STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K064	A. BUILDING 00 B. WING	06/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT HOME HEALTH SERVICES LLC	6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250

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G 0000 Bldg. 00	This was a federal home health recertification with complaint survey. The survey was extended. Survey Dates: May 30, 31, June 1, 2, and 5, 2017 Complaint number: IN00178995 Substantiated; Federal and State deficiencies were cited Facility Number: 012383 Medicaid Number: 201005950A Census: 71 Sample: 10 At Home Health Services is precluded from providing its own training and competency evaluation program for a period of 2 years beginning June 5, 2017 to June 5, 2019, for being found out of compliance with the 484.10 Patient Rights; 494.14 Organization, Services, and Administration; 484.18 Acceptance of Patients, Plan of Care, Medical Supervision; 484.30 Skilled Nursing Services; 484.36 Home Health Aide Services; 484.48 Clinical Records; and	G 0000		

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

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G 0100 Bldg. 00	484.55 Comprehensive Assessment of Patients. Based on record review and interview, the agency failed to maintain documentation that it had provided a patient a written notice of patient rights in 1 out of 1 record reviewed of a patient readmitted to services in a sample of 10 (See G103); failed to ensure the patient and / or caregiver were informed in advance of the disciplines that would furnish care, the type of care to be provided, the anticipated frequency / duration of visits to be provided and of any changes in their care in 2 out of 2 discharged records reviewed of changes in care and in 6 out of 6 admissions in 2016 and 2017 in a sample of 10 (See G 108); and failed to inform the patient, orally and in writing, the charges for services that may not be covered and that the individual may have to pay for 6 of 6 records reviewed of patients admitted between 2016 to 2017 to current in a sample of 10 (See G 114).	G 0100	See G103, G108, G114	08/25/2017

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	The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.10 Patient Rights. The cumulative effect of the systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.			
G 0103 Bldg. 00	484.10(a)(2) NOTICE OF RIGHTS The HHA must maintain documentation showing that it has complied with the requirements of this section. Based on record review and interview, the agency failed to maintain documentation that it had provided a patient a written notice of patient rights in 1 out of 1 record reviewed of a patient readmitted to services in a sample of 10. (#6) Findings include: 1. The clinical record for patient #6, SOC 1/30/17, was reviewed. The clinical record failed to evidence documentation that patient #6 had been provided with a written notice of patient rights. A. The Director of Clinical Services	G 0103	Director of Nursing/designee will in-service all nursing staff on the need to provide patient/caregiver with a copy of Patient Rights. (Complete 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on the need to provide patient/caregiver with a copy of Patient Rights. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of Admissions to ensure compliance with documentation indicating patient/caregiver received copy of Patient Rights. After 100% compliance is achieved, Director of Nursing/designee will audit 25% of admissions monthly to	08/25/2017

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	was interviewed on 6/5/17 at 9:45 a.m. and indicated the patient's certification period ended during a hospitalization and the agency was told by their consultant that new admission paperwork did not need to be provided or signatures obtained upon readmission. 2. An undated policy titled "Client Admission Process" C- 140, indicated " ... Provide the client with a copy of their privacy rights and the Notice of privacy practices, and obtain consent to use and disclose protected health information for treatment, payment and healh care operations. Provide the client / caregiver with a copy and an explaination of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the Statement of Privacy Rights related to the collection and transmission of personal health care information ... Obtain the client's signature on the Service Agreement, Home Care Bill of Rights, and other forms required by the agency .... "		monitor compliance with documenting patient/caregiver received copy of Patient Rights. (To begin by 8/25/17) Director of Nursing/designee will train nursing staff on need to readmit patient if their certification period ends while hospitalized. (To be done by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	
G 0108 Bldg. 00	484.10(c)(1) RIGHT TO BE INFORMED AND PARTICIPATE The patient has the right to be informed, in advance about the care to be furnished, and of any changes in the care to be furnished.			

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	The HHA must advise the patient in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished. The HHA must advise the patient in advance of any change in the plan of care before the change is made. Based on record review and interview, the agency failed to ensure the patient and / or caregiver were informed in advance of the disciplines that would furnish care, the type of care to be provided, the anticipated frequency / duration of visits to be provided and of any changes in their care in 2 out of 2 discharged records reviewed of changes in care (#1 and 10) and in 6 out of 6 admissions in 2016 and 2017 in a sample of 10. (#3, 4, 5, 6, 8 and 9) Findings include: 1. The clinical record for patient #1 SOC (start of care) 3/10/15, was reviewed and included a written plan of care for the certification of 5/9/15 to 7/7/15, with orders for home health aide services up to 10 hours a day 7 days a week to assist with grooming, hygiene, transfers, medication reminders, meal preparation / setup, and light housekeeping. The patient had a diagnosis of Multiple Sclerosis. .	G 0108	Director of Nursing will in-service nurses on reviewing ordered aide hours and comparing to what hours aides are actually providing. If aide hours are consistently below the maximum ordered hours, nurse will talk with patient/caregiver about decreasing hours, notify MD and obtain verbal order for new aide frequency based on patient's actual needs. (To be done by 8/2517) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training nurses on reviewing ordered aide hours and comparing to what hours aides are actually providing. If aide hours are consistently below the maximum ordered hours, nurse will talk with patient/caregiver about decreasing hours, notify MD and obtain verbal order for new aide frequency based on patient's actual needs. (To begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of aide notes and compare utilized frequency with MD ordered frequency to ensure compliance with having MD order that meets the patient's	08/25/2017

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	A. Review of the payroll time records, the home health aides were providing services up from 5 to 7 hours a day. . B. Review of the FSSA (Family Social Service Administration) Medicaid paperwork dated 6/2/15, indicated the patient's original prior authorization request was modified and that the requested units were excessie based on the medical documentation submitted. C. Review of the FSSA Medicaid paperwork dated 6/17/15, indicated the request to increase the home health aide services were denied as medically not necessary. D. Review of the communications notes dated 6/15/15, 6/18/15, 7/5/15 and a nursing visit on 6/30/15, the agency failed to evidence that the patient and / or caregiver was informed of Medicaid's decision to decrease the home health aide hours, therefore, making a change in the agency's ability to service the patient. 2. The clinical record number 3, SOC (start of care) 11/28/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be		actual aide needs. Once 100% compliance is achieved Director of Nursing/designee will audit 25% of aide notes monthly and compare utilized frequency with MD ordered frequency to ensure compliance with having MD order that meets patient's actual needs. (To begin by 8/25/17) Director of Nursing will in-service nurses on need to notify patient / caregiver if Medicaid decreases number of hours requested on the PA, obtain MD order for the hours approved by Medicaid and document in patient chart. (To be done by 8/25/17) Director of Nursing/designee will be responsible to ensure orientation of newly hired nurses includes training on need to notify patient / caregiver if Medicaid decreases number of hours requested on the PA, obtain MD order for any decrease in the hours approved by Medicaid and document in patient chart. (To begin by 8/25/17) Director of Nursing/designee will audit, weekly, all Medicaid authorizations received. If Medicaid decreased requested hours, Director of Nursing/designee will ensure there is documentation patient/caregiver was notified of the decrease and MD order was obtained for authorized frequency. Once 100% compliance is achieved, Director of Nursing/designee will audit, monthly, 25% of Medicaid	

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	provided, and the anticipated frequency / duration of visits to be provided. 3. The clinical record number 4, SOC 4/24/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 4. The clinical record for patient #5, SOC 11/21/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 5. The clinical record for patient #6, SOC 1/30/17, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 6. The clinical record for patient #8, SOC 8/3/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in		authorizations received that month to ensure compliance with notifying patient/caregiver of any decrease in hours approved and MD order obtained for authorized frequency. (To begin by 8/25/17) Director of Nursing will in-service nursing staff on documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions to ensure compliance with documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To begin by 8/25/17) Director of Nursing will in-service nursing staff on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient	

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	advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 7. The clinical record for patient #9, SOC 7/8/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 8. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders and light housekeeping per care plan. A. The clinical record evidenced a discharge OASIS discharge assessment dated 4/2/17. The clinical record failed to evidenced that the attending physician had been notified in advance of the patient's unscheduled discharge, the patient had been informed in advance of the discharge and failed to provide documentation in regards notifying the		from agency. Nurses to document these conversations in patient's chart. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of discharges to ensure compliance with notifying MD of upcoming discharge, notifying patient of discharge at least fifteen (15) days before discharge and notifying other agencies involved in patient's care of patient's upcoming discharge from agency. (To begin by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	other home health agency and verifying the type of services being provided . B. An interview with the Employee C, Interim Director of Clinical Services, on 5/31/17 at 2:30 p.m., the employee indicated the patient notified the agency and indicated another home health agency was in the home. At Home Health Services decided to discharge the patient. The employee indicated a 15 day notice was not provided. C. On 5/31/17 at 2:30 p.m., Employee C was not unable to provide any further documentation upon request. 9. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 10. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 11. An undated policy titled "Client Admission Process" C- 140, indicated " ... Review the plan for services, treatment, and care with the client / caregiver of any reasonable risk and / or			

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	alternate associated with any procedure provided in the home .... "			
G 0114 Bldg. 00	484.10(e)(1(i-iii) PATIENT LIABILITY FOR PAYMENT Before the care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid, or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual may have to pay. Based on clinical record review, the agency failed to inform the patient, orally and in writing, the charges for services that may not be covered and that the individual may have to pay for 6 of 6 records reviewed of patients admitted between 2016 to 2017 to current in a sample of 10. (#3) Findings include: 1. The clinical record for patient #3, SOC 11/28/16, was reviewed. The Admission Service Agreement dated 11/28/16, indicated "Medicaid (Project 100% covered after meeting spend down and / or other requirements)." The Admission Service Agreement failed to evidence the charges that may occur for	G 0114	Director of Nursing will in-service nursing staff on ensuring patient/caregiver is informed, verbally and in writing at the time of admission, of the cost of services to be provided should the payer not cover services. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of new nurses includes training on making sure patient/caregiver is informed, verbally and in writing at the time of admission, of the cost of services to be provided should the payer not cover charges. (To begin by 8/25/17) The agency has revised Service Agreement to include “estimated cost per visit.” (Completed 8/7/17) (See Attachment A) Director of Nursing will in-service nursing staff on how to complete the form appropriately – including	08/25/2017

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	services not covered by the insurance benefit. 2. The clinical record number 4, SOC 4/24/16, was reviewed. The Admission Service Agreement dated 4/24/17, failed to evidence the liability for payment and the charges that may occur for services not covered by the insurance benefit. 3. The clinical record for patient #5, SOC 11/21/16, was reviewed. The Admission Service Agreement dated 11/26/16, Medicare as the liability of payment. The agency provided Medicaid non-skilled services. The Admission Service Agreement failed to evidence the identify the correct liability of payment and failed to include charges that may occur for services not covered by the insurance benefit. 4. The clinical record for patient #6, SOC 1/30/17, was reviewed. The clinical record failed to evidence an Admission Service Agreement. A. The Director of Clinical Services was interviewed on 6/5/17 at 9:45 a.m. and indicated the patient's certification period ended during a hospitalization and the agency was told by their consultant that new admission paperwork did not need to be provided or signatures		cost of service to be provided and marking the correct payer. (Complete 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on how to complete the form appropriately. (To begin by 8/25/17) Director of Nursing/designee will audit all admissions to monitor for compliance with documenting patient/caregiver were informed, verbally and in writing at the time of admission, of cost of services should payer not cover services and that the service agreement has been completed appropriately - listing the cost of service provided and correct payer marked. (To begin 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	obtained upon readmission. 5. The clinical record for patient #8, SOC 8/3/16, was reviewed. The Admission Service Agreement dated 8/3/16, indicated "Medicaid (Project 100% covered after meeting spend down and / or other requirements)." The Admission Service Agreement failed to evidence the charges that may occur for services not covered by the insurance benefit. 6. The clinical record for patient #9, SOC 7/8/16, was reviewed. The Admission Service Agreement dated 7/8/16, indicated "Medicaid (Project 100% covered after meeting spend down and / or other requirements)." The Admission Service Agreement failed to evidence the charges that may occur for services not covered by the insurance benefit. 7. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 8. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by			

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	the exit conference on 6/5/17 at 3:50 p.m. 9. An undated policy titled "Client Admission Process" C- 140, indicated " ... Advise the client / caregiver of the charges and billing procedures and, to the extent possible, the anticipated insurance coverage, the client / caregiver financial liability, and other methods of payment. Explain the concept of assignment of benefits and the liability for payments received from the insurance company for the agency's services. Clients will be informed of any possible financial obligations related to the care .... "			
G 0122 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Based on record review and interview, the Administrator failed to ensure that clinical staff annual performance evaluations were completed every 9 to 15 months in 2 out of 7 employee records reviewed (See G 134); failed to ensure that their efforts were coordinated effectively with other health providers serving their patients in 5 out of 5 active records reviewed of patients receiving outside services in a sample of 10 (See G 143); failed to include minutes of case	G 0122	See G134, G143, G145, G147	08/25/2017

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	conferences of patient care in 8 out of 8 active records reviewed in a sample of 10 (See G 144); failed to ensure 60 day summaries were reflective of the patients progress towards goals being met and not being met for 4 out of 7 active records reviewed of patients with recertifications in a sample of 10 (See G 145); and failed to ensure that an overall plan and a budget that included annual operating budget and capital expenditure was provided upon request for 1 of 1 home health agency (See G 147). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.14 Organization, Services, & Administration. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure te provision of quality health care in a safe environment.			
G 0134 Bldg. 00	484.14(c) ADMINISTRATOR The administrator, who may also be the supervising physician or registered nurse required under paragraph (d) of this section, employs qualified personnel and ensures adequate staff education and evaluations.			

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	15K064	A. BUILDING 00 B. WING	06/05/2017

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	Based on record review and interview, the Administrator failed to ensure that clinical staff annual performance evaluations were completed every 9 to 15 months in 2 out of 7 employee records reviewed. (Employee G and H). Findings include: 1. The personnel record for Employee G, a home health aide, start date 3/21/11, failed to evidence an annual performance evaluation. 2. The personnel record for Employee H, a home health aide, start date 4/1/15, failed to evidence an annual performance evaluation. 3. Employee A, the Alternate Administrator, indicated on 6/5/17 at 12:00 p.m., that Employee G's annual performance was completed by the Administrator but was not printed out from her computer prior to her going on vacation. Employee A indicated she did not have access to the Administrators files. Employee A indicated Employee H's evaluation was not completed.	G 0134	Human Resources/designee will utilize a tracking system to ensure employee evaluations are completed every 9 to 15 months as required by regulation. (To be completed by 8/25/17) Human Resources will be responsible to audit all current employee files. Any employee who has an evaluation that is past due will have an evaluation completed by their respective supervisor. (To be completed by 8/25/17) Human Resources will be responsible to track outstanding evaluations to ensure they are completed by 8/25/17. Human Resources will notify supervisors monthly of employee evaluations due during that month and will monitor for compliance to ensure evaluations are completed timely. (To begin immediately) Administrator/Human Resources will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	08/25/2017
G 0143 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the			

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	objectives outlined in the plan of care. Based on record review and interview, the agency failed to ensure that their efforts were coordinated effectively with other health providers serving their patients in 5 out of 5 active records reviewed of patients receiving outside services in a sample of 10. (#5, 6, 7, 8 and 10). Findings include: 1. The clinical record of patient #5, SOC 11/21/16, was reviewed and included a plan of care for the certification period of 5/20/17 to 7/18/17. The plan of care indicated the patient was receiving physical, occupational, and speech therapy with a Medicare agency and that the patient resided in a group home with 24 hour supervision. The clinical record failed to evidence that the agency had coordinated services with the Medicare agency and failed to evidence coordination with the group home of its expectations / delineation of duties with the home health agency. 2. The clinical record of patient #6, SOC 1/30/17, was reviewed and included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 3 times a week and home health aide services 7 days a week.	G 0143	Director of Nursing will in-service nurses on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions, resumptions and re-certifications to monitor for compliance of coordinating care with other medical agencies, if there are any. (To begin by 8/25/17) Director of Nursing will in-service nursing staff on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To be completed by 8/25/17) Director of Nursing will be	08/25/2017

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	A. During a home visit on 6/2/17 at 9:30 a.m., the patient was observed to live in a group home. The clinical record failed to evidence that the agency had coordinated services with the group home of its expectations / delineation of duties with the home health agency. 3. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. A. Review of a recertification comprehensive assessment dated 4/7/17, the "Professional Services" narrative section indicated the patient was receiving home health services with a Medicare agency for wound treatments. The comprehensive assessment failed to evidence an complete skin assessment, including visual site, of the patient's wounds. The clinical record failed to evidence the attempted coordination with the Medicare agency. B. A communication log dated 5/2/17, indicated that the patient was receiving home health services with a different Medicare agency for the treatment of wounds. The clinical record		responsible to ensure orientation of newly hired nurses includes training on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of discharges to ensure compliance with notifying MD of upcoming discharge, notifying patient of discharge at least fifteen (15) days before discharge and notifying other agencies involved in patient's care of patient's upcoming discharge from agency. (To begin 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	failed to evidence that the agency had coordinated services with the correct Medicare agency. 4. The clinical record for patient #8, SOC 8/3/16, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for a home health aide up to 8 hours a day, 7 days a week. The plan of care indicated the patient was receiving skilled nursing and home health aide services with a Medicare agency. A. Review of the OASIS start of care comprehensive assessment dated 8/3/16, the "Professional Services" narrative indicated the patient was receiving home health services 3 times a week through a Medicare agency for management of pressure wounds to the patient's right arm and buttocks. B. Review of the OASIS comprehensive recertification assessment dated 1/25 and 3/30/17, the "Professional Services" narrative indicated the patient was receiving skilled nursing and home health aide services through a Medicare agency. The clinical record failed to evidence that the agency had coordinated services with the Medicare agency. 5. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and			

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	included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders and light housekeeping per care plan. A. The clinical record evidenced a discharge OASIS discharge assessment dated 4/2/17. The clinical record failed to evidenced that the attending physician had been notified in advance of the patient's unscheduled discharge, the patient had been informed in advance of the discharge and failed to provide documentation in regards notifying the other home health agency and verifying the type of services being provided . B. An interview with the Employee C, Interim Assistant Director of Clinical Services, on 5/31/17 at 2:30 p.m., the employee indicated the patient notified the agency and indicated another home health agency was in the home. At Home Health Services decided to discharge the patient. The employee indicated a 15 day notice was not provided. C. On 5/31/17 at 2:30 p.m., Employee C was not unable to provide any further documentation upon request.			

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	6. An interview with Employee B, the Director of Clinical Services and Employee C indicated they are aware of the care coordination component and acknowledged the agency had a problem with documentation of all conversations and coordinations. 7. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 8. An undated policy titled "Coordination of Client Services" C - 360, indicated "It shall be the policy of this agency to ensure effective interchange, reporting and coordination of care and information provided by ... other providers of care .... "			
G 0144 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. Based on record review and interview, the agency failed to include minutes of case conferences of patient care in 8 out of 8 active records reviewed in a sample of 10. (#2 - 9) Findings include:	G 0144	Director of Nursing/designee will in-service nurses on properly documenting the 60 Day Conference. Documentation to include current disciplines, frequency, duration, tasks being provided, progress towards stated goals – if not progressing then	08/25/2017

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	1. A "60 day Case Conference" sheets dated 4/6/17, was reviewed. No sign in sheet provided. A. Review of patient #2 case conference, the "Update / Comments" indicated "no new meds [medications] / lost 6 lbs [pounds]." No further documentation was included. B. Review of patient #3 case conference, the "Update / Comments" indicated "med changes, medset every 2 wks [weeks], wants new doc [doctor] - change southern." No further documentation was included. C. Review of patient #5 case conference, the "Update / Comments" indicated "no changes." No further documentation was included. D. Review of patient #6 case conference, the "Update / Comments" indicated Group Home not checking on her at night, kidney issues." No further documentation was included. E. Review of patient #7 case conference, the "Update / Comments" indicated "no changes, 101!, can't get out of recliner." No further documentation was included.		what changes need to be made, physical status, any concerns, names of any other medical agencies that are providing service, etc. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on properly documenting the 60 Day Conference. Documentation to include current disciplines, frequency, duration, tasks being provided, progress towards stated goals – if not progressing then what changes need to be made, physical status, any concerns, names of any other medical agencies that are providing service, etc. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of case conference notes, until 100% compliance is achieved, to monitor for compliance with proper documentation of case conference. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of case conference notes monthly to monitor for compliance with properly documenting required information. (To begin by 8/25/17) Director of Nursing/designee will ensure there is a sign in sheet for all participating staff to sign.(See Attachment B) (To be completed by 8/25/17) Director of Nursing/designee will instruct nurses that aides are to	

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	F. Review of patient #8 case conference, the "Update / Comments" indicated "no changes - hoyer lift, shower chair." G. Review of patient #9 case conference, the "Update / Comments" indicated "no changes, cath change e / o [every other] wk." No further documentation was included. 2. A 60 day Case Conference sheets dated 5/18/17, was reviewed. The sign in sheet included personnel from medical records, 2 schedulers, quality assurance, Employee A, the Alternate Administrator, Employee B, the Director of Clinical Services, and Employee C, the Interim Assistant Director of Clinical Services as Case Managers. The sign in sheet failed to evidence the attendance of the home health aides. A. Review of patient #2 case conference, the "Update / Comments" indicated "nothing new." No further documentation was included. B. Review of patient #3 case conference, the "Update / Comments" indicated "recert next week." No further documentation was included.		be involved in case conferences. Aides will be given notice of when case conferences are being done and their input will be asked. (To be completed by 8/25/17) Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	C. Review of patient #4 case conference, the "Update / Comments" indicated "deteriorated since 4/25, wheelchair, unable to ambulate." No further documentation was included. D. Review of patient #5 case conference, the "Update / Comments" indicated "no changes." No further documentation was included. E. Review of patient #6 case conference, the "Update / Comments" indicated "PA renewal." No further documentation was included. F. Review of patient #7 case conference, the "Update / Comments" indicated "had a fall." No further documentation was included. G. Review of patient #8 case conference, the "Update / Comments" indicated "no changes." No further documentation was included. H. Review of patient #9 case conference, the "Update / Comments" was left blank. The 60 day case conference failed to evidence the effective interchange in regards to reporting, interventions, and progress toward goals.			

