervision Form ..." 2. The clinical record for patient # 2 was reviewed on 1/17/19 and 1/28/19. The plan of care for the certification period 1/4/19 - 3/4/9 contained orders for HHA 2 hours day, 1 day a week for 1 week, then 2 hours a day for 3 days a week for 8 weeks and skilled nursing (SN) visit every 2 weeks. The clinical record failed to evidence documentation of supervisory visits every 30 days as evidenced by the following: During an interview on 1/28/19 at 1:00 PM employee U indicated she called the supervising nurse (employee W) to ask where the supervisory visits had been documented. Upon returning to the electronic record, the aide supervisory visits suddenly appeared, and were time stamped as follows: 12/12/18 was time stamped as entered on 1/28/19 at 11:14 AM; 12/26/18 as time stamped as entered on 1/28/19 at 12:23 PM; 1/9/19 was time stamped as entered on 1/28/19 at 12:29 PM; and 1/23/19 was time stamped as entered on 1/28/19 at		100% compliance achieved, then 10% will be reviewed.	

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	12:45 PM. During an interview on 1/28/19 at 1:43 PM with the administrator and director of nursing regarding marking of visits as complete in scheduling software, both stated the "C" on the calendar in front of the visits stated the visit was completed, and would have been entered after time sheet review, or through billing. They both stated the agency's scheduling software and documentation software did not communicate to mark visits as complete when documentation had been completed.3. The record for patient # 5 was reviewed on 1/28/19. The plan of care dated 1/2/19-3/2/19 evidenced HHA services were to be provided 2 hours a day, 5 days a week for 9 weeks. The record evidenced the last HHA supervisory visit had been conducted on 12/27/18. The record failed to evidence a supervisory visit had been conducted on or by 1/26/19. During an interview on 1/28/19 at 1:54 PM, the director of nursing stated the nurse had not yet completed the supervisory visit.			