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	3. Employee B and Employee C had no comment in relation to the above findings at 6/2/17 at 4:00 p.m. 4. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 5. An undated policy titled "Coordination of Client Services" C - 360, indicated " ... Care conferences will be held as necessary to establish interchange, reporting, and coordinated evaluation between all disciplines involved in the client's care ... Ongoing care conferences shall be conducted to evaluate the client's status and progress. Any problems will be discussed and an action plan developed .... "			
G 0145 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES A written summary report for each patient is sent to the attending physician at least every 60 days. Based on record review and interview, the agency failed to ensure 60 day summaries were reflective of the patients progress towards goals being met and not being met for 4 out of 7 active records reviewed of patients with recertifications in a sample of 10. (#2, 3, 5 and 6)	G 0145	Director of Nursing will in-service nurses on ensuring correct information, to include correct address and status of any caregivers – disabled, refuse to assist, etc, is on patient's Plan of Care. (To be done by 8/25/17) Director of Nursing will in-service nurses on proper way to write 60 day summaries. Summaries are	08/25/2017

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	Findings include: 1. The clinical record for patient #2, SOC (start of care) 03/06/12, was reviewed and included a plan of care for the certification period of 2/8/17 to 4/8/17 and 4/9/17 to 6/7/17. The goals indicated "The client's safety will be enhanced through the home care services AEB [as evidenced by] no falls / injuries or ER visits within cert period. The client's skin and mucous membranes will remain intact. The client's home environment will be clean and safe, hygiene and personal care needs will be met .... " A. A plan of care for the certification period of 02/08/17 to 04/08/17, included a 60 day summary that indicated "Client seen for comprehensive assessment and recertification of HHA [home health aide] services, client to be recertified for another episode of HHA services. Client is a Black female who lives with her son, who works outside the home in one storied home with basement, requires 24 hour supervision and assist with all ADL's [activities of daily living] and IADL's [Instrumental activities of daily living]. Patient is non ambulatory and non verbal d/t [due to] severe dementia. DX [diagnoses] of End Stage Alzheimer's Disease, HTN [hypertension], urinary and		to be updated each recertification to reflect patient's actual status for the previous certification period. This includes discussing progress toward goals set for patient. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes instruction on ensuring Plan of Care reflects correct information and that 60 day summaries reflect patient's actual status for the previous certification period. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of 60 day summaries to monitor for compliance with providing accurate summary of patient's status, including progress towards goals, the past cert period. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of 60 day summaries monthly to monitor for compliance. (To begin by 8/25/17). Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	bowel incontinence, and impaired gait. Client is non-ambulatory and requires total transfers, bathing, dressing, meal prep (mechanical soft diet), set up and feeding, medication reminders, incontinence care and light housekeeping. Client lives with her son who is employed full time outside the home and is need of assistance to care for patient. Client is incontinent of bowel and bladder increasing the risk of skin breakdown, patient does wear adult briefs. Caregiver present, stated patient just had lunch. Client asleep on sofa when nurse arrived, caregiver stated client had no change in condition, no new medications, no visits to ER / hospitalizations. Lung sounds were clear, heart irregular, bowel sounds WNL [within normal limits] x 4 quads, abdomen soft / non-tender to palpitation. Pedal pulses palpable, no edema noted ... patient unable to stand for height, Wt 76 pounds. Family reports satisfaction with care / services provided by agency. Client's MD notified of recertification of care with no changes to care plan." B. A plan of care for the certification period of 4/9/17 to 6/7/17, included a 60 day summary that indicated "Client seen for comprehensive assessment and recertification of HHA [home health aide] services, client to be recertified for			

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	another episode of HHA services. Client is a Black female who believes with her son, who works outside the home in one storied home with basement, requires 24 hour supervision and assist with all ADL's [activities of daily living] and IADL's [Instrumental activities of daily living]. Patient is non ambulatory and non verbal d/t [due to] severe dementia. DX [diagnoses] of End Stage Alzheimer's Disease, HTN [hypertension], urinary and bowel incontinence, and impaired gait. Client is non-ambulatory and requires total transfers, bathing, dressing, meal prep (mechanical soft diet), set up and feeding, medication reminders, incontinence care and light housekeeping. Client lives with her son who is employed full time outside the home and is need of assistance to care for patient. Client is incontinent of bowel and bladder increasing the risk of skin breakdown, patient does wear adult briefs. Caregiver present, stated patient just had lunch. Client asleep on sofa when nurse arrived, caregiver stated client had no change in condition, no new medications, no visits to ER / hospitalizations. Lung sounds were clear, heart irregular, bowel sounds WNL [within normal limits] x 4 quads, abdomen soft / non-tender to palpitation. Pedal pulses palpable, no edema noted ... patient unable to stand for height, Wt 76			

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	pounds. Family reports satisfaction with care / services provided by agency. Client's MD notified of recertification of care with no changes to care plan." C. A home visit on 6/1/17 at 9:15 a.m., was conducted at the patient's daughters home where the patient had been residing. The new address of residence was not listed on the plan of care. The plan of care included a former address where services were initially provided. During this time, the home health aide indicated the patient use to live with the son but moved in with the daughter and had been residing with the daughter for a long time and could not remember when the patient had moved. The home health aide also indicated that the daughter was disabled. The 60 day summaries was repetitive from the admission summary and failed to be updated and be reflective of the patient status during the 60 day period and progress toward goals at the time of the recertification. 2. The clinical record for patient #3, SOC 11/28/16, was reviewed and included a plan of care for the certification period of 3/26/17 to 5/26/17 and 5/27/17 to 7/27/17. The goals indicated "Client will take medications as			

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	15K064	A. BUILDING 00 B. WING	06/05/2017

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	set / ordered AEB visual inspection of pill box, client / caregiver verbalize compliance, pill count is appropriate this cert period, The patient's safety will be enhanced throughout the home care services AEB no falls / injuries or ER visits within cert period. The patient's skin and mucous membranes will remain intact. The patient's home environment will be clean and safe, hygiene and personal care needs will be met. A. The plan of care for the certification period of 3/26/17 to 5/26/17, included a 60 day summary that indicated "Client seen by RN for comprehensive assessment for recertification of services. Client to be recertified for another episode HHA services. Client is an elderly male / female who lives alone in an apartment with diagnosis of Rhabdomyolysis, diabetes, hypertension, kidney and ureter disorder, morbid obesity. Client is requiring SN every two weeks for medication setup, teaching medication and to monitor compliance with medication and efficacy and HHA for personal care, meal prep / set up, and light housekeeping. Client is a high fall risk, unsteady gait and ambulates with walker at all times, has poor endurance, is incontinent of urine and requires assistance with each incontinent episode. Denied visits to ER / hospitalizations this			

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	certification period. Client is alert and oriented but stated he / she is forgetful and HOH [hard of hearing] ... Client verbalized satisfaction with plan of care and services to be provided. Physician notified of recertification and POC [plan of care]. B. The plan of care for the certification period of 5/27/17 to 7/27/17, included a 60 day summary that indicated "Client seen by RN for comprehensive assessment for recertification of services. Client to be recertified for another episode HHA services. Client is an elderly male / female who lives alone in an apartment with diagnosis of Rhabdomyolysis, diabetes, hypertension, kidney and ureter disorder, morbid obesity. Client is requiring SN every two weeks for medication setup, teaching medication and to monitor compliance with medication and efficacy and HHA for personal care, meal prep / set up, light housekeeping. Client is a high fall risk, unsteady gait and ambulates with walker at all times, has poor endurance, is incontinent of urine and requires assistance with each incontinent episode. Denied visits to ER / hospitalizations this certification period. Client is alert and oriented but stated he / she is forgetful and HOH [hard of hearing] ... Client verbalized satisfaction with plan of care			

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	and services to be provided. Physician notified of recertification and POC. The 60 day summaries was repetitive from the admission summary and failed to be updated and be reflective of the patient status during the 60 day period and progress toward goals at the time of the recertification. 3. The clinical record for patient #5, SOC 11/21/16, was reviewed and included a plan of care for the certification period of 5/20/17 to 7/18/17. The goals indicated "The patient's safety will be enhanced throughout the home care services AEB no falls / injuries or ER visits with cert period. The patients skin and mucous membranes will remain intact. The patient's home environment will be clean and safe, hygiene and personal care needs will be met. A. The plan of care for the certification period of 11/21/17 to 1/19/17, included an admission summary that indicated "Client seen by RN for comprehensive assessment recertification. 64 year old male / female admitted for HHA with dx of dementia. Has decreased dexterity and mentation. Requires assist with medication reminders and personal care. Tires easily with minimal exertion. Is a fall risk and			

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	incontinent of bladder and bowel. Aide to assist with personal care, light housekeeping. Patient lives in a group home with one staff member to supervisor ... Client verbalized satisfaction with plan of care and services to be provided. Physician notified of recertification and POC. B. The plan of care for the certification period of 1/20/17 to 3/20/17, included an 60 day summary that indicated "Client seen by RN for comprehensive assessment recertification. 64 year old male / female admitted for HHA with dx of dementia. Has decreased dexterity and mentation. Requires assist with medication reminders and personal care. Tires easily with minimal exertion. Is a fall risk and incontinent of bladder and bowel. Aide to assist with personal care, light housekeeping. Patient lives in a group home with one staff member to supervisor ... Client verbalized satisfaction with plan of care and services to be provided. Physician notified of recertification and POC. C. Review of the clinical record, the patient was hospitalized in April for possible seizure activity AEB resumption of care assessment dated 04/21/17.			

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	D. The plan of care for the certification period of 5/20/17 to 7/18/17, included a 60 day summary that indicated "Client seen by RN for comprehensive assessment recertification. 64 year old male / female admitted for HHA with dx of dementia. Has decreased dexterity and mentation. Requires assist with medication reminders and personal care. Tires easily with minimal exertion. Is a fall risk and incontinent of bladder and bowel. Aide to assist with personal care, light housekeeping. Patient lives in a group home with one staff member to supervisor [sic] 24 hrs [hours] day ... Client verbalized satisfaction with plan of care and services to be provided. Physician notified of recertification and POC." E. An interview with the Director of Clinical Services on 6/5/17 at 12:45 p.m., indicated that the patient did not start home health aide services until 1/26/17 due to the agency waiting on Medicaid Prior Authorization approval. The 60 day summaries was repetitive from the admission summary and failed to be updated and be reflective of the patient status during the 60 day period and progress toward goals at the time of the recertification.			

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	4. The clinical record of patient #6, SOC 1/30/17, was reviewed and included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing to provide a bowel program 3 times a week, urostomy irrigation, and urostomy management. The goals indicated "SN [skilled nurse] is expected to be long term due to disease process. HHA [home health aide] care is expected to be long term due to disease process. The client's safety will be enhanced throughout the home care services AEB no falls / injuries or ER visits within cert period. The client's skin and mucous membranes will remain intact. The client's home environment will be clean and safe, hygiene and personal care needs will be met." A. The plan of care for the certification period of 1/30/17 to 3/30/17, included an admission summary that indicated "53 year old male / female admitted for SN [skilled nursing] and HHA [home health aide] r/t [related to] dx [diagnosis] of Spina Bifada. Has decreased dexterity and requires assist with bowel regime and ostomy care, patient unable to perform care for self, dependent for personal care, light housekeeping .... " B. The plan of care for the			

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	certification period of 3/31/17 to 5/29/17, included an 60 day summary that indicated "Client seen by RN for comprehensive assessment recertification. 53 year old male / female admitted for SN [skilled nursing] and HHA [home health aide] r/t [related to] dx [diagnosis] of Spina Bifada. Has decreased dexterity and requires assist with bowel regime and ostomy care, patient unable to perform care for self, dependent for personal care. Patient uses a slide board for transfers. Tires easily with minimal exertion. Is a high fall risk, incontinent of bowel and urostomy for urine. Aide to assist with personal care, light housekeeping .... " The 60 day summaries was repetitive from the admission summary and failed to be updated and be reflective of the patient status during the 60 day period and progress toward goals at the time of the recertification. 5. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no comment in relation to the above findings at 6/2/17 at 4:00 p.m. 6. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by			

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	the exit conference on 6/5/17 at 3:50 p.m.			
G 0147 Bldg. 00	484.14(i) INSTITUTIONAL PLANNING The HHA, under the direction of the governing body, prepares an overall plan and a budget that includes an annual operating budget and capital expenditure plan. (1) Annual operating budget. There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. However, it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense. (2) Capital expenditure plan. (i) There is a capital expenditure plan for at least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than $600,000 for items that would under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes			

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	assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time, but are components of an overall plan or patient care objective, are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds. (ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health and Crippled Children's Services) or title XVIII (Medicare) or title XIX (Medicaid) of the Social Security Act, the plan specifies the following: (A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. (B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations. (C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency. Based on interview, the agency failed to ensure that an overall plan and a budget that included annual operating budget	G 0147	Administrator will keep printed copy of Annual Operating Budget and Capital Expenditure Budget available in office. Will instruct	08/25/2017

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	and capital expenditure was provided upon request for 1 of 1 home health agency. Findings include: 1. On 06/05/17 at , the Alternate Administrator was unable to provide an overall plan and a budget that included annual operating budget and capital expenditure upon request. 2. Employee A, the Alternate Administrator, indicated on 06/05/17 at 2:00 p.m., that the Administrator was on vacation and was told that the information was in the Administrators computer. The Alternate Administrator indicated she was not able to locate the information.		Alternate Administrator and Director of Nursing on location of printed copy of budget. (To be done by 8/25/17) Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	
G 0156 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on record review and interview, the agency failed to ensure staff followed the plan of care in relation to frequency and duration of patient visits, personal care, and providing services without a physician's order in 3 of 7 active records reviewed in a sample of 10 (See G 158); failed to ensure the plan of care was updated to include the determination of	G 0156	See G158, G159, G160, G164	08/25/2017

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	duration of home health aide visits specific and pertinent to the patient's needs in 6 out of 7 active records reviewed of patients with home health aides in a sample of 10; failed to include parameters for skilled nursing to obtain oxygen saturations in 7 out of 8 active records reviewed in a sample of 10; failed to update a patient's personal location of services to be provided on the plan of care in 1 of 5 home visits conducted; failed to update a medication profile in 2 out of 8 active records reviewed, failed to include g-tube site care, the amount and frequency of water flushes, the name, amount, and frequency of tube feedings, and instruction on the use of the Trilogy vent and bypap machine for oxygen rescue in 1 of 1 record reviewed of a patient with g-tube and a vent / bypap machine; and failed to include other entities / agencies assisting with the patients care in 2 out of 4 active records of patients with more than one service in a sample of 10 (See G 159); failed to ensure physicians were consulted after an evaluation visit and approved the Registered Nurse recommendations for admission in 7 of 8 records reviewed of patients admitted since 2015 in a sample of 10 (See G 160); and failed to ensure that the physician was notified of a patient's early discharge in 1 of 2 records reviewed of			

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	discharged patients in a sample of 10 (See G 164). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.18 Acceptance of Patients, Plan of Care & Medical Supervision. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.			
G 0158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on record review and interview, the agency failed to ensure staff followed the plan of care in relation to frequency and duration of patient visits, personal care, and providing services without a physician's order in 3 of 7 active records reviewed in a sample of 10. (#3, 4 and 6) Findings include: 1. The clinical record for patient #3,	G 0158	Director of Nursing will in-service nurses on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there	08/25/2017

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	SOC 11/28/16, included a plan of care for the certification period of 03/28/17 to 5/26/17, with orders for skilled nursing every 14 days for medication set up. Review of the skilled nursing visit notes in the electronic clinical record, the patient record contained a skilled nursing visit note on 03/29/17, 4/21/17, 5/5/17, 5/18/17, and 5/23/17. The clinical record failed to evidence a skilled nursing visit between 04/09/17 to 4/15/17. 2. The clinical record for patient #4, SOC 4/24/17, included a plan of care for the certification period of 4/24/17 to 6/22/17, with orders for a licensed practical nurse (LPN) up to 3 hours per day, 5 days a week to assist with personal care, transfers, medication reminders, meal preparation / setup, and light housekeeping. A. During a home visit on 6/1/17 at 1:00 p.m., the LPN was observed to administer liquid dilantin (anti-seizure medication), tylenol and ibuprofen (used for mild pain and / or fever) and approximately 100 ml (milliliters) of water flush through the patient's gastric tube (g-tube) before, during, and after medication administration. In the kitchen, a piece of paper that was secured to a cabinet door contained a list of medications and water flushes with times		is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of nursing documentation weekly, until 100% compliance is achieved, to monitor compliance with following frequency and duration for disciplines ordered by MD as well MD ordered plan of care and that care provided follows the MD ordered Plan of Care. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of nursing documentation	

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	to administer. The LPN indicated the spouse would sometimes have the medications administered prior to their arrival and sometimes the clinical staff would have to administer. The LPN indicated she would provide g-tube site care after the patient received a bath. B. Review of the skilled nursing visit notes indicated the following: 1. On 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered tube feedings. 2. On 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered water flushes. 3. On 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse provided g-tube site care. 4. On 5/4, 5/17, 5/25, 5/31, 6/1, and 6/4/17, the visit notes indicated the skilled nurse was in the home for 4 hours and for 10 hours on 5/23/17. 5. Three (3) skilled nursing visits were made week 1 and 4 of the		monthly to monitor for continued compliance. (To begin 8/25/17) Director of Nursing/designee will instruct clinical staff, if patient is receiving services thru more than one payer, to indicate on visit note which payer this visit is for. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired clinical staff includes training on, if patient is receiving services thru more than one payer, to indicate on visit note which payer this visit is for. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of visit notes, weekly, for patients receiving visits thru multiple payers to monitor compliance with marking payer on documentation. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of visit notes, monthly, to monitor for compliance. (To begin by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	15K064	A. BUILDING 00 B. WING	06/05/2017

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	certification period and 4 skilled nursing visits were made week 2, 3, 5, and 6 of the certification period. 6. On 4/25, 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23 and 5/24/17, failed to evidence if personal care had been provided. The skilled nurses failed to follow the plan of care in regards to frequency and duration of visits, providing personal care, as well as providing services without a physician's order. 3. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week to remove and apply a urostomy wafer one day per week. A. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/12, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes failed to evidence that the patient's urostomy wafer had been changed weekly. The skilled nurse failed to follow the plan of care.			

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	4. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 5. Employee A, the Alternate Administrator and Employee B, indicated on 6/5/17 at 3:50 p.m., that the overage of hours may be due to waiver hours being included in the Medicaid Prior Authorization hours. Both indicated there is no delineation on notes. 6. An undated policy titled "Plan of Care" C - 580, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The individualized Plan of Care is based on a comprehensive assessment and information provided by the client / family and health team member ... The Plan of Care shall be completed in full to include ... Type, frequency, and duration of all visits / services, Medications, treatments, and procedures .... "			
G 0159	484.18(a) PLAN OF CARE			

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Bldg. 00	The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. Based on record review and interview, the agency failed to ensure the plan of care was updated to include the determination of duration of home health aide visits specific and pertinent to the patient's needs in 6 out of 7 active records reviewed (#2, 3, 4, 5, 7 and 8) of patients with home health aides in a sample of 10; failed to include parameters for skilled nursing to obtain oxygen saturations in 7 out of 8 active records reviewed (#2, 3, 4, 5, 6, 7 and 8) in a sample of 10; failed to update a patient's personal location of services to be provided on the plan of care in 1 of 5 home visits conducted (#2); failed to update a medication profile in 2 out of 8 active records reviewed (#3 and 6), failed to include g-tube site care, the amount and frequency of water flushes, the name, amount, and frequency of tube feedings, and instruction on the use of the Trilogy vent and bypap machine for oxygen rescue in 1 of 1 record reviewed of a patient with g-tube and a vent / bypap	G 0159	Director of Nursing/designee will instruct nurses when patient has order for home health aide to indicate who is responsible to determine how many hours patient needs when order says “up to” number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes instructing nurses when patient has order for home health aide to indicate who is responsible to determine how many hours patient needs when order says “up to” number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. (To begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of Plans of Care to monitor for compliance	08/25/2017

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	machine (#4); and failed to include other entities / agencies assisting with the patients care in 2 out of 4 active records of patients with more than one service in a sample of 10. (# 6 and 7) Findings include: 1. The clinical record for patient #2, SOC (start of care) 3/6/12, included a plan of care for the certification period of 4/9/17 to 6/7/17. A. The plan of care indicated home aide services up to 8 hours per day, 5 days per week. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. C. A home visit on 6/1/17 at 9:15 a.m., was conducted at the patient's daughters home where the patient had been residing. The new address of residence was not listed on the plan of		with indicating who is responsible to determine how many hours patient needs when order says "up to" number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of Plans of Care monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing/designee will instruct nurses to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). (To be completed by 8/25/17) Director of Nursing will be responsible to ensure newly hired nurses are trained to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when (nursing/aide). (To be begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of Plans of Care to monitor for compliance indicating the Plan of Care has the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). Once 100% compliance is achieved, Director of Nursing/designee will audit	

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	care. The plan of care included a former address where services were initially provided. During this time, the home health aide indicated the patient use to live with the son but moved in with the daughter and had been residing with the daughter for a long time and could not remember when the patient had moved. The home health aide also indicated that the daughter was disabled. 2. The clinical record for patient #3, SOC 11/28/16, included a plan of care with orders for skilled nursing every 14 days for medication set up, oxygen saturations as needed and home health aide services up to 8 hours per day, 7 days a week. A. On 5/31/17 at 3:00 p.m., Employee C, the Interim Assistant Director of Clinical Services, indicated she would make extra visits to the patient's home to fix the medication box due to medications not being refilled before her visit. B. On 5/31/17 at 4:10 p.m., Employee C indicated she was going to go to the patient's home that evening and make sure the patient had his / her medication for our home visit on 6/1/17. C. On 6/2/17 at 4:45 p.m., Employee		25% of Plans of Care monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing/designee will instruct nurses that a verbal order is needed from MD to make extra visits that fall outside the ordered visit frequency for that discipline of the Plan of Care. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on needing a verbal order from MD to make extra visits that fall outside the ordered visit frequency for that discipline of the Plan of Care. (To begin by 8/25/17) Director of Nursing/designee will track all nursing visits for a month to monitor for compliance with following ordered frequency and if extra visits are noted there is a verbal order for that visit. Once 100% compliance is achieved, Director of Nursing will track 25% of patients monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	C indicated she did not obtain orders nor did she complete nursing visit notes. D. Review of the home health aide visit notes dated 03/29, 4/4, 4/9, 4/21, 4/29, 5/5, 5/8, 5/18, and 5/23/17, the home health aide provided services approximately from 3 hours to 7 hours. The plan of care failed to be updated to include extra visits for skilled nursing in the management of the patient's medications in between scheduled visits, duration of home health aide hours failed to be patient specific to include the minimal hours per day for the home health aide to be in the home as well as who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours and when to obtain oxygen saturations. 3. The clinical record for patient #4, SOC 4/24/17, included a plan of care for the certification period of 4/24/17 to 6/22/17, with orders for a LPN (licensed practical nurse) up to 3 hours per day, 5 days a week to assist with personal care, transfers, medication reminders, meal preparation / setup, and light housekeeping. The plan of care also indicated for the skilled nurse to obtain oxygen saturations as needed.			

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	A. During a home visit on 6/1/17 at 1:00 p.m., with Employee E, a LPN, was observed to administer liquid dilantin (anti-seizure medication), tylenol and ibuprofen (used for mild pain and / or fever) and approximately 100 ml (milliliters) of water flush through the patient's gastric tube (g-tube) before, during, and after medication administration. In the kitchen, a piece of paper that was secured to a cabinet door contained a list of medications and water flushes with times to administer. The Employee E indicated the spouse would sometimes have the medications administered prior to their arrival and sometimes the clinical staff would have to administer. Employee E indicated she would provide g-tube site care after the patient received a bath. Employee E and the patient discussed using the Trilogy vent and bypap machine for oxygen rescue. B. Review of the skilled nursing visit notes indicated the following: 1. On 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17,5/18, 5/22, 5/23, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered tube feedings and water flushes.			

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	2. On 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse provided g-tube site care. The plan of care failed to be updated to include g-tube site care, the amount and frequency of water flushes per g-tube, the name, amount, and frequency of tube feedings per g-tube, when to obtain oxygen saturations, and instruction on the use of the Trilogy vent and bypap machine for oxygen rescue. 4. The clinical record for patient #5, SOC 11/21/16, included a plan of care for the certification period of 3/19/17 to 5/19/17, with orders for home health aide services up to 6 hours per day, 5 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 1.25 to 3 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 6 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as			

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	needed. The plan of care failed to indicate when to obtain oxygen saturations. 5. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week for the instillation of medication / irrigation solution via catheter into bladder every visit. The medication profile evidenced Clorpactin to be administered every Monday, Wednesday, and Friday via urostomy flush and order for skilled nursing to obtain oxygen saturations as needed. A. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/12, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes failed to evidence that the instillation of the medication / irrigation solution via catheter into the bladder had been provided B. The Director of Clinical Services was interviewed on 06/05/17 at 1:30 and indicated the patient's Clorpactin instillation into the bladder had been discontinued. The Director of Clinical Services provided a physician's script /			

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	order dated 3/2/17, indicated to discontinue the Clorpactin instillation. C. A. During a home visit on 6/2/17 at 9:30 a.m., the patient was observed to live in a group home. The plan of care failed to be updated to exclude the Clorpactin medication instillation / irrigation, failed to indicate when to obtain oxygen saturations and failed to include that the patient resided and received services within a group home. 6. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 3.5 to 6 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 6 hours.			

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	B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. C. Review of a recertification comprehensive assessment dated 4/7/17, the "Professional Services" narrative section indicated the patient was receiving home health services with a Medicare agency for wound treatments. The plan of care failed to evidence that the patient's wounds were being managed by a Medicare agency. 7. The clinical record for patient #8, SOC 8/3/16, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for home health aide services up to 8 hours per day, 7 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 3.50 to 8 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours.			

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	B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. 8. Employee B, the Director of Clinical Services and Employee C, the Interim Alternate Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 9. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 10. An undated policy titled "Plan of Care" C - 580, indicated " ... Communication with a patient's physician is required in the following cases: Upon admission, recertification or discharge ... change in the plan of The individualized Plan of Care is based on a comprehensive assessment and information provided by the client / family and health team member ... The Plan of Care shall be completed in full to include ... Type, frequency, and duration of all visits / services, Medications, treatments, and procedures .... "			

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	11. An undated policy titled "Skilled Nursing Services" C - 200, indicated " ... The Registered Nurse ... Regularly reevaluates the clients needs, and coordinates the necessary services ... Initiates the Plan of Care and necessary revisions and updates to the plan of care and the care plan ... " G 0160 484.18(a) PLAN OF CARE Bldg. 00 If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modification to the original plan. Based on record review and interview, the agency failed to ensure physicians were consulted after an evaluation visit and approved the Registered Nurse recommendations for admission in 7 of 8 records reviewed of patients admitted since 2015 in a sample of 10. (# 1, 3, 4, 5, 6, 8, 9) Findings include: 1. The clinical record for patient #1, SOC (Start of Care) 3/10/15, was reviewed. A. The clinical record evidenced an OASIS comprehensive start of care assessment dated 3/10/15, which failed to evidence that the physician had been	G 0160	Director of Nursing/designee will in-service nurses on contacting MD after start of care visit to discuss visit findings, suggested plan of care to include disciplines, frequency and tasks. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on contacting MD after start of care visit to discuss visit findings, suggested plan of care to include disciplines, frequency and tasks. (To begin 8/25/17) Director of Nursing/designee will audit 100% of admissions to monitor for compliance with contacting MD after start of care visit to discuss visit findings, suggested plan of care to include disciplines, frequency and tasks. Once 100% compliance has been achieved, Director of	08/25/2017

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	15K064	A. BUILDING 00 B. WING	06/05/2017

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	contacted. B. Review of the coordination notes and physician orders, the clinical record failed to evidence that the physician was notified, consulted, and orders obtained after the evaluation visit dated 03/10/17. 2. The clinical record for patient #3, SOC 11/28/16, was reviewed. A. The clinical record evidenced an OASIS comprehensive start of care assessment dated 11/28/16, which failed to evidence that the physician had been contacted. B. Review of the coordination notes and physician orders, the clinical record failed to evidence that the physician was notified, consulted, and orders obtained after the evaluation / admission visit dated 11/28/16. 3. The clinical record for patient #4, SOC 4/24/17, was reviewed. An order dated 4/21/17 indicated for the skilled nurse to evaluate for home care services for 4/24/17. A. The clinical record evidenced an OASIS comprehensive start of care assessment dated 4/24/17, which failed to evidence that the physician had been		Nursing/designee will audit 25% of admissions monthly to monitor for compliance. (To begin 8/25/17) Director of Nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

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	contacted. B. Review of the coordination notes and physician orders, the clinical record failed to evidence that the physician was notified, consulted, and orders obtained after the evaluation / admission visit dated 4/24/17. 4. The clinical record for patient #5, SOC 11/21/16, was reviewed. A. A physician order dated 11/21/16, indicated a skilled nurse visit x 1 for skilled assessment for home health aide and start of care. B. The clinical record evidenced an OASIS comprehensive start of care assessment dated 11/21/16, which failed to evidence that the physician had been contacted. C. Review of the coordination notes and physician orders, the clinical record failed to evidence that the physician was notified, consulted, and orders obtained after the evaluation / admission visit dated 11/21/16. 5. The clinical record for patient #6, SOC 1/30/17, was reviewed. A. The clinical record evidenced an			

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	OASIS comprehensive start of care assessment dated 1/30/17, which failed to evidence that the physician had been contacted. B. Review of the coordination notes and physician orders, the clinical record failed to evidence that the physician was notified, consulted, and orders obtained after the evaluation visit dated 1/30/17. 6. The clinical record for patient #8, SOC 8/3/16, was reviewed. A. A physician order dated 7/28/16, indicated for skilled nursing to evaluate for home health services. B. The clinical record evidenced an OASIS comprehensive start of care assessment dated 8/3/16, which failed to evidence that the physician had been contacted. C. Review of the coordination notes and physician orders, the clinical record failed to evidence that the physician was notified, consulted, and orders obtained after the evaluation visit dated 8/3/16. 7. The clinical record for patient #9, SOC 7/8/16, was reviewed. A. The clinical record evidenced an			

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	OASIS comprehensive start of care assessment dated 7/8/16, which failed to evidence that the physician had been contacted. B. Review of the coordination notes and physician orders, the clinical record failed to evidence that the physician was notified, consulted, and orders obtained after the evaluation visit dated 7/8/16. 8. During the entrance conference with the Employee C, the Interim Assistant Director of Clinical Services and with Employee A, the Alternate Administrator on 5/30/17 at 11:10 a.m. Employee A indicated orders were obtained from physician prior to admission. Employee A and Employee C could not indicate if the physician was contacted after the evaluation visit. 9. An undated policy titled "Physician Orders" C - 635, indicateed " ... Communication with a patient's physician is required in the following cases: Upon admission, recertification or discharge ... change in the plan of care .... " 10. An undated policy titled "Plan of Care" C - 580, indicated " ... Communication with a patient's physician is required in the following cases: Upon admission, recertification or discharge ...			

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	change in the plan of The individualized Plan of Care is based on a comprehensive assessment and information provided by the client / family and health team member ... If a physician refers a client under a Plan of Care that cannot be completed until after an assessment visit, the physician shall be consulted to approve additions or modifications to the original plan .... "			
G 0164 Bldg. 00	484.18(b) PERIODIC REVIEW OF PLAN OF CARE Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care. Based on record review and interview, the agency failed to ensure that the physician was notified of a patient's early discharge in 1 of 2 records reviewed of discharged patients in a sample of 10. (#10) Findings include: 1. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication	G 0164	Director of Nursing will in-service nursing staff on requirement to notify MD of a patient's discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to notify MD of a patient's discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To begin by 8/25/17)	08/25/2017

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	reminders and light housekeeping per care plan. A. The clinical record evidenced a discharge OASIS discharge assessment dated 4/2/17. The clinical record failed to evidenced that the attending physician had been notified of the patient's unscheduled discharge. 2. An interview with the Employee C, Interim Director of Clinical Services, on 5/31/17 at 2:30 p.m., the employee indicated the patient would send aides home but one day, the patient called and indicated another home health agency was in the home. At Home Health Services decided to discharge the patient. 3. On 5/31/17 at 2:30 p.m., the agency was unable to provide any further documentation such as physician orders or coordination notes with the physician in regards to the discharge upon request. 4. An undated policy titled "Physician Orders" C - 635, indicateed " ... Communication with a patient's physician is required in the following cases: Upon admission, recertification or discharge ... change in the plan of care .... "		Director of Nursing/designee will audit 100% of discharges to ensure compliance with notifying MD of upcoming discharge and notifying other agencies involved in patient's care of patient's upcoming discharge from agency. (To begin by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
G 0168 Bldg. 00	484.30 SKILLED NURSING SERVICES			

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	Based on record review and interview, the agency failed to ensure staff followed the plan of care in relation to frequency and duration of patient visits, personal care, and providing services without a physician's order in 1 out of 4 active records reviewed of patients with skilled nursing services in a sample of 10 (See G 170); failed to ensure that a Registered Nurse reassessed a patient following surgery in 1 out of 1 record reviewed of a patient who received surgical procedure during a certification period in a sample of 10 (See G 172); failed to ensure the plan of care was updated to include the determination of duration of home health aide visits specific and pertinent to the patient's needs in 6 out of 7 active records reviewed of patients with home health aides in a sample of 10; failed to include parameters for skilled nursing to obtain oxygen saturations in 7 out of 8 active records reviewed in a sample of 10; failed to update a patient's personal location of services to be provided on the plan of care in 1 of 5 home visits conducted; failed to update a medication profile in 2 out of 8 active records reviewed; failed to include g-tube site care, the amount and frequency of water flushes, the name, amount, and frequency of tube feedings, and instruction on the use of the Trilogy vent and bypap machine for oxygen rescue in 1 of 1	G 0168	See G170, G172, G173, G180, G181, G183	08/25/2017

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	record reviewed of a patient with g-tube and a vent / bypap machine; and failed to include other entities / agencies assisting with the patients care in 2 out of 4 active records of patients with more than one service in a sample of 10 (See G 173); failed to ensure the License Practical Nurse (LPN) documented on a patient's urostomy care and bowel program in 1 of 4 active records reviewed of patients with skillned nursing in a sample of 10 (See G 180); failed to ensure the Licensed Practical Nurse (LPN) followed the plan of care in relation to frequency and duration of patient visits, personal care, and providing services without a physician's order in 2 out of 4 active records reviewed of patients with skilled nursing in a sample of 10 (See G 181); and failed to document in the skilled nursing visit notes the tube feeding administered, outcome of the fluid intake, specific the medication that was taught to the patient, specific diet teaching, disease process teaching, reason for physician notification as well as the follow up on the material educated with the patient and physician notification in 1 of 10 records reviewed (See G 183). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of			

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	Participation 484.30 Skilled Nursing Services. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.			
G 0170 Bldg. 00	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on record review and interview, the agency failed to ensure staff followed the plan of care in relation to frequency and duration of patient visits, personal care, and providing services without a physician's order in 1 out of 4 active records reviewed of patients with skilled nursing services in a sample of 10. (#3) Findings include: 1. The clinical record for patient #3, SOC 11/28/16, included a plan of care for the certification period of 03/28/17 to 5/26/17, with orders for skilled nursing every 14 days for medication set up. Review of the skilled nursing visit notes in the electronic clinical record, the patient record contained a skilled nursing visit note on 03/29/17, 4/21/17, 5/5/17,	G 0170	Director of Nursing will in-service nurses on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit.. (To begin 8/25/17) Director of Nursing/designee will	08/25/2017

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	5/18/17, and 5/23/17. The clinical record failed to evidence a skilled nursing visit between 04/09/17 to 4/15/17. 2. Employee B, the Director of Clinical Services and Employee C, the Interim Alternate Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 3. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 4. An undated policy titled "Plan of Care" C - 580, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The individualized Plan of Care is based on a comprehensive assessment and information provided by the client / family and health team member ... The Plan of Care shall be completed in full to include ... Type, frequency, and duration of all visits / services, Medications, treatments, and procedures .... "		audit 100% of nursing documentation weekly, until 100% compliance is achieved, to monitor compliance with following frequency and duration for disciplines ordered by MD as well MD ordered plan of care and that care provided follows the MD ordered Plan of Care. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of nursing documentation monthly to monitor for continued compliance. (To begin by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
G 0172 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse regularly re-evaluates the patients nursing needs. Based on record review and interview,	G 0172	Director of Nursing/designee will	08/25/2017

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	the agency failed to ensure that a Registered Nurse reassessed a patient following surgery in 1 out of 1 record reviewed of a patient who received surgical procedure during a certification period in a sample of 10. (#6) Findings include: 1. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 3 times a week. A. A Communication log dated 3/30/17, indicated the patient declined home health aide visit on 7/6/17 (verified by Director of Clinical Services as a typo and should read 4/6/17) due to having surgery. 1. A nursing visit note dated 4/7/17, indicated a LPN (Licensed Practical Nurse) conducted a visit, which failed to evidence the surgical procedure the patient had on 4/6/17. Employee C, the Interim Assistant Director of Clinical Services made a supervisory visit on 4/21/17, but failed to assess the patient. B. A Communication log dated 5/3/17, indicated the patient declined a home health aide visit on 5/4/17, due to		instruct staff on proofing documentation before submitting to ensure dates are correct. (To be done 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired staff are instructed on proofing documentation before submitting to ensure dates are correct. (To begin 8/25/17) Director of Nursing/designee will audit 100% of documentation weekly to ensure the dates on documentation are correct. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of documentation monthly to monitor for compliance. (To begin by 8/25/17). Director of Nursing/designee will in-service RN's on need to assess patient, before any other discipline makes visit, when they have had a hospital stay or a surgical procedure done to see if plan of care needs to be adjusted. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired RN's includes training on need to assess patient, before any other discipline makes visit, when they have had a hospital stay or a surgical procedure done to see if plan of care needs to be adjusted. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of documentation for patients who have had a hospital stay or a surgical procedure done	

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	having surgery. 1. A nursing visit note dated 5/5/17, indicated a LPN conducted a visit, which failed to evidence the surgical procedure the patient had on 5/4/17. Employee C made a supervisory visit on 5/17/17, but failed to assess the patient. C. The next Registered Nurse recertification assessment visit was conducted on 5/29/17, by Employee C. Employee C failed to conduct the initial visit and reassess the patient after the patient had surgery. D. Employee C was unable to provide any further documentation when asked on 6/5/17 at 1:30 p.m. 2. An undated policy titled "Skilled Nursing Services" C - 200, indicated " ... The Registered Nurse ... Regularly reevaluates the clients needs, and coordinates the necessary services ... "		to monitor for compliance with documentation they have been assessed by an RN before any other disciplines provide care. Once 100% compliance is achieved 25% of documentation will be audited monthly for those patients to ensure compliance. (To begin by 8/25/17) Director of Nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	
G 0173 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on record review and interview, the agency failed to ensure the plan of care was updated to include the determination of duration of home health	G 0173	Director of Nursing/designee will instruct nurses when patient has order for home health aide to indicate who is responsible to determine how many hours	08/25/2017

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	aide visits specific and pertinent to the patient's needs in 6 out of 7 active records reviewed (#2, 3, 4, 5, 7 and 8) of patients with home health aides in a sample of 10; failed to include parameters for skilled nursing to obtain oxygen saturations in 7 out of 8 active records reviewed (#2, 3, 4, 5, 6, 7 and 8) in a sample of 10; failed to update a patient's personal location of services to be provided on the plan of care in 1 of 5 home visits conducted (#2); failed to update a medication profile in 2 out of 8 active records reviewed (#3 and 6), failed to include g-tube site care, the amount and frequency of water flushes, the name, amount, and frequency of tube feedings, and instruction on the use of the Trilogy vent and bypap machine for oxygen rescue in 1 of 1 record reviewed of a patient with g-tube and a vent / bypap machine (#4); and failed to include other entities / agencies assisting with the patients care in 2 out of 4 active records of patients with more than one service in a sample of 10. (# 6 and 7) Findings include: 1. The clinical record for patient #2, SOC (start of care) 3/6/12, included a plan of care for the certification period of 4/9/17 to 6/7/17.		patient needs when order says "up to" number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes instructing nurses when patient has order for home health aide to indicate who is responsible to determine how many hours patient needs when order says "up to" number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. (To begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of Plans of Care to monitor for compliance with indicating who is responsible to determine how many hours patient needs when order says "up to" number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of Plans of Care monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing/designee will instruct nurses to indicate on Plan	

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	15K064	A. BUILDING 00 B. WING	06/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT HOME HEALTH SERVICES LLC	6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250

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	A. The plan of care indicated home aide services up to 8 hours per day, 5 days per week. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. C. A home visit on 6/1/17 at 9:15 a.m., was conducted at the patient's daughters home where the patient had been residing. The new address of residence was not listed on the plan of care. The plan of care included a former address where services were initially provided. During this time, the home health aide indicated the patient use to live with the son but moved in with the daughter and had been residing with the daughter for a long time and could not remember when the patient had moved. The home health aide also indicated that the daughter was disabled. 2. The clinical record for patient #3, SOC 11/28/16, included a plan of care		of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). (To be completed by 8/25/17) Director of Nursing will be responsible to ensure newly hired nurses are trained to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). (To be begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of Plans of Care to monitor for compliance indicating the Plan of Care has the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of Plans of Care monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing/designee will instruct nurses that a verbal order is needed from MD to make extra visits that fall outside the ordered visit frequency for that discipline of the Plan of Care and the nurse must complete documentation for all visits made. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on needing a verbal order	

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	with orders for skilled nursing every 14 days for medication set up, oxygen saturations as needed and home health aide services up to 8 hours per day, 7 days a week. A. On 5/31/17 at 3:00 p.m., Employee C, the Interim Assistant Director of Clinical Services, indicated she would make extra visits to the patient's home to fix the medication box due to medications not being refilled before her visit. B. On 5/31/17 at 4:10 p.m., Employee C indicated she was going to go to the patient's home that evening and make sure the patient had his / her medication for our home visit on 6/1/17. C. On 6/2/17 at 4:45 p.m., Employee C indicated she did not obtain orders nor did she complete nursing visit notes. D. Review of the home health aide visit notes dated 03/29, 4/4, 4/9, 4/21, 4/29, 5/5, 5/8, 5/18, and 5/23/17, the home health aide provided services approximately from 3 hours to 7 hours. The plan of care failed to be updated to include extra visits for skilled nursing in the management of the patient's medications in between scheduled visits,		from MD to make extra visits that fall outside the ordered visit frequency for that discipline of the Plan of Care and nurse must complete documentation for all visits made. (To begin by 8/25/17) Director of Nursing/designee will track all nursing visits for a month to monitor for compliance with following ordered frequency and if extra visits are noted there is a verbal order for that visit and that nurse has completed documentation for all visits. Once 100% compliance is achieved, Director of Nursing will track 25% of patients monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing will instruct nurses on including reason for doing pulse oximetry, if there is an order on Plan of Care to do one. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on including reason for doing pulse oximetry, if there is an order on Plan of Care to do one. (To begin by 8/25/17) Director of Nursing will in-service nurses on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation	

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	duration of home health aide hours failed to be patient specific to include the minimal hours per day for the home health aide to be in the home as well as who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours and when to obtain oxygen saturations. 3. The clinical record for patient #4, SOC 4/24/17, included a plan of care for the certification period of 4/24/17 to 6/22/17, with orders for a LPN (licensed practical nurse) up to 3 hours per day, 5 days a week to assist with personal care, transfers, medication reminders, meal preparation / setup, and light housekeeping. The plan of care also indicated for the skilled nurse to obtain oxygen saturations as needed. A. During a home visit on 6/1/17 at 1:00 p.m., with Employee E, a LPN, was observed to administer liquid dilantin (anti-seizure medication), tylenol and ibuprofen (used for mild pain and / or fever) and approximately 100 ml (milliliters) of water flush through the patient's gastric tube (g-tube) before, during, and after medication administration. In the kitchen, a piece of paper that was secured to a cabinet door contained a list of medications and water flushes with times to administer. The		of newly hired nurses includes training on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions, resumptions and re-certifications to monitor for compliance of coordinating care with other medical agencies, if there are any. (To begin by 8/25/17) Director of Nursing is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	Employee E indicated the spouse would sometimes have the medications administered prior to their arrival and sometimes the clinical staff would have to administer. Employee E indicated she would provide g-tube site care after the patient received a bath. Employee E and the patient discussed using the Trilogy vent and bypap machine for oxygen rescue. B. Review of the skilled nursing visit notes indicated the following: 1. On 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17,5/18, 5/22, 5/23, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered tube feedings and water flushes. 2. On 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse provided g-tube site care. The plan of care failed to be updated to include g-tube site care, the amount and frequency of water flushes per g-tube, the name, amount, and frequency of tube feedings per g-tube, when to obtain oxygen saturations, and instruction on the use of the Trilogy vent and bypap machine for oxygen rescue.			

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	4. The clinical record for patient #5, SOC 11/21/16, included a plan of care for the certification period of 3/19/17 to 5/19/17, with orders for home health aide services up to 6 hours per day, 5 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 1.25 to 3 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 6 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. 5. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week for the instillation of medication / irrigation solution via catheter into bladder every visit. The medication profile evidenced Clorpactin			

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	to be administered every Monday, Wednesday, and Friday via urostomy flush and order for skilled nursing to obtain oxygen saturations as needed. A. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/12, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes failed to evidence that the instillation of the medication / irrigation solution via catheter into the bladder had been provided B. The Director of Clinical Services was interviewed on 06/05/17 at 1:30 and indicated the patient's Clorpactin instillation into the bladder had been discontinued. The Director of Clinical Services provided a physician's script / order dated 3/2/17, indicated to discontinue the Clorpactin instillation. C. A. During a home visit on 6/2/17 at 9:30 a.m., the patient was observed to live in a group home. The plan of care failed to be updated to exclude the Clorpactin medication instillation / irrigation, failed to indicate when to obtain oxygen saturations and failed to include that the patient resided and received services within a group			

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	home. 6. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 3.5 to 6 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 6 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. C. Review of a recertification comprehensive assessment dated 4/7/17, the "Professional Services" narrative section indicated the patient was receiving home health services with a Medicare agency for wound treatments. The plan of care failed to evidence that			

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	the patient's wounds were being managed by a Medicare agency. 7. The clinical record for patient #8, SOC 8/3/16, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for home health aide services up to 8 hours per day, 7 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 3.50 to 8 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. 8. Employee B, the Director of Clinical Services and Employee C, the Interim Alternate Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m.			

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	9. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 10. An undated policy titled "Plan of Care" C - 580, indicated " ... Communication with a patient's physician is required in the following cases: Upon admission, recertification or discharge ... change in the plan of The individualized Plan of Care is based on a comprehensive assessment and information provided by the client / family and health team member ... The Plan of Care shall be completed in full to include ... Type, frequency, and duration of all visits / services, Medications, treatments, and procedures .... " 11. An undated policy titled "Skilled Nursing Services" C - 200, indicated " ... The Registered Nurse ... Regularly reevaluates the clients needs, and coordinates the necessary services ... "			
G 0180 Bldg. 00	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse prepares clinical and progress notes. Based on record review and interview, the agency failed to ensure the License Practical Nurse (LPN) documented on a	G 0180	Director of Nursing will in-service nurses on requirement to follow Plan of Care which includes tasks nurse is to provide.	08/25/2017

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	patient's urostomy care and bowel program in 1 of 4 active records reviewed of patients with skillned nursing in a sample of 10. (#6) Findings include: 1. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week to remove and apply a urostomy wafer one day per week and for the instillation of medication / irrigation solution via catheter into bladder every visit. The medication profile evidenced Clorpactin to be administered every Monday, Wednesday, and Friday via urostomy flush and order for skilled nursing to obtain oxygen saturations as needed. A. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, failed to evidence that the patient's urostomy wafer had been changed weekly. B. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/14, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8,		Care documented must follow orders on Plan of Care. Nurses to document how patient tolerated the procedure being done. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to follow Plan of Care. Care documented must follow orders on Plan of Care. Nurses to document how patient tolerated the procedure being done. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of nursing documentation weekly, until 100% compliance is achieved, to monitor compliance with following MD ordered plan of care and that care provided follows the MD ordered Plan of Care and that nurses document how patient tolerated the procedure being done. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of nursing documentation monthly to monitor for continued compliance. (To begin by 8/25/17) Director of Nursing will be responsible for monitoring these corrective changes to ensure this deficiency is corrected and does not recur.	

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	5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes indicated an 18 Fr foley catheter had been inserted with urine return. The notes failed to include where and why the double lumen foley catheter insertion. C. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/10, 4/14, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, failed to evidence that the patient's bowel program had been conducted, the outcome of the bowel program, and the patient's tolerance of the procedures. D. The Director of Clinical Services was interviewed on 06/05/17 at 1:30 and indicated the patient's Clorpactin instillation into the bladder had been discontinued. The Director of Clinical Services provided a physician's script / order dated 3/2/17, indicated to discontinue the Clorpactin instillation. E. The Alternate Administrator and the Director of Clinical Services had not further information or documentation by the exit conference on 06/05/17 at 3:50 p.m. 3. An undated policy titled "Skilled Nursing Services" C - 200, indicated " ...			

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	The Licensed Practical Nurse ... Assists the regisered nurse to complete the physician plan of care for skilled services ... Prepares clinical and progress notes .... " G 0181 484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE Bldg. 00 The licensed practical nurse assists the physician and registered nurse in performing specialized procedures. Based on record review and interview, the agency failed to ensure the Licensed Practical Nurse (LPN) followed the plan of care in relation to frequency and duration of patient visits, personal care, and providing services without a physician's order in 2 out of 4 active records reviewed of patients with skilled nursing in a sample of 10. (#4 and 6) Findings include: 1. The clinical record for patient #4, SOC 4/24/17, included a plan of care for the certification period of 4/24/17 to 6/22/17, with orders for a licensed practical nurse (LPN) up to 3 hours per day, 5 days a week to assist with personal care, transfers, medication reminders, meal preparation / setup, and light housekeeping. A. During a home visit on 6/1/17 at	G 0181	Director of Nursing will in-service nurses on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a	08/25/2017

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	15K064	A. BUILDING 00 B. WING	06/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT HOME HEALTH SERVICES LLC	6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1:00 p.m., Employee E, LPN was observed to administer liquid dilantin (anti-seizure medication), tylenol and ibuprofen (used for mild pain and / or fever) and approximately 100 ml (milliliters) of water flush through the patient's gastric tube (g-tube) before, during, and after medication administration. In the kitchen, a piece of paper that was secured to a cabinet door contained a list of medications and water flushes with times to administer. Employee E indicated the spouse would sometimes have the medications administered prior to their arrival and sometimes the clinical staff would have to administer. Employee E indicated she would provide g-tube site care after the patient received a bath. B. Review of the skilled nursing visit notes indicated the following: 1. On 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered tube feedings. 2. On 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered water flushes.		visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of nursing documentation weekly, until 100% compliance is achieved, to monitor compliance with following frequency and duration for disciplines ordered by MD as well MD ordered plan of care and that care provided follows the MD ordered Plan of Care. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of nursing documentation monthly to monitor for continued compliance. (To begin by 8/25/17) Director of Nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

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	3. On 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse provided g-tube site care. 4. On 5/4, 5/17, 5/25, 5/31, 6/1, and 6/4/17, the visit notes indicated the skilled nurse was in the home for 4 hours and for 10 hours on 5/23/17. 5. Three (3) skilled nursing visits were made week 1 and 4 of the certification period and 4 skilled nursing visits were made week 2, 3, 5, and 6 of the certification period. 6. On 4/25, 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23 and 5/24/17, failed to evidence if personal care had been provided. The skilled nurses failed to follow the plan of care in regards to frequency and duration of visits, providing personal care, as well as providing services without a physician's order. 3. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week to remove and apply a			

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	urostomy wafer one day per week. A. Review of the LPN visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/17, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes failed to evidence that the patient's urostomy wafer had been changed weekly. The skilled nurse failed to follow the plan of care. 4. Employee B, the Director of Clinical Services and Employee C, the Interim Alternate Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 5. Employee A, the Alternate Administrator and Employee B, indicated on 6/5/17 at 3:50 p.m., that the overage of hours may be due to waiver hours being included in the Medicaid Prior Authorization hours. Both indicated there is no delineation on notes. 6. An undated policy titled "Plan of Care" C - 580, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The individualized Plan of Care is based on a comprehensive assessment and information provided by			

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	the client / family and health team member ... The Plan of Care shall be completed in full to include ... Type, frequency, and duration of all visits / services, Medications, treatments, and procedures .... " 7. An undated policy titled "Skilled Nursing Services" C - 200, indicated " ... The Licensed Practical Nurse ... Assists the regisered nurse to complete the physician plan of care for skilled services ... Prepares clinical and progress notes .... "			
G 0183 Bldg. 00	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse assists the patient in learning appropriate self-care techniques. Based on record review and interview, the Licensed Practical Nurse (LPN) failed to document in the skilled nursing visit notes the tube feeding administered, outcome of the fluid intake, specific the medication that was taught to the patient, specific diet teaching, disease process teaching, reason for physician notification as well as the follow up on the material educated with the patient and physician notification in 1 of 10 records reviewed. (#4) Findings include:	G 0183	Director of Nursing/designee will in-service nursing staff on accurately documenting care provided specifically indicating what education was done and patient/caregiver response, if MD was notified of changes or concerns what changes if any were ordered, explaining tasks that were done in detail – i.e. tube feedings to include type of solution and amount administered, assessment as ordered on Plan of Care. Nurses to sign documentation. (To be completed by 8/25/17) Director of Nursing is responsible to ensure orientation of newly	08/25/2017

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	1. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed. The skilled nursing visit notes indicated the following: A. On 4/27/17, the visit note indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings. The visit note failed to evidence the medications, diet, and disease process that were taught and patient's understanding as well as the type and amount of tube feeding administered. B. On 4/28, 5/2, 5/17, 5/19, 5/22 and 5/23/17, the visit note indicated the interventions provided were the administration of tube feedings. The visit note failed to evidence the type and amount of tube feedings administered. C. On 5/3, 5/4 and 5/5/17, the visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes failed to evidence what was educated in regards to tube feedings, the patient's understanding of tube feedings, and the type and amount of tube feedings administered.		hired nurses includes training on accurately documenting care provided specifically indicating what education was done and patient/caregiver response, if MD was notified of changes or concerns what changes if any were ordered, explaining tasks that were done in detail – i.e. tube feedings to include type of solution and amount administered, assessment as ordered on Plan of Care. Nurses to sign documentation. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of visit notes weekly to monitor for compliance. Once 100% compliance has been achieved, 25% of visit notes will be audited monthly to monitor for compliance. (To begin by 8/25/17). Director of Nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

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	D. On 5/8/17, the visit note indicated the interventions provided were education and administration of tube feedings as well indicated that there were significant changes and the physician was notified after the case manager was informed. The visit notes failed to evidence what was educated in regards to tube feedings, the patient's understanding of tube feedings, type of tube feedings administered, what the specific changes in condition was, and physician response to notification of said change. The visit note also failed to evidence a blood pressure, temperature, heart rate, respirations, and pain assessment. E. On 5/9, 5/10 and 5/11/17, the visit notes indicated the interventions provided were education and administration of tube feedings as well indicated that there were significant changes and the physician was notified after the case manager was informed. The visit notes failed to evidence what was educated in regards to tube feedings, the patient's understanding of tube feedings, the type of tube feedings provided, what the specific changes in condition were, and physician response to notification of said change. F. On 5/16 and 5/24/17, the visit note indicated the interventions provided were			

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	administration of tube feedings. The visit note failed to evidence the type of tube feeding administered. G. On 5/25 and 5/30/17, the visit notes indicated the interventions provided were education of g-tube feedings, medication instruction, signs and symptoms of disease process, and g-tube site care. The visit note failed to evidence what was educated in regards to tube feedings, medications, and signs / symptoms of the disease process, the patient's understanding of the education provided, and an assessment of the g-tube site and the specific "care" provided. H. A visit note on 5/26/17, was provided on 6/2/17. The visit note was incomplete and failed to include cardiovascular, gastrointestinal, neurological / mental status, genitourinary, pulmonary, musculoskeletal, integumentary assessments, interventions, and professional services provided. The note also failed to include a signature with date. On 6/5/17, the agency provided another visit note that evidenced an assessment of the cardiovascular, gastrointestinal, neurological / mental status, genitourinary, pulmonary, musculoskeletal, integumentary systems but failed to evidence a pain assessment,			

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	interventions, and professional services provided. I. On 5/31 and 6/1/17, the visit note indicated the interventions provided was education of g-tube feedings, medication instruction, signs and symptoms of disease process, and g-tube site care. The visit note also indicated the patient's medications were reconciled per phone with the physician. The visit note failed to evidence what was educated in regards to tube feedings, medications, and signs / symptoms of the disease process, the patient's understanding of the education provided, and an assessment of the g-tube site and the specific "care" provided as well as the medications that were reconciled with the physician. J. On 6/2/17, the visit note indicated the interventions provided was education of g-tube feedings, medication instruction, signs and symptoms of disease process, and g-tube site care. The note also indicated the spouse notified the physician and to "see narrative." The visit note failed to evidence what was educated in regards to tube feedings, medications, and signs / symptoms of the disease process, the patient's understanding of the education provided, and an assessment of the g-tube site and the specific "care" provided as well as the			

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	"narrative" in regards to the patient's spouse physician notification. 2. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 3. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 4. An undated policy titled "Skilled Nursing Services" C - 200, indicated " ... The Licensed Practical Nurse ... Assists the client in learning appropriate self care techniques ... "			
G 0202 Bldg. 00	484.36 HOME HEALTH AIDE SERVICES Based on record review and interview, the agency failed to ensure that the home health aide written patient instructions failed to coincide with the physician plan of care to include the patient diagnosis(es), diet, mental status, and failed to be specific to the patient needs in relation to frequency and duration of visits, frequency of tasks to be performed and diagnoses in 7 out of 7 active records	G 0202	See G224, G225, G229, G230	08/25/2017

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	reviewed of patients with home health aide services in a sample of 10 (See G 224); failed to follow the plan of care in relation to light house keeping duties in 1 out of 2 home health aide visits conducted in a sample of 5 home visits (See G 225); failed to ensure that a Registered Nurse conducted a home health aide supervisory visit every 14 days in 3 out of 3 active records reviewed of patients receiving a home health aide with skilled nursing services in a sample of 10 (G 229); and failed to ensure that a Registered Nurse conducted a home health aide supervisory visit every 60 days in 2 out of 5 active records reviewed of home health aide only services in a sample of 10 (See G 230). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.36: Home Health Aide Services. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.			

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G 0224 Bldg. 00	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on record review and interview, the agency failed to ensure that the home health aide written patient instructions failed to coincide with the physician plan of care to include the patient diagnosis(es), diet, mental status, and failed to be specific to the patient needs in relation to frequency and duration of visits, frequency of tasks to be performed and diagnoses in 7 out of 7 active records reviewed of patients with home health aide services in a sample of 10. (#2, 3, 5, 6, 7, 8 and 9) Findings include: 1. The clinical record for patient #2, SOC (start of care) 3/6/12, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home aide services up to 8 hours per day, 5 days per week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping. The nutrition requirement (locator 16) indicated the patient was on a mechanical soft diet and	G 0224	Director of Nursing/designee will in-service nurses on ensuring home health aide plan of care is specific, for each patient, regarding tasks aide to perform, frequency and duration of visits and frequency of tasks to be performed. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on ensuring home health aide plan of care is specific, for each patient, regarding tasks aide to perform, frequency and duration of visits and frequency of tasks to be performed. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of aide plans of care to monitor for compliance with making sure it specific regarding tasks aide to perform, frequency and duration of visits and frequency of tasks to be performed. Once 100% compliance is achieved, 25% of aide plans of care will be audited monthly to monitor for compliance. (To begin by 8/25/17).	08/25/2017

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	the patient was a total feed. The functional limitations (locator 18) indicated the patient was hearing and speech impaired. The mental status (locator 19) indicated the patient was non - verbal. The patient's diagnoses included, but not limited to, Alzheimer's disease and dementia with behavioral disturbances. A. The home health aide written patient instructions indicated the patient was an assist with feeding, bed, commode, elimination, mobility, transfers, and wheelchair. The home health aide written patient instructions indicated the patient was on a regular diet. The home health aide written patient instructions included a complete bed bath, skin inspection, foot care, light housekeeping in the bathroom, kitchen, and bedroom, linen change, nail care, encourage fluids, hair care, meal prep, medication reminder, oral care, shampoo, wash clothes, and placement / removal of an orthopedic brace. The home health aide written instructions failed to be accurate and coincide with the physician plan of care. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed.			

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	2. The clinical record for patient #3, SOC 11/28/16, included a plan of care for the certification period of 5/27/17 to 7/25/17, with orders for home aide services up to 8 hours per day, 7 days per week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping. The nutrition requirement (locator 16) indicated the patient's diet was carbohydrate controlled (a diet in which carbohydrate intake is either limited or set at a particular value to help stabilize blood sugars). The patient's diagnoses included, but not limited to, Rhabdomyolysis, type 2 diabetes, kidney disorder, morbid obesity, hypothyroidism, and hypertension. A. The home health aide written patient instructions indicated the patient was on a carb controlled diet and no concentrated sweets. The home health aide written patient instructions included a shower, skin inspection, foot care, light housekeeping in the bathroom, kitchen, and bedroom, linen change, nail care, hair care, meal prep, medication reminder, oral care, shampoo, and wash clothes. The diet in the home health aide written instructions failed to coincide with the physician plan of care and failed to be specific and include frequency and duration of visits, frequency of tasks to			

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	be performed. The nail and foot care failed to be specific with indicating that the home health aide would not perform trimming of nails due to the patient diabetes. 3. The clinical record for patient #5, SOC 11/21/16, included a plan of care for the certification period of 5/20/17 to 7/18/17, with orders for home health aide services up to 6 hours per day, 5 days per week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping. The patient's diagnoses included, but not limited to, Tuberous sclerosis, dementia, weakness, and epilepsy / epileptic syndrome with seizures. A. The home health aide written patient instructions included to assist the patient with a shower, skin inspection, transfers, walker, light housekeeping in the bathroom, kitchen, and bedroom, linen change, foot care, dressing, ambulation, bed, hair care, meal prep, medication reminder, oral care, shampoo, and wash clothes. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed.			

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	4. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for home health aide services 1 - 2 visits per day up to 3 hours a day, 7 days a week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping per care plan. The patient diagnoses included, but not limited to, Spina bifida, urostomy, diabetes, and constipation. A. The home health aide written patient instructions included to assist the patient with dressing, bed, elimination, mobility, shower, skin inspection, transfers, equipment care, hair care, meal prep, medication reminder, oral care, positioning, peri care after incontinent episode, shampoo, nail care, light housekeeping in the bathroom, kitchen, and bedroom, linen change, and wash clothes. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed. The nail care failed to be specific with indicating that the home health aide would not perform trimming of nails due to the patient diabetes. 5. The clinical record for patient #7, SOC 12/31/16, included a plan of care for			

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	the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping per care plan. The patient diagnoses included, but not limited to, venous insufficiency, convulsions, diabetes, and venous embolism. A. The home health aide written patient instructions included to assist the patient with ambulation, chair, dressing, bed, elimination, mobility, bed bath, skin inspection, foot care, commode, transfers, walker, wheel chair, equipment care, hair care, meal prep, feeding, medication reminder, oral care, positioning, peri care after incontinent episode, shampoo, light housekeeping in the bathroom, kitchen, and bedroom, linen change, and wash clothes. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed. The foot care failed to be specific with indicating that the home health aide would not perform trimming of nails due to the patient diabetes. 6. The clinical record for patient #8, SOC 8/3/16, included a plan of care for			

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	the certification period of 3/3117 to 5/29/17, with orders for home health aide services up to 8 hours per day, 7 days a week. to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping per care plan. A. The home health aide written patient instructions included to assist the patient with bed, elimination, bed bath, skin inspection, nail care, clean dentures, transfers, inspect dressing, hair care, meal prep, medication reminder, oral care, positioning, peri care after incontinent episode, light housekeeping in the bathroom, kitchen, and bedroom, linen change, and wash clothes. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed. 7. The clinical record for patient #9, SOC 7/8/16, was reviewed. A communication log dated 5/16/17, indicated the home health aide was providing services up to 5 hours a day, 7 days a week to assist with grooming, hygiene, transfers, medication reminders / setup, and light housekeeping. The plan of care for the certification period 5/4/17 to 7/2/17, failed to be provided upon request on 5/30/17 and 6/2/17.			

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A. The home health aide written patient instructions included to assist the patient with chair, dressing, feeding, bed, elimination, mobility, shower, skin inspection, transfers, wheelchair, equipment care, encourage fluids, hair care, meal prep, medication reminder, oral care, positioning, and light housekeeping in the bathroom, kitchen, and bedroom, linen change, and wash clothes. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed.

8. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m.

9. Employee A, the Alternate Administrator, indicated at 12:00 p.m., that she was aware of the specific information needed for the home health aide care plan.

10. An undated policy titled "Home Health Aide / Certified Nursing Assistant (HHA ...) Care Plan" C - 751, indicated " ... To provide a means of assigning duties to the HHA ... that are clear to the Nurse,

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	HHA ..., and to the client / caregiver being served ... To provide documentation that the client's care is individualized to his / her specific needs.			
G 0225 Bldg. 00	484.36(c)(2) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE The home health aide provides services that are ordered by the physician in the plan of care and that the aide is permitted to perform under state law. Based on record review and interview, the home health aide failed to follow the plan of care in relation to light house keeping duties in 1 out of 2 home health aide visits conducted in a sample of 5 home visits. (#2) Findings include: 1. The clinical record for patient #2, SOC (start of care) 3/6/12, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 8 hours per day, 5 days per week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping per care plan. A. The home health aide written patient instructions indicated the home health aide was to provide light housekeeping in the bathroom, kitchen,	G 0225	Director of Nursing/designee will in-service aides on following patient's care plan as written by nurse and ordered by MD. (To be done by 8/25/17) Director of Nursing will be responsible to ensure to orientation of newly hired aides includes training on following patient's care plan as written by nurse and ordered by MD. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of aide care plans for compliance until 100% compliance is achieved. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of aide care plans monthly to monitor compliance. (To begin by 8/25/17) Director of Nursing/designee will in-service nurses on specifying what housekeeping tasks aide is to perform for each patient. It will be clearly indicated on care plan. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation	08/25/2017

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	and bedroom. During home visit on 6/1/17 at 9:00 a.m., the patient's bedroom was noted to have thick layer of dark colored dust on the furniture and ceiling fan. B. During the home visit with Employee F, a home health aide, the Director of Clinical Services observed the dust, including the dust on the ceiling fan, and indicated dusting was part of the "light housekeeping" in the patient's bedroom. The home health aide failed to follow the plan of care. 2. The clinical record for patient #5, SOC 11/21/16, included a plan of care for the certification period of 5/20/17 to 7/18/17, with orders for home health aide services up to 6 hours per day, 5 days per week to assist with personal care, bathing, dressing, activities of daily living, emal prep, medication reminders, and light housekeeping per care plan. A. The home health aide written patient instuctions indicated the home health aide was to provide a shower to the patient. B. During the home visit with Employee G, a home health aide indicated that the patient would receive a shower on Monday and Wednesday, but		of newly hired nurses includes training on specifying what housekeeping tasks aide is to perform for each patient. It will be clearly indicated on care plan. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of aide care plans for compliance until 100% compliance is achieved. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of aide care plans monthly to monitor compliance. (To begin by 8/25/17)	

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	would be washed off at the sink on Fridays. The home health aide failed to follow the plan of care.			
G 0229 Bldg. 00	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on record review and interview, the agency failed to ensure that a Registered Nurse conducted a home health aide supervisory visit every 14 days in 3 out of 3 active records reviewed of patients receiving a home health aide with skilled nursing services in a sample of 10. (#3, 6, and 9) Findings include: 1. The clinical record for patient #3, SOC 11/28/16, was reviewed and included orders for skilled nursing and home health aide services. The clinical record evidenced a home health aide supervisory visit on 03/24/17 and 5/23/17. The clinical record failed to evidence a home health aide supervisory visit every 14 days. 2. The clinical record for patient #6,	G 0229	Director of Nursing/designee will in-service nurses on supervising aide at least every fourteen (14) days in cases where patient is receiving skilled nurse and aide services. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on supervising aide at least every fourteen (14) days in cases where patient is receiving skilled nurse and aide services. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of aide supervisory notes weekly until 100% compliance is achieved. Once 100% compliance is achieved, 25% of aide supervisory notes will be audited monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing is responsible for monitoring corrective actions to this deficiency is corrected and will not recur.	08/25/2017

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	SOC 1/30/17, was reviewed and included orders for skilled nursing and home health aide services. The clinical record evidenced a home health aide supervisory visit on 4/21/17 and 5/17/17. The clinical record failed to evidence a home health aide supervisory visit every 14 days. 3. The clinical record for patient #9, SOC 7/8/16, was reviewed and included orders for skilled nursing and home health aide. The clinical record evidenced home health aide supervisory visit on 1/2/17, 3/1/17 and 4/28/17. The clinical record failed to evidence a home health aide supervisory visit every 14 days. 4. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, were aware of the supervisory visits had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 5. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m.			
G 0230	484.36(d)(3) SUPERVISION			

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Bldg. 00	If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy or speech-language pathology services, the registered nurse must make a supervisory visit to the patient's home no less frequently than every 60 days. In these cases, to ensure that the aide is properly caring for the patient, each supervisory visit must occur while the home health aide is providing patient care. Based on record review and interview, the agency failed to ensure that a Registered Nurse conducted a home health aide supervisory visit every 60 days in 2 out of 5 active records reviewed of home health aide only services in a sample of 10. (# 2 and 5) Findings include: 1. The clinical record for patient #2, SOC (start of care) 3/6/12, was reviewed. The clinical record failed to evidence a 60 day home health aide supervisory visit between 1/5/17 to 5/3/17. 2. The clinical record for patient #5, SOC 11/21/16, was reviewed. The clinical record failed to evidence a 60 day home health aide supervisory visit between 1/26/17 to 6/2/17. 3. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services,	G 0230	Director of Nursing/designee will in-service nurses on requirement to supervise aide at least every sixty (60) days in cases where patient has aide only services. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure newly hired nurse are trained on requirement to supervise aide at least every sixty (60) days in cases where patient has aide only services. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of aide supervisory notes weekly until 100% compliance is achieved. Once 100% compliance is achieved, 25% of aide supervisory notes will be audited monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing is responsible for monitoring corrective actions to this deficiency is corrected and will not recur.	08/25/2017

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	were aware of the supervisory visits had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m.			
G 0235 Bldg. 00	484.48 CLINICAL RECORDS Based on record review, the agency failed to ensure that visit notes were accessible in an electronic medical record in 1 of 2 closed records reviewed (#1) in a sample of 10, failed to update a clinical record with a correct address location of a patient receiving services in 1 out of 5 home visits conducted (#2), failed to physician orders were written for prn (as needed) visits and that those prn skilled nursing visits were documented in 1 out of 4 records reviewed (#3) of patients with skilled nursing in a sample of 10; failed to ensure electronic medical records identified an employee as a LPN and not an RN in 2 out of 2 records reviewed (#4 and 6) of patients receiving skilled nursing services from Employee E in a sample of 10; failed to ensure visit notes were completed and signed / dated by the clinican in a timely manner in 1 of 8 active records reviewed (#4) in a sample of 10; failed to ensure that the physician signed the initial plan of care orders within a timely manner in 1 out of 8 active records reviewed (#5) in a	G 0235	See G236	08/25/2017

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	sample of 10; and failed to evidence a plan of care in 1 out of 8 active records reviewed (#9) in a sample of 10. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.48: Clinical Records. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.			
G 0236 Bldg. 00	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. Based on record review, the agency failed to ensure that visit notes were accessible in an electronic medical record in 1 of 2 closed records reviewed (#1) in a sample of 10, failed to update a clinical record with a correct address location of a	G 0236	Administrator/designee will ensure that if agency changes electronic records vendor agency has copies, either paper or electronic, of all patient records before changing vendor. (To begin immediately) Director of Nursing/designee will	08/25/2017

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	patient receiving services in 1 out of 5 home visits conducted (#2), failed to physician orders were written for prn (as needed) visits and that those prn skilled nursing visits were documented in 1 out of 4 records reviewed (#3) of patients with skilled nursing in a sample of 10; failed to ensure electronic medical records identified an employee as a LPN and not an RN in 2 out of 2 records reviewed (#4 and 6) of patients receiving skilled nursing services from Employee E in a sample of 10; failed to ensure visit notes were completed and signed / dated by the clinican in a timely manner in 1 of 8 active records reviewed (#4) in a sample of 10; failed to ensure that the physician signed the initial plan of care orders within a timely manner in 1 out of 8 active records reviewed (#5) in a sample of 10; and failed to evidence a plan of care in 1 out of 8 active records reviewed (#9) in a sample of 10. Findings include: 1. The clinical record for patient #1, Start of Care (SOC) 03/10/15, was reviewed on 05/31/17. The electronic medical record system provided visit dates and times but did not provide access to the actual visit notes. At 2:30 p.m., Employee B, the Director of Clinical Services, was requested to		instruct nurses to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). (To be completed by 8/25/17) Director of Nursing will be responsible to ensure newly hired nurses are trained to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when (nursing/aide). (To be begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of Plans of Care to monitor for compliance indicating the Plan of Care has the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when (nursing/aide). Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of Plans of Care monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing/designee will instruct nurses that a verbal order is needed from MD to make extra visits that fall outside the ordered visit frequency for that discipline of the Plan of Care. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on needing a verbal order from MD to make extra visits that	

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	provide home health aide visit notes. A. On 06/01/17 at 3:20 p.m., Employee B was requested again to provide copies of home health aide visit notes. B. On 06/02/17 at 11:50 a.m., Employee B the provided a print out of home health aide visits of recorded time in and time out between 04/12/15 to 06/12/15. Employee B indicated she was not able to provide any information after 06/12/17. C. On 06/05/17 at 9:45 a.m., Employee A, the Alternate Administrator, was requested to provide patient #1 home health supervisory visit records. At 12:00 p.m., Employee A indicated the company had changed software and she was not able to obtain the visit notes and would contact the Administrator to see if the agency would pay the former software company to get into the clinical record and obtain the information. D. On 06/05/17 at 3:40 p.m., Employee A was only able to provide nursing visit records 04/21, 04/23 - 4/28/15 and 06/30 - 06/17/15, 07/20 - 07/31/15, and 08/18 - 08/19/15. Employee A indicated she kept getting an		fall outside the ordered visit frequency for that discipline of the Plan of Care. (To begin by 8/25/17) Director of Nursing/designee will track all nursing visits for a month to monitor for compliance with following ordered frequency and if extra visits are noted there is a verbal order for that visit. Once 100% compliance is achieved, Director of Nursing will track 25% of patients monthly to monitor for compliance. (To begin by 8/25/17) The nurse who signed her electronic notes as “RN” when she only had an Indiana license was an oversight when putting her credentials in the system. That has been corrected and she is listed and signs as an "LPN." She is an “RN” in Illinois and has an “LPN” license in Indiana. She is working as an LPN for the agency and follows the Nurse Practice Act standards for LPN. She has not functioned in the capacity of an RN while employed by this agency. Director of Nursing is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	"error" and was not able to access the home health aide visit notes. 2. The clinical record for patient #2, SOC (start of care) 03/06/12, was reviewed on 6/2/17. The plan of care included a former address where services were initially provided. A. A home visit on 6/1/17 at 9:00 a.m., was conducted at the patient's daughters home where the patient had been residing. During this time, the home health aide indicated the patient use to live with the son but moved in with the daughter and had been residing with the daughter for a long time and could not remember when the patient had moved. The plan of care failed to be updated with accurate information of the patient's residence to where services were to be provided. 3. The clinical record for patient #3, SOC 11/28/16, was reviewed on 5/31/17. The plan of care included orders for skilled nursing every 14 days for medication set up. A. On 5/31/17 at 3:00 p.m., Employee C, the Interim Assistant Director of Clinical Services, indicated she would make extra visits to the patient's home to fix the medication box			

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	due to medications not being refilled before her visit. The clinical record failed to evidence physician orders and visit notes for the extra visits made. B. On 5/31/17 at 4:10 p.m., Employee C indicated she was going to go to the patient's home that evening and make sure the patient had his / her medication for our home visit on 6/1/17. C. On 6/2/17 at 4:45 p.m., Employee C indicated she did not obtain orders nor did she complete nursing visit notes. 4. The clinical record for patient #4 SOC 4/26/17, was reviewed. The skilled nursing visit notes indicated the following: A. A visit note on 5/26/17, was provided on 6/2/17. The visit note was incomplete and failed to include cardiovascular, gastrointestinal, neurological / mental status, genitourinary, pulmonary, musculoskeletal, integumentary assessments, interventions, and professional services provided. The note also failed to include a signature with date. B. On 6/5/17, the agency provided another visit note dated 5/26/17 that			

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	evidenced an assessment of the cardiovascular, gastrointestinal, neurological / mental status, genitourinary, pulmonary, musculoskeletal, integumentary systems but failed to evidence a pain assessment, interventions, and professional services provided. At the top of the visit note, it is indicated that the LPN signed the visit note on 6/4/17 and at the bottom of the page, the note indicated the LPN signed the visit note on 5/26/17. C. The first page of the skilled nursing visit notes dated 4/25, 5/2, 5/8, 5/9, 5/15, 5/16, 5/22, 5/23, 5/25, 6/1, and 6/2/17, indicated the notes were completed by Employee E, a Registered Nurse but the last page of the visit notes were electronically signed by Employee E, a Licensed Practical Nurse. 1. The Indiana Professional Licensing website was reviewed and indicated that Employee E was a LPN only. The only Registered Nurses with Employee E name were licensed in Illinois. 2. The Employee A, the Alternate Administrator, and Employee B, the Director of Clinical Services, were intereviewed on 6/5/17 at 3:45 p.m. Employee A and B indicated that the			

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discrepancy was a computor error and that Employee E worked for a local hospital with his / her RN license and worked for the home health agency under his / her LPN license due to a contract with the hospital.

5. The clinical record for patient #5 SOC 11/21/16, was reviewed. The initial plan of care dated 11/21/16 to 1/20/17, evidenced that the physician signed the plan of care on 1/13/17. The agency failed to ensure that the physician signed the initial plan of care orders within a timely manner.

6. The clinical record for patient #6, SOC 1/30/17, was reviewed.

A. Skilled nursing visit notes dated 4/12, 4/17, 4/19, 4/24, 5/1 and 5/17/17, indicated the notes were completed by Employee E, a Registered Nurse but the visit notes were electronically signed by Employee E, a Licensed Practical Nurse.

1. The Indiana Professional Licensing website was reviewed and indicated that Employee E was a LPN only. The only Registered Nurses with Employee E name were licensed in Illinois.

2. The Alternate Administrator

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	and Director of Clinical Services were intereviewed on 6/5/17 at 3:45 p.m., and they indicated that the discrepancy was a computor error and that Employee E worked for a local hospital with his / her RN license and worked for the home health agency under his / her LPN license due to a contract with the hospital. The agency did not verify if Employee E was truly a registered nurse. 7. The clinical record for patient #9, SOC 7/8/16, was reviewed. A request for physician orders and the plan of care for the current certification period was requested on 5/30/17 and again on 6/2/17. The agency failed to evidence patient #9's physician orders and plan of care. 9. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 10. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m.			
G 0237	484.48(a)			

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Bldg. 00	RETENTION OF RECORDS Clinical records are retained for 5 years after the month the cost report to which the records apply is filed with the intermediary, unless State law stipulates a longer period of time. Policies provide for retention even if the HHA discontinues operations. Based on record review and interview, the agency failed to ensure that all the contents of a patient's clinical record was retained and accessible in 1 of 1 record reviewed in a sample of 10. (#1) Findings include: 1. The clinical record for patient # 1, Start of Care (SOC) 03/10/15, was reviewed on 05/31/17. The electronic medical record system provided visit dates and times but did not provide access to the actual visit notes. At 2:30 p.m., Employee B, the Director of Clinical Services, was requested to provide home health aide visit notes. 2. On 06/01/17 at 3:20 p.m., Employee B was requested again to provide copies of home health aide visit notes. 3. On 06/02/17 at 11:50 a.m., Employee B provided a print out of home health aide visits of recorded time in and time out between 04/12/15 to 06/12/15. Employee B indicated she was not able to provide any information after 06/12/17.	G 0237	Administrator/designee will ensure that if agency changes electronic records vendor agency has copies, either paper or electronic, of all patient records before changing vendor. (To be done by 8/25/2017) Director of Nursing/designee will ensure there is someone available, in office or by phone, who can assist with computer issues when staff is unable to access patient electronic records. There will be a list posted in office, in a central location, indicating who to contact and how to contact them. During staff meetings Director of Nursing/designee will remind staff of who to contact when having issues retrieving patient's electronic records. This will be documented in the meeting notes. (To begin by 8/25/17)	08/25/2017

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	4. On 06/05/17 at 9:45 a.m., Employee A, the Alternate Administrator, was requested to provide patient #1 home health supervisory visit records. At 12:00 p.m., Employee A indicated the company had changed software and she was not able to obtain the visit notes and would contact the Administrator to see if the agency would pay the former software company to get into the clinical record and obtain the information. 5. On 06/05/17 at 3:40 p.m., Employee A was only able to provide nursing visit records 04/21, 04/23 -4/28/15 and 06/30 - 06/17/15, 07/20 - 07/31/15, and 08/18 - 08/19/15. Employee A indicated she kept getting an "error" and was not able to access the home health aide visit notes.			
G 0250 Bldg. 00	484.52(b) CLINICAL RECORD REVIEW At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. Based on record review and interview, the agency failed to ensure that a quarterly meeting was conducted to review the scope of the agency's program,	G 0250	Administrator and Director of Nursing/designee will be responsible to ensure quarterly QAPI is done. Director of Nursing will be responsible to obtain	08/25/2017

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	reviewed a sample of both active and closed records to determine whether established policies were being followed in furnishing services. Findings include: 1. On 6/5/17 at 2:00 p.m., the QAPI (Quality Assurance Performance Improvement) program was asked to be reviewed. During this time, Employee A, the Alternate Administrator, indicated that there was not a 2017 QAPI to review but provided consultant notes of their review of the agency. Employee A indicated they did not take the information from the consultant and implemented that into their QAPI program. Employee A indicated the consultant wanted to wait until the end of June - beginning July before coming to the agency to assist them.		information required for QAPI and write the report. Director of Nursing will be responsible to notify those needing to attend of the meeting date and time, having materials avail for review during meeting, having sign in sheet, keeping meeting minutes, which will include: what was discussed, what is the plan to address issues, who will monitor and what the goals are for each issue. (To be done by 8/25/17) Administrator and Director of Nursing will be responsible to ensure any reports, reviews, audits, etc. that are done by an outside entity that are pertinent to the QAPI requirements are included in the quarterly report. The material to presented will be reviewed prior to meeting to ensure they contain all required information. (To be done by 8/25/17)	
G 0330 Bldg. 00	484.55 COMPREHENSIVE ASSESSMENT OF PATIENTS Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes. The comprehensive assessment must identify the patient's continuing need for home care			

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	and meet the patient's medical, nursing, rehabilitative, social, and discharge planning needs. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. The comprehensive assessment must also incorporate the use of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary Based on record review and interview, the agency failed to ensure that a Registered Nurse conducted an initial assessment visit in order to determine the immediate needs of patients in 7 of 8 records reviewed of patients admitted since 2015 in a sample of 10 (See G 332); failed to ensure that the Registered Nurse comprehensive assessment was complete and included skin assessments of gastric tube and urostomy sites, diet clarified, and failed to completely assess a patients pain and respiratory system in 2 out of 4 records reviewed of patients with skilled nursing services in a sample of 10 (G 334); failed to ensure that the medication profile was updated upon initiation of new orders in 1 out of 8 active records reviewed in a sample of 10 and failed to ensure the medication profile include correct start date, physician, phone numbers to the physician and pharmacy, purpose of	G 0330	See G332, G334, G337, G339	08/25/2017

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	medications and potential side effects in 3 out of 8 active records reviewed in a sample of 10 (See G 337); failed to ensure that the Registered Nurse conducted a complete skin assessment in 2 of 2 active records reviewed of a patient receiving wound treatments with a Medicare agency in a sample of 10 (See G 339); and failed to ensure the Registered Nurse completed a discharge assessment based on last skilled nursing visit in 1 of 2 discharged records reviewed in a sample of 10 (See G 339). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.55: Comprehensive Assessments. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment.			
G 0332 Bldg. 00	484.55(a)(1) INITIAL ASSESSMENT VISIT The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date. Based on record review and interview,	G 0332	Director of Nursing/designee will in-service staff on requirement to	08/25/2017

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	the agency failed to ensure that a Registered Nurse conducted an initial assessment visit in order to determine the immediate needs of patients in 7 of 8 records reviewed of patients admitted since 2015 in a sample of 10. (# 1, 3, 4, 5, 6, 8, 9) Findings include: 1. The clinical record for patient #1, Start of Care (SOC) 03/10/15, was reviewed and failed to evidence an initial assessment visit note. 2. The clinical record for patient #3, SOC 11/28/16, was reviewed. The clinical record included a referral form dated 9/19/16. The clinical record failed to evidence an initial assessment visit note within 48 hours of the referral. 3. The clinical record for patient #4, SOC 4/24/17, was reviewed. The clinical record included a referral form dated 3/15/17. The clinical record failed to evidence an initial assessment visit note within 48 hours of the referral. 4. The clinical record for patient #5, SOC 11/21/16, was reviewed. The clinical record included a referral form dated 11/15/16. The clinical record failed to evidence an initial assessment		make initial assessment of patient within forty-eight (48) hours of receiving referral. If initial evaluation visit cannot be made within forty-eight hours, there must be documentation to support why not made (needs to be patient's choice) and must be made as soon as possible. Director of Nursing will implement a process ensuring nurses are notified of referral immediately so an order can be obtained to make evaluation visit to assess patient for appropriateness of home health care needs and eligibility. If it is determined patient is not appropriate for home health care or they refuse services, nurse must notify MD of this and document on paperwork. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to make initial assessment of patient within forty-eight (48) hours of receiving referral. If initial evaluation visit cannot be made within forty-eight hours, there must be documentation to support why not made (needs to be patient's choice) and must be made as soon as possible. Director of Nursing will implement a process ensuring nurses are notified of referral immediately so an order can be obtained to make evaluation visit to assess patient for appropriateness of home health care needs and eligibility. If	

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	visit note within 48 hours of the referral. 5. The clinical record for patient #6, SOC 1/30/17, was reviewed. The clinical record failed to evidence a referral form and / or a coordination note which indicated when the patient would be discharged from the hospital. The clinical record failed to evidence an initial assessment visit note. 6. The clinical record for patient #8, SOC 8/3/16, was reviewed. The clinical record included a referral form dated 5/25/16. The clinical record failed to evidence an initial assessment visit note within 48 hours of the referral. 7. The clinical record for patient #9, SOC 7/8/16, was reviewed. The clinical record included a referral form dated 6/9/16. The clinical record failed to evidence an initial assessment visit note within 48 hours of the referral. 8. During the entrance conference with the Employee C, the Interim Assistant Director of Clinical Services and with Employee A, the Alternate Administrator on 5/30/17 at 11:10 a.m. Employee A indicated that their referral process included referral, verify insurance or obtain prior authorization with Medicaid, once prior authorization obtained, orders		it is determined patient is not appropriate for home health care or they refuse services, nurse must notify MD of this and document on paperwork. (To be done by 8/25/17) Director of Nursing/designee will be notified of all referrals immediately. Director/designee will be responsible to track referrals to monitor for compliance with making initial assessment visit within time frame or if it was determined patient was not eligible for home care referral source/MD is notified. Director will be responsible to monitor for compliance with initial assessment visit being done within forty-eight (48) hours. This will be done by comparing date of referral to date on initial assessment visit. (To begin by 8/25/17	

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	obtained from physician for admission, then the patient would be admitted. Employee A indicated that patients were not assessed within 48 hours of referral. Employee C indicated the 48 hour initial assessment made sense and indicated even when orders are obtained, that patient's were not admitted due to inappropriateness or their inability to provide they care and services the potential clients need. 9. An undated policy titled "Client Admission Process" C- 140, indicated " ... Each client referred to the agency shall be evaluated by a Registered Nurse to determine the immediate care and support needs of the client; and for clients, to determine eligibility for home health benefit. The initial assessment will be completed within forty - eight (48) hours of referral or within forty - eight (48) hours of the client's return home, or on the receipt of a signed physician ordered / client requested start of care date .... "			
G 0334 Bldg. 00	484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on record review and interview,	G 0334	Director of Nursing/designee will	08/25/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the agency failed to ensure that the Registered Nurse comprehensive assessment was complete and included skin assessments of gastric tube and urostomy sites, diet clarified, and failed to completely assess a patients pain and respiratory system in 2 out of 4 records reviewed of patients with skilled nursing services in a sample of 10. (#4 and 6) Findings include: 1. The clinical record for patient #4, SOC (start of care) 4/24/17, was reviewed. A. Review of a comprehensive assessment dated 4/24/17, indicated in the "Professional Services" narrative note that the patient had an increase incidence of choking and a g-tube (feeding tube in the stomach) placed last week ... still eating some foods but all medication is being placed through the g-tube. With incidence of choiking, patient is being suctioned and also has Trilogy machine with oxygen, stated he / she uses Trilogy when sleeping .... " 1. Review of the integumentary section and the gastrointestinal section, the admitting registered nurse failed to include an assessment of the g-tube site.		in-service nurses on completing a proper assessment and documenting findings – this is to include assessing g-tube site if has one, clarifying patient's diet when patient has a feeding tube and/or has a history of choking, if has pain how does patient manage it, if patient has shortness of breath how do they relieve it, if patient has any type of ostomy describe skin around area. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on completing a proper assessment and documenting findings – this is to include assessing g-tube site if has one, clarifying patient's diet when patient has a feeding tube and/or has a history of choking, if has pain how does patient manage it, if patient has shortness of breath how do they relieve it, if patient has any type of ostomy describe skin around area. (To begin by 8/25/17) Director of Nursing/designee will audit all nursing documentation weekly to monitor for compliance with completing and documenting a complete appropriate assessment until 100% compliance is achieved. Once 100% compliance is achieved, 25% of nursing documentation will be audited monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing will be	

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	15K064	A. BUILDING 00 B. WING	06/05/2017

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	2. Review of the nutritional status, the diet indicated a regular 2 "Kal HD." Due to the patient's assessment of choking and feeding tube placement, the admitting registered nurse failed to clarify the patient's diet with the attending physician. 3. Review of the pain assessment, the admitting registered nurse failed to complete the assessment by leaving pattern, what makes the pain worse / better, and the medication and / or non-pharmacological relief measures measures. 4. Review of the respiratory assessment, the admitting registered nurse failed to include the measures that the patient uses to relieve shortness of breath (Rescue oxgyen with Trilogy machine and use of machine when sleeping). 2. The clinical record for patient #6, SOC 1/30/17, was reviewed. A. Review of the start of care comprehensive assessment dated 1/30/17, indicated in the "Professional Services" narrative note that the patient had a urostomy bag and required the wafer around the stoma site to be changed weekly. The comprehensive assessment		responsible for monitoring these corrective actions to ensure deficiencies are corrected and will not recur.	

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	failed to include a skin assessment of the urostomy site. 3. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 4. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 5. An undated policy titled "Comprehensive Client Assessment" C - 145, indicated " ... In addition to general health status / system assessment, the agency comprehensive assessment tool with OASIS will include ... Respiratory status ... Formal Pain Assessment, pain intervention, and management ... Integumentary status. Pressure ulcer risk assessment, prevention measures and effective healing principles ... Nutritional status is assessed ... Assessments are prioritized based on client need. All clients will have the Comprehensive Client Assessment completed within five (5) days of the initial visit .... "			
G 0337 Bldg. 00	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must			

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	include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record reviewed and interview, the agency failed to ensure that the medication profile was updated upon initiation of new orders in 1 out of 8 active records reviewed (#3) in a sample of 10 and failed to ensure the medication profile include correct start date, physician, phone numbers to the physician and pharmacy, purpose of medications and potential side effects in 3 out of 8 active records reviewed in a sample of 10. (#4, 8 and 9) Findings include: 1. The clinical record for patient #3, SOC 11/28/16, was reviewed on 5/31/17. The plan of care and the medication profile indicated the patient was taking Levothyroxine sodium (synthroid) 25 mcg (micro-milligrams), 1 tablet every Monday, Wednesday, and Friday. A. During a home visit on 6/1/17 at 11:00 a.m., a piece of paper was observed on the patient's table where the medication boxes were located. The piece of paper indicated between 5/22/17	G 0337	Director of Nursing/designee will in-service nurses on need to ensure medication profile is complete – to include name of physician and number, pharmacy name and number, who administers meds, start dates of meds purpose of meds, purpose of meds, side effects of meds and is updated when there is a medication change. If nurse is setting up medications for patient and there are certain meds patient handles themselves this is to be documented on medication profile and on the Plan of Care/verbal order. Nurses to make sure dates listed are correct. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on ensure medication profile is complete – to include name of physician and number, pharmacy name and number, who administers meds, start dates of meds purpose of meds, purpose of meds, side effects of meds and is updated when there is a medication change. If nurse is setting up medications for patient and there are certain meds patient handles themselves this is to be documented on	08/25/2017

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	to 5/26/17, to increase the synthroid to 50 mcg daily. During this time, the skilled nurse and the patient indicated the patient manages the synthroid with him / herself and that the skilled nurse did not put th medication in the med box per patient request. The patient also verified the increase of synthroid 25 mcg daily. The medication profile failed to be updated with the accurate dose of synthroid. 2. The clinical record for patient #4 SOC 11/21/16, was reviewed. A medication profile indicated all of the patient's medications started on 11/21/17. The medication failed to evidence the correct year the patient's medication started. 3. The clinical record for patient #8, SOC 8/3/16, was reviewed. Review of the medication profile, the Registered Nurse failed to include patient information such as the name of physician, phone number of the physician and pharmacy, dates of when the medicaton was started, purpose of medications and potential side effects. 4. The clinical record for patient #9, SOC 7/8/16, was reviewed. Review of the medication profile, the Registered Nurse failed to include patient information such as the name of physician, phone number of the physician		medication profile and on the Plan of Care/verbal order. Nurses to make sure dates are correct. (To begin by 8/25/17) Director of Nursing/designee will audit all medication profiles on new admissions, re-certifications, resumptions to monitor for compliance with the above. Once 100% compliance is achieved 25% of medication profiles for admissions, re-certs, resumptions will be audited monthly to monitor compliance. (To begin by 8/25/17)	

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	and pharmacy, who the medications were administered by, dates of when the medicaton was started, purpose of medications and potential side effects. 5. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 6. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 7. An undated policy titled "Medication Profile" C - 700, indicated " ... The Medication Profile shall document ... Date medication ordered or care initiated ... Contraindications or special precautions. Medication actions and side effects ... The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication .... "			
G 0339 Bldg. 00	484.55(d)(1) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) the last 5 days			

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	of every 60 days beginning with the start of care date, unless there is a beneficiary elected transfer; or significant change in condition resulting in a new case mix assessment; or discharge and return to the same HHA during the 60 day episode. Based on record review and interview, the agency failed to ensure that the Registered Nurse conducted a complete skin assessment in 2 of 2 active records reviewed of a patient receiving wound treatments with a Medicare agency in a sample of 10. (#7 and 8) Findings include: 1. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. A. Review of a recertification comprehensive assessment dated 4/7/17, the "Professional Services" narrative section indicated the patient was receiving home health services with a Medicare agency for wound treatments. The comprehensive assessment failed to evidence an complete skin assessment, including visual site, of the patient's wounds. The clinical record failed to evidence the attempted coordination with the Medicare agency.	G 0339	Director of Nursing/designee will in-service nurses on conducting a complete assessment at start of care, recertification – this is to include a complete skin assessment. If patient has skin impairments, including wounds, nurse will assess those areas and document findings. If it is documented patient has a wound then all documentation for that patient for that time needs to reflect the same thing. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on conducting a complete assessment at start of care, recertification – this is to include a complete skin assessment. If patient has skin impairments, including wounds, nurse will assess those areas and document findings. If it is documented patient has a wound then all documentation for that patient for that time needs to reflect the same thing. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admission and re-certifications to monitor for compliance with documenting a complete assessment, to include skin. Once 100% compliance is	08/25/2017

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	B. A communication log dated 5/2/17, indicated that the patient was receiving home health services with a different Medicare agency for the treatment of wounds. C. An interview with the Director of Clinical Services on 5/31/17 at 11:00 a.m., the Director of Clinical Services indicated that she was not able to set up a joint visit with the Medicare agency, but did not indicate which agency the patient was with. The Director of Clinical Services indicated she did not want to disrupt the patient's dressing to assess the patient's skin. 2. The clinical record for patient #8, SOC 8/3/16, included a plan of care for the certification period of 3/31/17 to 5/29/17. The plan of care indicated the patient was receiving skilled nursing and home health aide services with a Medicare agency. A. Review of the OASIS start of care comprehensive assessment dated 8/3/16, the "Professional Services" narrative indicated the patient was receiving home health services 3 times a week through a Medicare agency for management of pressure wounds to the patient's right arm		achieved 25% of admissions, re-certifications will be audited monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing will in-service nurses on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions, resumptions and re-certifications to monitor for compliance of coordinating care with other medical agencies, if there are any. (To begin by 8/25/17)	

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	and buttocks. B. Review of the OASIS comprehensive recertification assessment dated 1/25 and 3/30/17, the "Professional Services" narrative indicated the patient was receiving skilled nursing and home health aide services through a Medicare agency. The skin assessments indicated the patient did not have a wound. C. The home health aide written patient instructions dated 3/30/17, indicated for the home health aide to inspect the patient's dressing. The clinical record failed to be consistent in relation to the patient's wound status, failed to evidence an assessment of the wound, and failed to evidence communication / narrative notes related to the error. 3. Employee B, the Director of Clinical Services indicated on 6/2/17 at 4:15 p.m., that the agency was having issues with their computer program and she had notified the company on the problem. Employee B indicated in the meantime, the nursing staff was to write a communication note / narrative indicating the problem and correctly identifying the questions with the correct answers. Employee B was not able to provide			

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	evidence of her communication with the computer software company.			
G 0341 Bldg. 00	484.55(d)(3) UPDATE OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be updated and revised (including the administration of the OASIS) at discharge. Based on record review and interview, the agency failed to ensure the Registered Nurse completed a discharge assessment based on last skilled nursing visit in 1 of 2 discharged records reviewed in a sample of 10. (#10) Findings include: 1. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activies of daily living, meal prep, medication reminders and light housekeeping per care plan. A. The clinical record evidenced a discharge OASIS discharge assessment dated 4/2/17. The discharge assessment was completed Employee C, Interim Director of Clinical Services.	G 0341	Director of Nursing/designee will in-service nurses on needing to make a discharge visit. If patient refuses a visit or is hospitalized at discharge, the discharge assessment is based on the last assessment. Nurse must indicate on the discharge when a visit not made what assessment date documentation is being used to complete the discharge assessment. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on needing to make a discharge visit. If patient refuses a visit or is hospitalized at discharge, the discharge assessment is based on the last assessment. Nurse must indicate on the discharge when a visit not made what assessment date documentation is being used to complete the discharge assessment. (To begin by 8/25/17) Director of Nursing/designee will audit all discharges to monitor for compliance with making a discharge visit and if one isn't made, the nurse has documented	08/25/2017

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	B. The 1/3/17 and the 3/2/17 skilled nursing recertification assessments was conducted by a former employee. 2. An interview with the Employee C, on 5/31/17 at 2:30 p.m., indicated a discharge visit was not conducted. The employee indicated the assessment was based off her own assessment but could not indicate when the last time she had assessed the patient. Employee C indicated the former Director of Clinical Services took over as the patient's case manager last year and provided the last skilled nursing assessment.		what assessment date paperwork is being used to complete the discharge. Once 100% compliance is achieved 25% of discharges will audited monthly to monitor for compliance. (To begin by 8/25/17)	
N 0000 Bldg. 00	This was a state home health relicensure with complaint survey. Survey Dates: May 30, 31, June 1, 2, and 5, 2017 Complaint number: IN00178995 Substantiated; Federal and State deficiencies were cited Facility Number: 012383	N 0000		

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	Medicaid Number: 201005950A Census: 71 Sample: 10			
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the Administrator failed to ensure that clinical staff annual performance evaluations were completed every 9 to 15 months in 2 out of 7 employee records reviewed. (Employee G and H). Findings include: 1. The personnel record for Employee G, a home health aide, start date 3/21/11,	N 0458	Human Resources/designee will utilize a tracking system to ensure employee evaluations are completed every 9 to 15 months as required by regulation. (To be completed by 8/25/17) Human Resources will be responsible to audit all current employee files. Any employee who has an evaluation that is past due will have an evaluation completed by their respective supervisor. (To be completed by 8/25/17)	08/25/2017

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	failed to evidence an annual performance evaluation. 2. The personnel record for Employee H, a home health aide, start date 4/1/15, failed to evidence an annual performance evaluation. 3. Employee A, the Alternate Administrator, indicated on 6/5/17 at 12:00 p.m., that Employee G's annual performance was completed by the Administrator but was not printed out from her computer prior to her going on vacation. Employee A indicated she did not have access to the Administrators files. Employee A indicated Employee H's evaluation was not completed.		Human Resources will be responsible to track outstanding evaluations to ensure they are completed by 8/25/17. Human Resources will notify supervisors monthly of employee evaluations due during that month and will monitor for compliance to ensure evaluations are completed timely. (To begin immediately) Administrator/Human Resources will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	
N 0472 Bldg. 00	410 IAC 17-12-2(a) Q A and performance improvement Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview, the agency failed to ensure that a	N 0472	Administrator and Director of Nursing/designee will be responsible to ensure quarterly	08/25/2017

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	quarterly meeting was conducted to review the scope of the agency's program, reviewed a sample of both active and closed records to determine whether established policies were being followed in furnishing services. Findings include: 1. On 6/5/17 at 2:00 p.m., the QAPI (Quality Assurance Performance Improvement) program was asked to be reviewed. During this time, Employee A, the Alternate Administrator, indicated that there was not a 2017 QAPI to review but provided consultant notes of their review of the agency. Employee A indicated they did not take the information from the consultant and implemented that into their QAPI program. Employee A indicated the consultant wanted to wait until the end of June - beginning July before coming to the agency to assist them.		QAPI is done. Director of Nursing will be responsible to obtain information required for QAPI and write the report. Director of Nursing will be responsible to notify those needing to attend of the meeting date and time, having materials avail for review during meeting, having sign in sheet, keeping meeting minutes, which will include: what was discussed, what is the plan to address issues, who will monitor and what the goals are for each issue. (To begin by 8/25/17) Administrator and Director of Nursing will be responsible to ensure any reports, reviews, audits, etc. that are done by an outside entity that are pertinent to the QAPI requirements are included in the quarterly report. The material to presented will be reviewed prior to meeting to ensure they contain all required information. (To begin by 8/25/17)	
N 0476 Bldg. 00	410 IAC 17-12-2(c) Q A and performance improvement Rule 12 Sec. 2(c) In all cases involving the provision of home health aide services the home health agency shall provide case management by a health care professional acting within the scope of his or her practice. Such case management shall include an initial home visit for assessment of a patient's needs to determine the type,			

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	15K064	A. BUILDING 00 B. WING	06/05/2017

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	appropriateness, and adequacy of requested service, and the development of the patient care plan. Based on record review and interview, the agency failed to ensure that a Registered Nurse conducted an initial assessment visit in order to determine the immediate needs of patients in 7 of 8 records reviewed of patients admitted since 2015 in a sample of 10. (# 1, 3, 4, 5, 6, 8, 9) Findings include: 1. The clinical record for patient #1, Start of Care (SOC) 03/10/15, was reviewed and failed to evidence an initial assessment visit note. 2. The clinical record for patient #3, SOC 11/28/16, was reviewed. The clinical record included a referral form dated 9/19/16. The clinical record failed to evidence an initial assessment visit note within 48 hours of the referral. 3. The clinical record for patient #4, SOC 4/24/17, was reviewed. The clinical record included a referral form dated 3/15/17. The clinical record failed to evidence an initial assessment visit note within 48 hours of the referral. 4. The clinical record for patient #5,	N 0476	Director of Nursing/designee will in-service staff on requirement to make initial assessment of patient within forty-eight (48) hours of receiving referral. If initial evaluation visit cannot be made within forty-eight hours, there must be documentation to support why not made (needs to be patient's choice) and must be made as soon as possible. Director of Nursing will implement a process ensuring nurses are notified of referral immediately so an order can be obtained to make evaluation visit to assess patient for appropriateness of home health care needs and eligibility. If it is determined patient is not appropriate for home health care or they refuse services, nurse must notify MD of this and document on paperwork. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to make initial assessment of patient within forty-eight (48) hours of receiving referral. If initial evaluation visit cannot be made within forty-eight hours, there must be documentation to support why not made (needs to be patient's choice) and must be made as soon as possible. Director of Nursing will implement a process ensuring nurses are	08/25/2017

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	SOC 11/21/16, was reviewed. The clinical record included a referral form dated 11/15/16. The clinical record failed to evidence an initial assessment visit note within 48 hours of the referral. 5. The clinical record for patient #6, SOC 1/30/17, was reviewed. The clinical record failed to evidence a referral form and / or a coordination note which indicated when the patient would be discharged from the hospital. The clinical record failed to evidence an initial assessment visit note. 6. The clinical record for patient #8, SOC 8/3/16, was reviewed. The clinical record included a referral form dated 5/25/16. The clinical record failed to evidence an initial assessment visit note within 48 hours of the referral. 7. The clinical record for patient #9, SOC 7/8/16, was reviewed. The clinical record included a referral form dated 6/9/16. The clinical record failed to evidence an initial assessment visit note within 48 hours of the referral. 8. During the entrance conference with the Employee C, the Interim Assistant Director of Clinical Services and with Employee A, the Alternate Administrator on 5/30/17 at 11:10 a.m. Employee A		notified of referral immediately so an order can be obtained to make evaluation visit to assess patient for appropriateness of home health care needs and eligibility. If it is determined patient is not appropriate for home health care or they refuse services, nurse must notify MD of this and document on paperwork. (To be done by 8/25/17 and be on-going) Director of Nursing/designee will be notified of all referrals immediately. Director/designee will be responsible to track referrals to monitor for compliance with making initial assessment visit within time frame or if it was determined patient was not eligible for home care referral source/MD is notified. Director will be responsible to monitor for compliance with initial assessment visit being done within forty-eight (48) hours. This will be done by comparing date of referral to date on initial assessment visit. (To begin by 8/25/17) Director of Nursing/designee will be responsible to ensure there is a referral form completed all patients. Will ensure there is documentation on referral form if patient is in hospital indicating anticipated discharge date. All referral forms to be audited by Director of Nursing/designee to monitor for compliance.(To begin by 8/25/17)	

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	indicated that their referral process included referral, verify insurance or obtain prior authorization with Medicaid, once prior authorization obtained, orders obtained from physician for admission, then the patient would be admitted. Employee A indicated that patients were not assessed within 48 hours of referral. Employee C indicated the 48 hour initial assessment made sense and indicated even when orders are obtained, that patient's were not admitted due to inappropriateness or their inability to provide they care and services the potential clients need. 9. An undated policy titled "Client Admission Process" C- 140, indicated " ... Each client referred to the agency shall be evaluated by a Registered Nurse to determine the immediate care and support needs of the client; and for clients, to determine eligibility for home health benefit. The initial assessment will be completed within forty - eight (48) hours of referral or within forty - eight (48) hours of the client's return home, or on the receipt of a signed physician ordered / client requested start of care date .... "			
N 0484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective			

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	communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences. Based on record review and interview, the agency failed to include minutes of case conferences of patient care in 8 out of 8 active records reviewed in a sample of 10. (#2 - 9) Findings include: 1. A "60 day Case Conference" sheets dated 4/6/17, was reviewed. No sign in sheet provided. A. Review of patient #2 case conference, the "Update / Comments" indicated "no new meds [medications] / lost 6 lbs [pounds]." No further documentation was included. B. Review of patient #3 case conference, the "Update / Comments" indicated "med changes, medset every 2 wks [weeks], wants new doc [doctor] - change southern." No further documentation was included. C. Review of patient #5 case conference, the "Update / Comments" indicated "no changes." No further documentation was included.	N 0484	Director of Nursing/designee will in-service nurses on properly documenting the 60 Day Conference. Documentation to include current disciplines, frequency, duration, tasks being provided, progress towards stated goals – if not progressing then what changes need to be made, physical status, any concerns, names of any other medical agencies that are providing service, etc. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on properly documenting the 60 Day Conference. Documentation to include current disciplines, frequency, duration, tasks being provided, progress towards stated goals – if not progressing then what changes need to be made, physical status, any concerns, names of any other medical agencies that are providing service, etc. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of case conference notes, until 100% compliance is achieved, to monitor for compliance with proper	08/25/2017

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	D. Review of patient #6 case conference, the "Update / Comments" indicated Group Home not checking on her at night, kidney issues." No further documentation was included. E. Review of patient #7 case conference, the "Update / Comments" indicated "no changes, 101!, can't get out of recliner." No further documentation was included. F. Review of patient #8 case conference, the "Update / Comments" indicated "no changes - hoyer lift, shower chair." G. Review of patient #9 case conference, the "Update / Comments" indicated "no changes, cath change e / o [every other] wk." No further documentation was included. 2. A 60 day Case Conference sheets dated 5/18/17, was reviewed. The sign in sheet included personnel from medical records, 2 schedulers, quality assurance, Employee A, the Alternate Administrator, Employee B, the Director of Clinical Services, and Employee C, the Interim Assistant Director of Clinical Services as Case Managers. The sign in sheet failed to evidence the attendance of		documentation of case conference. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of case conference notes monthly to monitor for compliance with properly documenting required information. (To begin by 8/25/17) Director of Nursing/designee will ensure there is a sign in sheet for all participating staff to sign.(See Attachment B) (To be completed by 8/25/17) Director of Nursing/designee will instruct nurses that aides are to be involved in case conferences. Aides will be given notice of when case conferences are being done and their input will be asked. (To be completed by 8/25/17) Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	the home health aides. A. Review of patient #2 case conference, the "Update / Comments" indicated "nothing new." No further documentation was included. B. Review of patient #3 case conference, the "Update / Comments" indicated "recert next week." No further documentation was included. C. Review of patient #4 case conference, the "Update / Comments" indicated "deteriorated since 4/25, wheelchair, unable to ambulate." No further documentation was included. D. Review of patient #5 case conference, the "Update / Comments" indicated "no changes." No further documentation was included. E. Review of patient #6 case conference, the "Update / Comments" indicated "PA renewal." No further documentation was included. F. Review of patient #7 case conference, the "Update / Comments" indicated "had a fall." No further documentation was included. G. Review of patient #8 case			

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	conference, the "Update / Comments" indicated "no changes." No further documentation was included. H. Review of patient #9 case conference, the "Update / Comments" was left blank. The 60 day case conference failed to evidence the effective interchange in regards to reporting, interventions, and progress toward goals. 3. Employee B and Employee C had no comment in relation to the above findings at 6/2/17 at 4:00 p.m. 4. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 5. An undated policy titled "Coordination of Client Services" C - 360, indicated "It shall be the policy of this agency to ensure effective interchange, reporting and coordination of care and information provided by ... other providers of care ... Care conferences will be held as necessary to establish interchange, reporting, and coordinated evaluation between all disciplines involved in the client's care ... Ongoing care conferences shall be			

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	conducted to evaluate the client's status and progress. Any problems will be discussed and an action plan developed .... "			
N 0486 Bldg. 00	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the agency failed to ensure that their efforts were coordinated effectively with other health providers serving their patients in 5 out of 5 active records reviewed of patients receiving outside services in a sample of 10. (#5, 6, 7, 8 and 10). Findings include: 1. The clinical record of patient #5, SOC 11/21/16, was reviewed and included a plan of care for the certification period of 5/20/17 to 7/18/17. The plan of care indicated the patient was receiving physical, occupational, and speech therapy with a Medicare agency and that the patient resided in a group home with 24 hour supervision. The clinical record failed to evidence that the agency had coordinated services with the Medicare agency and failed to evidence coordination with the group home of its	N 0486	Director of Nursing will in-service nurses on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions, resumptions and re-certifications to monitor for compliance of coordinating care with other medical agencies, if there are any. (To begin by 8/25/17) Director of Nursing will in-service nursing staff on requirement to notify MD of a patient's discharge,	08/25/2017

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	expectations / delineation of duties with the home health agency. 2. The clinical record of patient #6, SOC 1/30/17, was reviewed and included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 3 times a week and home health aide services 7 days a week. A. During a home visit on 6/2/17 at 9:30 a.m., the patient was observed to live in a group home. The clinical record failed to evidence that the agency had coordinated services with the group home of its expectations / delineation of duties with the home health agency. 3. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. A. Review of a recertification comprehensive assessment dated 4/7/17, the "Professional Services" narrative section indicated the patient was receiving home health services with a Medicare agency for wound treatments. The comprehensive assessment failed to evidence an complete skin assessment, including visual site, of the patient's		notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of discharges to ensure compliance with notifying MD of upcoming discharge, notifying patient of discharge at least fifteen (15) days before discharge and notifying other agencies involved in patient's care of patient's upcoming discharge from agency. (To begin 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	wounds. The clinical record failed to evidence the attempted coordination with the Medicare agency. B. A communication log dated 5/2/17, indicated that the patient was receiving home health services with a different Medicare agency for the treatment of wounds. The clinical record failed to evidence that the agency had coordinated services with the correct Medicare agency. 4. The clinical record for patient #8, SOC 8/3/16, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for a home health aide up to 8 hours a day, 7 days a week. The plan of care indicated the patient was receiving skilled nursing and home health aide services with a Medicare agency. A. Review of the OASIS start of care comprehensive assessment dated 8/3/16, the "Professional Services" narrative indicated the patient was receiving home health services 3 times a week through a Medicare agency for management of pressure wounds to the patient's right arm and buttocks. B. Review of the OASIS comprehensive recertification assessment dated 1/25 and 3/30/17, the "Professional			

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	Services" narrative indicated the patient was receiving skilled nursing and home health aide services through a Medicare agency. The clinical record failed to evidence that the agency had coordinated services with the Medicare agency. 5. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders and light housekeeping per care plan. A. The clinical record evidenced a discharge OASIS discharge assessment dated 4/2/17. The clinical record failed to evidenced that the attending physician had been notified in advance of the patient's unscheduled discharge, the patient had been informed in advance of the discharge and failed to provide documentation in regards notifying the other home health agency and verifying the type of services being provided . B. An interview with the Employee C, Interim Assistant Director of Clinical Services, on 5/31/17 at 2:30 p.m., the employee indicated the patient notified			

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	the agency and indicated another home health agency was in the home. At Home Health Services decided to discharge the patient. The employee indicated a 15 day notice was not provided. C. On 5/31/17 at 2:30 p.m., Employee C was not unable to provide any further documentation upon request. 6. An interview with Employee B, the Director of Clinical Services and Employee C indicated they are aware of the care coordination component and acknowledged the agency had a problem with documentation of all conversations and coordinations. 7. An undated policy titled "Coordination of Client Services" C - 360, indicated "It shall be the policy of this agency to ensure effective interchange, reporting and coordination of care and information provided by ... other providers of care .... "			
N 0494 Bldg. 00	410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following:			

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	(1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section. Based on record review and interview, the agency failed to maintain documentation that it had provided a patient a written notice of patient rights in 1 out of 1 record reviewed of a patient readmitted to services in a sample of 10. (#6) Findings include: 1. The clinical record for patient #6, SOC 1/30/17, was reviewed. The clinical record failed to evidence documentation that patient #6 had been provided with a written notice of patient rights. A. The Director of Clinical Services was interviewed on 6/5/17 at 9:45 a.m. and indicated the patient's certification period ended during a hospitalization and the agency was told by their consultant that new admission paperwork did not need to be provided or signatures obtained upon readmission. 2. An undated policy titled "Client Admission Process" C- 140, indicated "	N 0494	Director of Nursing/designee will in-service all nursing staff on the need to provide patient/caregiver with a copy of Patient Rights. (Complete 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on the need to provide patient/caregiver with a copy of Patient Rights. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of Admissions to ensure compliance with documentation indicating patient/caregiver received copy of Patient Rights. After 100% compliance is achieved, Director of Nursing/designee will audit 25% of admissions monthly to monitor compliance with documenting patient/caregiver received copy of Patient Rights. (To begin by 8/25/17) Director of Nursing/designee will train nursing staff on need to readmit patient if their certification period ends while hospitalized. (To be done by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure this	08/25/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K064	A. BUILDING 00 B. WING	06/05/2017

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	... Provide the client with a copy of their privacy rights and the Notice of privacy practices, and obtain consent to use and disclose protected health information for treatment, payment and healh care operations. Provide the client / caregiver with a copy and an explaination of the Home Care Bill of Rights and Responsibilities, and the procedures for filing a complaint. This includes the Statement of Privacy Rights related to the collection and transmission of personal health care information ... Obtain the client's signature on the Service Agreement, Home Care Bill of Rights, and other forms required by the agency .... "		deficiency is corrected and will not recur.	
N 0504 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Based on record review and interview, the agency failed to ensure the patient and / or caregiver were informed in advance of the disciplines that would	N 0504	Director of Nursing will in-service nursing staff on documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of	08/25/2017

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	furnish care, the type of care to be provided, the anticipated frequency / duration of visits to be provided and of any changes in their care in 2 out of 2 discharged records reviewed of changes in care (#1 and 10) and in 6 out of 6 admissions in 2016 and 2017 in a sample of 10. (#3, 4, 5, 6, 8 and 9) Findings include: 1. The clinical record for patient #1 SOC (start of care) 3/10/15, was reviewed and included a written plan of care for the certification of 5/9/15 to 7/7/15, with orders for home health aide services up to 10 hours a day 7 days a week to assist with grooming, hygiene, transfers, medication reminders, meal preparation / setup, and light housekeeping. The patient had a diagnosis of Multiple Sclerosis. . A. Review of the payroll time records, the home health aides were providing services up from 5 to 7 hours a day. . B. Review of the FSSA (Family Social Service Administration) Medicaid paperwork dated 6/2/15, indicated the patient's original prior authorization request was modified and that the requested units were excessie based on		care to be provided, and frequency/duration of visits. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions to ensure compliance with documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To begin by 8/25/17) Director of Nursing will in-service nursing staff on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before	

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	the medical documentation submitted. C. Review of the FSSA Medicaid paperwork dated 6/17/15, indicated the request to increase the home health aide services were denied as medically not necessary. D. Review of the communications notes dated 6/15/15, 6/18/15, 7/5/15 and a nursing visit on 6/30/15, the agency failed to evidence that the patient and / or caregiver was informed of Medicaid's decision to decrease the home health aide hours, therefore, making a change in the agency's ability to service the patient. 2. The clinical record number 3, SOC (start of care) 11/28/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 3. The clinical record number 4, SOC 4/24/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided.		discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of discharges to ensure compliance with notifying MD of upcoming discharge, notifying patient of discharge at least fifteen (15) days before discharge and notifying other agencies involved in patient's care of patient's upcoming discharge from agency. (To begin by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	4. The clinical record for patient #5, SOC 11/21/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 5. The clinical record for patient #6, SOC 1/30/17, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 6. The clinical record for patient #8, SOC 8/3/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 7. The clinical record for patient #9, SOC 7/8/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be			

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	provided, and the anticipated frequency / duration of visits to be provided. 8. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders and light housekeeping per care plan. A. The clinical record evidenced a discharge OASIS discharge assessment dated 4/2/17. The clinical record failed to evidenced that the attending physician had been notified in advance of the patient's unscheduled discharge, the patient had been informed in advance of the discharge and failed to provide documentation in regards notifying the other home health agency and verifying the type of services being provided . B. An interview with the Employee C, Interim Director of Clinical Services, on 5/31/17 at 2:30 p.m., the employee indicated the patient notified the agency and indicated another home health agency was in the home. At Home Health Services decided to discharge the patient. The employee indicated a 15 day			

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	notice was not provided. C. On 5/31/17 at 2:30 p.m., Employee C was not unable to provide any further documentation upon request. 9. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 10. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 11. An undated policy titled "Client Admission Process" C- 140, indicated " ... Review the plan for services, treatment, and care with the client / caregiver of any reasonable risk and / or alternate associated with any procedure provided in the home .... "			
N 0505 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to			

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	be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment. Based on record review and interview, the agency failed to ensure the patient and / or caregiver were informed in advance of the disciplines that would furnish care, the type of care to be provided, the anticipated frequency / duration of visits to be provided and of any changes in their care in 2 out of 2 discharged records reviewed of changes in care (#1 and 10) and in 6 out of 6 admissions in 2016 and 2017 in a sample of 10. (#3, 4, 5, 6, 8 and 9) Findings include: 1. The clinical record for patient #1 SOC (start of care) 3/10/15, was reviewed and included a written plan of care for the certification of 5/9/15 to 7/7/15, with orders for home health aide services up to 10 hours a day 7 days a week to assist with grooming, hygiene, transfers, medication reminders, meal preparation / setup, and light housekeeping. The patient had a diagnosis of Multiple Sclerosis. .	N 0505	Director of Nursing will in-service nurses on need to notify patient / caregiver if Medicaid decreases number of hours requested on the PA, obtain MD order for the hours approved by Medicaid and document in patient chart. (To be done by 8/25/17) Director of Nursing/designee will be responsible to ensure orientation of newly hired nurses includes training on need to notify patient / caregiver if Medicaid decreases number of hours requested on the PA, obtain MD order for any decrease in the hours approved by Medicaid and document in patient chart. (To begin by 8/25/17) Director of Nursing/designee will audit, weekly, all Medicaid authorizations received. If Medicaid decreased requested hours, Director of Nursing/designee will ensure there is documentation patient/caregiver was notified of the decrease and MD order was obtained for authorized frequency. Once 100% compliance is achieved, Director of Nursing/designee will audit, monthly, 25% of Medicaid authorizations received that	08/25/2017

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	A. Review of the payroll time records, the home health aides were providing services up from 5 to 7 hours a day. . B. Review of the FSSA (Family Social Service Administration) Medicaid paperwork dated 6/2/15, indicated the patient's original prior authorization request was modified and that the requested units were excessie based on the medical documentation submitted. C. Review of the FSSA Medicaid paperwork dated 6/17/15, indicated the request to increase the home health aide services were denied as medically not necessary. D. Review of the communications notes dated 6/15/15, 6/18/15, 7/5/15 and a nursing visit on 6/30/15, the agency failed to evidence that the patient and / or caregiver was informed of Medicaid's decision to decrease the home health aide hours, therefore, making a change in the agency's ability to service the patient. 2. The clinical record number 3, SOC (start of care) 11/28/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be		month to ensure compliance with notifying patient/caregiver of any decrease in hours approved and MD order obtained for authorized frequency. (To begin by 8/25/17) Director of Nursing will in-service nursing staff on documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions to ensure compliance with documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To begin by 8/25/17) Director of Nursing will in-service nursing staff on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document	

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	provided, and the anticipated frequency / duration of visits to be provided. 3. The clinical record number 4, SOC 4/24/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 4. The clinical record for patient #5, SOC 11/21/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 5. The clinical record for patient #6, SOC 1/30/17, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 6. The clinical record for patient #8, SOC 8/3/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in		these conversations in patient's chart. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of discharges to ensure compliance with notifying MD of upcoming discharge, notifying patient of discharge at least fifteen (15) days before discharge and notifying other agencies involved in patient's care of patient's upcoming discharge from agency. (To begin by 8/25/17) Director of Nursing will in-service nursing staff on documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of	

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	advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 7. The clinical record for patient #9, SOC 7/8/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 8. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders and light housekeeping per care plan. A. The clinical record evidenced a discharge OASIS discharge assessment dated 4/2/17. The clinical record failed to evidenced that the attending physician had been notified in advance of the patient's unscheduled discharge, the patient had been informed in advance of the discharge and failed to provide documentation in regards notifying the		care to be provided, and frequency/duration of visits. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions to ensure compliance with documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To begin by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	other home health agency and verifying the type of services being provided . B. An interview with the Employee C, Interim Director of Clinical Services, on 5/31/17 at 2:30 p.m., the employee indicated the patient notified the agency and indicated another home health agency was in the home. At Home Health Services decided to discharge the patient. The employee indicated a 15 day notice was not provided. C. On 5/31/17 at 2:30 p.m., Employee C was not unable to provide any further documentation upon request. 9. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 10. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 11. An undated policy titled "Client Admission Process" C- 140, indicated " ... Review the plan for services, treatment, and care with the client / caregiver of any reasonable risk and / or			

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	alternate associated with any procedure provided in the home .... "			
N 0506 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice. Based on record review and interview, the agency failed to ensure the patient and / or caregiver were informed in advance of the disciplines that would furnish care, the type of care to be provided, the anticipated frequency / duration of visits to be provided and of any changes in their care in 2 out of 2 discharged records reviewed of changes in care (#1 and 10) and in 6 out of 6 admissions in 2016 and 2017 in a sample of 10. (#3, 4, 5, 6, 8 and 9) Findings include: 1. The clinical record for patient #1 SOC (start of care) 3/10/15, was reviewed and included a written plan of care for the certification of 5/9/15 to 7/7/15, with orders for home health aide services up to	N 0506	Director of Nursing will in-service nurses on need to notify patient / caregiver if Medicaid decreases number of hours requested on the PA, obtain MD order for the hours approved by Medicaid and document in patient chart. (To be done by 8/25/17) Director of Nursing/designee will be responsible to ensure orientation of newly hired nurses includes training on need to notify patient / caregiver if Medicaid decreases number of hours requested on the PA, obtain MD order for any decrease in the hours approved by Medicaid and document in patient chart. (To begin by 8/25/17) Director of Nursing/designee will audit, weekly, all Medicaid authorizations received. If Medicaid decreased requested hours, Director of Nursing/designee will ensure	08/25/2017

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	15K064	A. BUILDING 00 B. WING	06/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT HOME HEALTH SERVICES LLC	6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250

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	10 hours a day 7 days a week to assist with grooming, hygiene, transfers, medication reminders, meal preparation / setup, and light housekeeping. The patient had a diagnosis of Multiple Sclerosis. . A. Review of the payroll time records, the home health aides were providing services up from 5 to 7 hours a day. . B. Review of the FSSA (Family Social Service Administration) Medicaid paperwork dated 6/2/15, indicated the patient's original prior authorization request was modified and that the requested units were excessie based on the medical documentation submitted. C. Review of the FSSA Medicaid paperwork dated 6/17/15, indicated the request to increase the home health aide services were denied as medically not necessary. D. Review of the communications notes dated 6/15/15, 6/18/15, 7/5/15 and a nursing visit on 6/30/15, the agency failed to evidence that the patient and / or caregiver was informed of Medicaid's decision to decrease the home health aide hours, therefore, making a change in the agency's ability to service the patient.		there is documentation patient/caregiver was notified of the decrease and MD order was obtained for authorized frequency. Once 100% compliance is achieved, Director of Nursing/designee will audit, monthly, 25% of Medicaid authorizations received that month to ensure compliance with notifying patient/caregiver of any decrease in hours approved and MD order obtained for authorized frequency. (To begin by 8/25/17) Director of Nursing will in-service nursing staff on documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions to ensure compliance with documenting, at time of admission, that patient/caregiver was notified of disciplines to be provided, type of care to be provided, and frequency/duration of visits. (To begin by 8/25/17) Director of Nursing will in-service	

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	2. The clinical record number 3, SOC (start of care) 11/28/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 3. The clinical record number 4, SOC 4/24/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 4. The clinical record for patient #5, SOC 11/21/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 5. The clinical record for patient #6, SOC 1/30/17, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will		nursing staff on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of discharges to ensure compliance with notifying MD of upcoming discharge, notifying patient of discharge at least fifteen (15) days before discharge and notifying other agencies involved in patient's care of patient's upcoming discharge from agency. (To begin by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 6. The clinical record for patient #8, SOC 8/3/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 7. The clinical record for patient #9, SOC 7/8/16, was reviewed. The clinical record failed to evidence that the patient / caregiver was informed and agreed in advance of the disciplines that will furnish care, the type of care to be provided, and the anticipated frequency / duration of visits to be provided. 8. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders and light housekeeping per care plan. A. The clinical record evidenced a			

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	discharge OASIS discharge assessment dated 4/2/17. The clinical record failed to evidenced that the attending physician had been notified in advance of the patient's unscheduled discharge, the patient had been informed in advance of the discharge and failed to provide documentation in regards notifying the other home health agency and verifying the type of services being provided . B. An interview with the Employee C, Interim Director of Clinical Services, on 5/31/17 at 2:30 p.m., the employee indicated the patient notified the agency and indicated another home health agency was in the home. At Home Health Services decided to discharge the patient. The employee indicated a 15 day notice was not provided. C. On 5/31/17 at 2:30 p.m., Employee C was not unable to provide any further documentation upon request. 9. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 10. Employee A, the Alternate Administrator and Employee B, had no			

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	further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 11. An undated policy titled "Client Admission Process" C- 140, indicated " ... Review the plan for services, treatment, and care with the client / caregiver of any reasonable risk and / or alternate associated with any procedure provided in the home .... "			
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on record review and interview, the agency failed to ensure staff followed the plan of care in relation to frequency and duration of patient visits, personal care, and providing services without a physician's order in 3 of 7 active records reviewed in a sample of 10. (#3, 4 and 6) Findings include: 1. The clinical record for patient #3, SOC 11/28/16, included a plan of care for the certification period of 03/28/17 to 5/26/17, with orders for skilled nursing every 14 days for medication set up. Review of the skilled nursing visit notes in the electronic clinical record, the	N 0522	Director of Nursing will in-service nurses on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To be completed by 8/25/17)	08/25/2017

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	patient record contained a skilled nursing visit note on 03/29/17, 4/21/17, 5/5/17, 5/18/17, and 5/23/17. The clinical record failed to evidence a skilled nursing visit between 04/09/17 to 4/15/17. 2. The clinical record for patient #4, SOC 4/24/17, included a plan of care for the certification period of 4/24/17 to 6/22/17, with orders for a licensed practical nurse (LPN) up to 3 hours per day, 5 days a week to assist with personal care, transfers, medication reminders, meal preparation / setup, and light housekeeping. A. During a home visit on 6/1/17 at 1:00 p.m., the LPN was observed to administer liquid dilantin (anti-seizure medication), tylenol and ibuprofen (used for mild pain and / or fever) and approximately 100 ml (milliliters) of water flush through the patient's gastric tube (g-tube) before, during, and after medication administration. In the kitchen, a piece of paper that was secured to a cabinet door contained a list of medications and water flushes with times to administer. The LPN indicated the spouse would sometimes have the medications administered prior to their arrival and sometimes the clinical staff would have to administer. The LPN indicated she would provide g-tube site		Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of nursing documentation weekly, until 100% compliance is achieved, to monitor compliance with following frequency and duration for disciplines ordered by MD as well MD ordered plan of care and that care provided follows the MD ordered Plan of Care. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of nursing documentation monthly to monitor for continued compliance. (To begin 8/25/17) Director of Nursing/designee will instruct clinical staff, if patient is receiving services thru more than one payer, to indicate on visit note which payer this visit is for.	

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	care after the patient received a bath. B. Review of the skilled nursing visit notes indicated the following: 1. On 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered tube feedings. 2. On 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered water flushes. 3. On 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse provided g-tube site care. 4. On 5/4, 5/17, 5/25, 5/31, 6/1, and 6/4/17, the visit notes indicated the skilled nurse was in the home for 4 hours and for 10 hours on 5/23/17. 5. Three (3) skilled nursing visits were made week 1 and 4 of the certification period and 4 skilled nursing visits were made week 2, 3, 5, and 6 of the certification period. 6. On 4/25, 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16,		(To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired clinical staff includes training on, if patient is receiving services thru more than one payer, to indicate on visit note which payer this visit is for. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of visit notes, weekly, for patients receiving visits thru multiple payers to monitor compliance with marking payer on documentation. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of visit notes, monthly, to monitor for compliance. (To begin by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	5/17, 5/18, 5/22, 5/23 and 5/24/17, failed to evidence if personal care had been provided. The skilled nurses failed to follow the plan of care in regards to frequency and duration of visits, providing personal care, as well as providing services without a physician's order. 3. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week to remove and apply a urostomy wafer one day per week. A. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/12, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes failed to evidence that the patient's urostomy wafer had been changed weekly. The skilled nurse failed to follow the plan of care. 4. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m.			

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	5. Employee A, the Alternate Administrator and Employee B, indicated on 6/5/17 at 3:50 p.m., that the overage of hours may be due to waiver hours being included in the Medicaid Prior Authorization hours. Both indicated there is no delineation on notes.			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure the plan of care was updated to include the	N 0524	Director of Nursing/designee will instruct nurses when patient has order for home health aide to indicate who is responsible to	08/25/2017

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	determination of duration of home health aide visits specific and pertinent to the patient's needs in 6 out of 7 active records reviewed (#2, 3, 4, 5, 7 and 8) of patients with home health aides in a sample of 10; failed to include parameters for skilled nursing to obtain oxygen saturations in 7 out of 8 active records reviewed (#2, 3, 4, 5, 6, 7 and 8) in a sample of 10; failed to update a patient's personal location of services to be provided on the plan of care in 1 of 5 home visits conducted (#2); failed to update a medication profile in 2 out of 8 active records reviewed (#3 and 6), failed to include g-tube site care, the amount and frequency of water flushes, the name, amount, and frequency of tube feedings, and instruction on the use of the Trilogy vent and bypap machine for oxygen rescue in 1 of 1 record reviewed of a patient with g-tube and a vent / bypap machine (#4); and failed to include other entities / agencies assisting with the patients care in 2 out of 4 active records of patients with more than one service in a sample of 10. (# 6 and 7) Findings include: 1. The clinical record for patient #2, SOC (start of care) 3/6/12, included a plan of care for the certification period of 4/9/17 to 6/7/17.		determine how many hours patient needs when order says "up to" number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes instructing nurses when patient has order for home health aide to indicate who is responsible to determine how many hours patient needs when order says "up to" number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. (To begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of Plans of Care to monitor for compliance with indicating who is responsible to determine how many hours patient needs when order says "up to" number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of Plans of Care monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing/designee will	

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	A. The plan of care indicated home aide services up to 8 hours per day, 5 days per week. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. C. A home visit on 6/1/17 at 9:15 a.m., was conducted at the patient's daughters home where the patient had been residing. The new address of residence was not listed on the plan of care. The plan of care included a former address where services were initially provided. During this time, the home health aide indicated the patient use to live with the son but moved in with the daughter and had been residing with the daughter for a long time and could not remember when the patient had moved. The home health aide also indicated that the daughter was disabled. 2. The clinical record for patient #3,		instruct nurses to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). (To be completed by 8/25/17) Director of Nursing will be responsible to ensure newly hired nurses are trained to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when (nursing/aide). (To be begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of Plans of Care to monitor for compliance indicating the Plan of Care has the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of Plans of Care monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing/designee will instruct nurses that a verbal order is needed from MD to make extra visits that fall outside the ordered visit frequency for that discipline of the Plan of Care. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on needing a verbal order from MD to make extra visits that	

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	SOC 11/28/16, included a plan of care with orders for skilled nursing every 14 days for medication set up, oxygen saturations as needed and home health aide services up to 8 hours per day, 7 days a week. A. On 5/31/17 at 3:00 p.m., Employee C, the Interim Assistant Director of Clinical Services, indicated she would make extra visits to the patient's home to fix the medication box due to medications not being refilled before her visit. B. On 5/31/17 at 4:10 p.m., Employee C indicated she was going to go to the patient's home that evening and make sure the patient had his / her medication for our home visit on 6/1/17. C. On 6/2/17 at 4:45 p.m., Employee C indicated she did not obtain orders nor did she complete nursing visit notes. D. Review of the home health aide visit notes dated 03/29, 4/4, 4/9, 4/21, 4/29, 5/5, 5/8, 5/18, and 5/23/17, the home health aide provided services approximately from 3 hours to 7 hours. The plan of care failed to be updated to include extra visits for skilled nursing in the management of the patient's		fall outside the ordered visit frequency for that discipline of the Plan of Care. (To begin by 8/25/17) Director of Nursing/designee will track all nursing visits for a month to monitor for compliance with following ordered frequency and if extra visits are noted there is a verbal order for that visit. Once 100% compliance is achieved, Director of Nursing will track 25% of patients monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	15K064	A. BUILDING 00 B. WING	06/05/2017

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	medications in between scheduled visits, duration of home health aide hours failed to be patient specific to include the minimal hours per day for the home health aide to be in the home as well as who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours and when to obtain oxygen saturations. 3. The clinical record for patient #4, SOC 4/24/17, included a plan of care for the certification period of 4/24/17 to 6/22/17, with orders for a LPN (licensed practical nurse) up to 3 hours per day, 5 days a week to assist with personal care, transfers, medication reminders, meal preparation / setup, and light housekeeping. The plan of care also indicated for the skilled nurse to obtain oxygen saturations as needed. A. During a home visit on 6/1/17 at 1:00 p.m., with Employee E, a LPN, was observed to administer liquid dilantin (anti-seizure medication), tylenol and ibuprofen (used for mild pain and / or fever) and approximately 100 ml (milliliters) of water flush through the patient's gastric tube (g-tube) before, during, and after medication administration. In the kitchen, a piece of paper that was secured to a cabinet door contained a list of medications and water			

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	flushes with times to administer. The Employee E indicated the spouse would sometimes have the medications administered prior to their arrival and sometimes the clinical staff would have to administer. Employee E indicated she would provide g-tube site care after the patient received a bath. Employee E and the patient discussed using the Trilogy vent and bypap machine for oxygen rescue. B. Review of the skilled nursing visit notes indicated the following: 1. On 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17,5/18, 5/22, 5/23, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered tube feedings and water flushes. 2. On 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse provided g-tube site care. The plan of care failed to be updated to include g-tube site care, the amount and frequency of water flushes per g-tube, the name, amount, and frequency of tube feedings per g-tube, when to obtain oxygen saturations, and instruction on the use of the Trilogy vent and bypap machine for oxygen rescue.			

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	4. The clinical record for patient #5, SOC 11/21/16, included a plan of care for the certification period of 3/19/17 to 5/19/17, with orders for home health aide services up to 6 hours per day, 5 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 1.25 to 3 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 6 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. 5. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week for the instillation of medication / irrigation solution via catheter into bladder every visit. The			

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	medication profile evidenced Clorpactin to be administered every Monday, Wednesday, and Friday via urostomy flush and order for skilled nursing to obtain oxygen saturations as needed. A. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/12, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes failed to evidence that the instillation of the medication / irrigation solution via catheter into the bladder had been provided B. The Director of Clinical Services was interviewed on 06/05/17 at 1:30 and indicated the patient's Clorpactin instillation into the bladder had been discontinued. The Director of Clinical Services provided a physician's script / order dated 3/2/17, indicated to discontinue the Clorpactin instillation. C. A. During a home visit on 6/2/17 at 9:30 a.m., the patient was observed to live in a group home. The plan of care failed to be updated to exclude the Clorpactin medication instillation / irrigation, failed to indicate when to obtain oxygen saturations and failed to include that the patient resided			

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	and received services within a group home. 6. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 3.5 to 6 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 6 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. C. Review of a recertification comprehensive assessment dated 4/7/17, the "Professional Services" narrative section indicated the patient was receiving home health services with a Medicare agency for wound treatments.			

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	The plan of care failed to evidence that the patient's wounds were being managed by a Medicare agency. 7. The clinical record for patient #8, SOC 8/3/16, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for home health aide services up to 8 hours per day, 7 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 3.50 to 8 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. 8. Employee B, the Director of Clinical Services and Employee C, the Interim Alternate Director of Clinical Services, had no further information or documentation in relation to the above			

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	findings on 6/2/17 at 4:00 p.m. 9. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 10. An undated policy titled "Plan of Care" C - 580, indicated " ... Communication with a patient's physician is required in the following cases: Upon admission, recertification or discharge ... change in the plan of The individualized Plan of Care is based on a comprehensive assessment and information provided by the client / family and health team member ... The Plan of Care shall be completed in full to include ... Type, frequency, and duration of all visits / services, Medications, treatments, and procedures .... "			
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 that the physician was notified of a patient's early discharge in 1 of 2 records reviewed of discharged patients in a sample of 10. (#10)	N 0527	Director of Nursing will in-service nursing staff on requirement to notify MD of a patient's discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document	08/25/2017

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	Findings include: 1. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders and light housekeeping per care plan. A. The clinical record evidenced a discharge OASIS discharge assessment dated 4/2/17. The clinical record failed to evidenced that the attending physician had been notified of the patient's unscheduled discharge. 2. An interview with the Employee C, Interim Director of Clinical Services, on 5/31/17 at 2:30 p.m., the employee indicated the patient would send aides home but one day, the patient called and indicated another home health agency was in the home. At Home Health Services decided to discharge the patient. 3. On 5/31/17 at 2:30 p.m., the agency was unable to provide any further documentation such as physician orders or coordination notes with the physician		these conversations in patient's chart. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to notify MD of a patient's discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of discharges to ensure compliance with notifying MD of upcoming discharge and notifying other agencies involved in patient's care of patient's upcoming discharge from agency. (To begin by 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	in regards to the discharge upon request. 4. An undated policy titled "Physician Orders" C - 635, indicateed " ... Communication with a patient's physician is required in the following cases: Upon admission, recertification or discharge ... change in the plan of care .... "			
N 0529 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the agency failed to ensure 60 day summaries were reflective of the patients progress towards goals being met and not being met for 4 out of 7 active records reviewed of patients with recertifications in a sample of 10. (#2, 3, 5 and 6) Findings include: 1. The clinical record for patient #2, SOC (start of care) 03/06/12, was reviewed and included a plan of care for the certification period of 2/8/17 to 4/8/17 and 4/9/17 to 6/7/17. The goals indicated "The client's safety will be enhanced through the home care services	N 0529	Director of Nursing will in-service nurses on ensuring correct information, to include correct address and status of any caregivers – disabled, refuse to assist, etc, is on patient's Plan of Care. (To be done by 8/25/17) Director of Nursing will in-service nurses on proper way to write 60 day summaries. Summaries are to be updated each recertification to reflect patient's actual status for the previous certification period. This includes discussing progress toward goals set for patient. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes instruction on ensuring Plan of Care reflects correct information	08/25/2017

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	AEB [as evidenced by] no falls / injuries or ER visits within cert period. The client's skin and mucous membranes will remain intact. The client's home environment will be clean and safe, hygiene and personal care needs will be met .... " A. A plan of care for the certification period of 02/08/17 to 04/08/17, included a 60 day summary that indicated "Client seen for comprehensive assessment and recertification of HHA [home health aide] services, client to be recertified for another episode of HHA services. Client is a Black female who lives with her son, who works outside the home in one storied home with basement, requires 24 hour supervision and assist with all ADL's [activities of daily living] and IADL's [Instrumental activities of daily living]. Patient is non ambulatory and non verbal d/t [due to] severe dementia. DX [diagnoses] of End Stage Alzheimer's Disease, HTN [hypertension], urinary and bowel incontinence, and impaired gait. Client is non-ambulatory and requires total transfers, bathing, dressing, meal prep (mechanical soft diet), set up and feeding, medication reminders, incontinence care and light housekeeping. Client lives with her son who is employed full time outside the home and is need of assistance to care for patient.		and that 60 day summaries reflect patient's actual status for the previous certification period. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of 60 day summaries to monitor for compliance with providing accurate summary of patient's status, including progress towards goals, the past cert period. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of 60 day summaries monthly to monitor for compliance. (To begin by 8/25/17).	

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	Client is incontinent of bowel and bladder increasing the risk of skin breakdown, patient does wear adult briefs. Caregiver present, stated patient just had lunch. Client asleep on sofa when nurse arrived, caregiver stated client had no change in condition, no new medications, no visits to ER / hospitalizations. Lung sounds were clear, heart irregular, bowel sounds WNL [within normal limits] x 4 quads, abdomen soft / non-tender to palpitation. Pedal pulses palpable, no edema noted ... patient unable to stand for height, Wt 76 pounds. Family reports satisfaction with care / services provided by agency. Client's MD notified of recertification of care with no changes to care plan." B. A plan of care for the certification period of 4/9/17 to 6/7/17, included a 60 day summary that indicated "Client seen for comprehensive assessment and recertification of HHA [home health aide] services, client to be recertified for another episode of HHA services. Client is a Black female who believes with her son, who works outside the home in one storied home with basement, requires 24 hour supervision and assist with all ADL's [activities of daily living] and IADL's [Instrumental activities of daily living]. Patient is non ambulatory and non verbal d/t [due to] severe dementia.			

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	DX [diagnoses] of End Stage Alzheimer's Disease, HTN [hypertension], urinary and bowel incontinence, and impaired gait. Client is non-ambulatory and requires total transfers, bathing, dressing, meal prep (mechanical soft diet), set up and feeding, medication reminders, incontinence care and light housekeeping. Client lives with her son who is employed full time outside the home and is need of assistance to care for patient. Client is incontinent of bowel and bladder increasing the risk of skin breakdown, patient does wear adult briefs. Caregiver present, stated patient just had lunch. Client asleep on sofa when nurse arrived, caregiver stated client had no change in condition, no new medications, no visits to ER / hospitalizations. Lung sounds were clear, heart irregular, bowel sounds WNL [within normal limits] x 4 quads, abdomen soft / non-tender to palpitation. Pedal pulses palpable, no edema noted ... patient unable to stand for height, Wt 76 pounds. Family reports satisfaction with care / services provided by agency. Client's MD notified of recertification of care with no changes to care plan." C. A home visit on 6/1/17 at 9:15 a.m., was conducted at the patient's daughters home where the patient had been residing. The new address of			

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	residence was not listed on the plan of care. The plan of care included a former address where services were initially provided. During this time, the home health aide indicated the patient use to live with the son but moved in with the daughter and had been residing with the daughter for a long time and could not remember when the patient had moved. The home health aide also indicated that the daughter was disabled. The 60 day summaries was repetitive from the admission summary and failed to be updated and be reflective of the patient status during the 60 day period and progress toward goals at the time of the recertification. 2. The clinical record for patient #3, SOC 11/28/16, was reviewed and included a plan of care for the certification period of 3/26/17 to 5/26/17 and 5/27/17 to 7/27/17. The goals indicated "Client will take medications as set / ordered AEB visual inspection of pill box, client / caregiver verbalize compliance, pill count is appropriate this cert period, The patient's safety will be enhanced throughout the home care services AEB no falls / injuries or ER visits within cert period. The patient's skin and mucous membranes will remain intact. The patient's home environment			

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	will be clean and safe, hygiene and personal care needs will be met. A. The plan of care for the certification period of 3/26/17 to 5/26/17, included a 60 day summary that indicated "Client seen by RN for comprehensive assessment for recertification of services. Client to be recertified for another episode HHA services. Client is an elderly male / female who lives alone in an apartment with diagnosis of Rhabdomyolysis, diabetes, hypertension, kidney and ureter disorder, morbid obesity. Client is requiring SN every two weeks for medication setup, teaching medication and to monitor compliance with medication and efficacy and HHA for personal care, meal prep / set up, and light housekeeping. Client is a high fall risk, unsteady gait and ambulates with walker at all times, has poor endurance, is incontinent of urine and requires assistance with each incontinent episode. Denied visits to ER / hospitalizations this certification period. Client is alert and oriented but stated he / she is forgetful and HOH [hard of hearing] ... Client verbalized satisfaction with plan of care and services to be provided. Physician notified of recertification and POC [plan of care]. B. The plan of care for the			

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	15K064	A. BUILDING 00 B. WING	06/05/2017

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	certification period of 5/27/17 to 7/27/17, included a 60 day summary that indicated "Client seen by RN for comprehensive assessment for recertification of services. Client to be recertified for another episode HHA services. Client is an elderly male / female who lives alone in an apartment with diagnosis of Rhabdomyolysis, diabetes, hypertension, kidney and ureter disorder, morbid obesity. Client is requiring SN every two weeks for medication setup, teaching medication and to monitor compliance with medication and efficacy and HHA for personal care, meal prep / set up, light housekeeping. Client is a high fall risk, unsteady gait and ambulates with walker at all times, has poor endurance, is incontinent of urine and requires assistance with each incontinent episode. Denied visits to ER / hospitalizations this certification period. Client is alert and oriented but stated he / she is forgetful and HOH [hard of hearing] ... Client verbalized satisfaction with plan of care and services to be provided. Physician notified of recertification and POC. The 60 day summaries was repetitive from the admission summary and failed to be updated and be reflective of the patient status during the 60 day period and progress toward goals at the time of the recertification.			

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	3. The clinical record for patient #5, SOC 11/21/16, was reviewed and included a plan of care for the certification period of 5/20/17 to 7/18/17. The goals indicated "The patient's safety will be enhanced throughout the home care services AEB no falls / injuries or ER visits with cert period. The patients skin and mucous membranes will remain intact. The patient's home environment will be clean and safe, hygiene and personal care needs will be met. A. The plan of care for the certification period of 11/21/17 to 1/19/17, included an admission summary that indicated "Client seen by RN for comprehensive assessment recertification. 64 year old male / female admitted for HHA with dx of dementia. Has decreased dexterity and mentation. Requires assist with medication reminders and personal care. Tires easily with minimal exertion. Is a fall risk and incontinent of bladder and bowel. Aide to assist with personal care, light housekeeping. Patient lives in a group home with one staff member to supervisor ... Client verbalized satisfaction with plan of care and services to be provided. Physician notified of recertification and POC.			

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	B. The plan of care for the certification period of 1/20/17 to 3/20/17, included an 60 day summary that indicated "Client seen by RN for comprehensive assessment recertification. 64 year old male / female admitted for HHA with dx of dementia. Has decreased dexterity and mentation. Requires assist with medication reminders and personal care. Tires easily with minimal exertion. Is a fall risk and incontinent of bladder and bowel. Aide to assist with personal care, light housekeeping. Patient lives in a group home with one staff member to supervisor ... Client verbalized satisfaction with plan of care and services to be provided. Physician notified of recertification and POC. C. Review of the clinical record, the patient was hospitalized in April for possible seizure activity AEB resumption of care assessment dated 04/21/17. D. The plan of care for the certification period of 5/20/17 to 7/18/17, included a 60 day summary that indicated "Client seen by RN for comprehensive assessment recertification. 64 year old male / female admitted for HHA with dx of dementia. Has decreased dexterity and mentation. Requires assist with medication reminders and personal care.			

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	Tires easily with minimal exertion. Is a fall risk and incontinent of bladder and bowel. Aide to assist with personal care, light housekeeping. Patient lives in a group home with one staff member to supervisor [sic] 24 hrs [hours] day ... Client verbalized satisfaction with plan of care and services to be provided. Physician notified of recertification and POC." E. An interview with the Director of Clinical Services on 6/5/17 at 12:45 p.m., indicated that the patient did not start home health aide services until 1/26/17 due to the agency waiting on Medicaid Prior Authorization approval. The 60 day summaries was repetitive from the admission summary and failed to be updated and be reflective of the patient status during the 60 day period and progress toward goals at the time of the recertification. 4. The clinical record of patient #6, SOC 1/30/17, was reviewed and included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing to provide a bowel program 3 times a week, urostomy irrigation, and urostomy management. The goals indicated "SN [skilled nurse] is expected to be long term due to disease process.			

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	HHA [home health aide] care is expected to be long term due to disease process. The client's safety will be enhanced throughout the home care services AEB no falls / injuries or ER visits within cert period. The client's skin and mucous membranes will remain intact. The client's home environment will be clean and safe, hygiene and personal care needs will be met." A. The plan of care for the certification period of 1/30/17 to 3/30/17, included an admission summary that indicated "53 year old male / female admitted for SN [skilled nursing] and HHA [home health aide] r/t [related to] dx [diagnosis] of Spina Bifada. Has decreased dexterity and requires assist with bowel regime and ostomy care, patient unable to perform care for self, dependent for personal care, light housekeeping .... " B. The plan of care for the certification period of 3/31/17 to 5/29/17, included an 60 day summary that indicated "Client seen by RN for comprehensive assessment recertification. 53 year old male / female admitted for SN [skilled nursing] and HHA [home health aide] r/t [related to] dx [diagnosis] of Spina Bifada. Has decreased dexterity and requires assist			

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	with bowel regime and ostomy care, patient unable to perform care for self, dependent for personal care. Patient uses a slide board for transfers. Tires easily with minimal exertion. Is a high fall risk, incontinent of bowel and urostomy for urine. Aide to assist with personal care, light housekeeping .... " The 60 day summaries was repetitive from the admission summary and failed to be updated and be reflective of the patient status during the 60 day period and progress toward goals at the time of the recertification. 5. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no comment in relation to the above findings at 6/2/17 at 4:00 p.m. 6. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m.			
N 0533 Bldg. 00	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home health aide services in the absence of a skilled service.			

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	(b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan. Based on record review and interview, the agency failed to ensure that the home health aide written patient instructions failed to coincide with the physician plan of care to include the patient diagnosis(es), diet, mental status, and failed to be specific to the patient needs in relation to frequency and duration of visits, frequency of tasks to be performed and diagnoses in 4 out of 4 active records reviewed of patients with home health aide only services in a sample of 10. (#2, 5, 7 and 8) Findings include: 1. The clinical record for patient #2, SOC (start of care) 3/6/12, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home aide services up to 8 hours per day, 5	N 0533	Director of Nursing/designee will in-service nurses on ensuring home health aide plan of care is specific, for each patient, regarding tasks aide to perform, frequency and duration of visits and frequency of tasks to be performed. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on ensuring home health aide plan of care is specific, for each patient, regarding tasks aide to perform, frequency and duration of visits and frequency of tasks to be performed. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of aide plans of care to monitor for compliance with making sure it specific regarding tasks aide to perform, frequency and duration of visits and frequency of tasks to be	08/25/2017

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	days per week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping. The nutrition requirement (locator 16) indicated the patient was on a mechanical soft diet and the patient was a total feed. The functional limitations (locator 18) indicated the patient was hearing and speech impaired. The mental status (locator 19) indicated the patient was non - verbal. The patient's diagnoses included, but not limited to, Alzheimer's disease and dementia with behavioral disturbances. A. The home health aide written patient instructions indicated the patient was an assist with feeding, bed, commode, elimination, mobility, transfers, and wheelchair. The home health aide written patient instructions indicated the patient was on a regular diet. The home health aide written patient instructions included a complete bed bath, skin inspection, foot care, light housekeeping in the bathroom, kitchen, and bedroom, linen change, nail care, encourage fluids, hair care, meal prep, medication reminder, oral care, shampoo, wash clothes, and placement / removal of an orthopedic brace. The home health aide written instructions failed to be accurate and coincide with the physician		performed. Once 100% compliance is achieved, 25% of aide plans of care will be audited monthly to monitor for compliance. (To begin by 8/25/17).	

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	plan of care. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed. 2. The clinical record for patient #5, SOC 11/21/16, included a plan of care for the certification period of 5/20/17 to 7/18/17, with orders for home health aide services up to 6 hours per day, 5 days per week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping. The patient's diagnoses included, but not limited to, Tuberous sclerosis, dementia, weakness, and epilepsy / epileptic syndrome with seizures. A. The home health aide written patient instructions included to assist the patient with a shower, skin inspection, transfers, walker, light housekeeping in the bathroom, kitchen, and bedroom, linen change, foot care, dressing, ambulation, bed, hair care, meal prep, medication reminder, oral care, shampoo, and wash clothes. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed.			

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	3. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping per care plan. The patient diagnoses included, but not limited to, venous insufficiency, convulsions, diabetes, and venous embolism. A. The home health aide written patient instructions included to assist the patient with ambulation, chair, dressing, bed, elimination, mobility, bed bath, skin inspection, foot care, commode, transfers, walker, wheel chair, equipment care, hair care, meal prep, feeding, medication reminder, oral care, positioning, peri care after incontinent episode, shampoo, light housekeeping in the bathroom, kitchen, and bedroom, linen change, and wash clothes. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed. The foot care failed to be specific with indicating that the home health aide would not perform trimming of nails due to the patient diabetes.			

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	4. The clinical record for patient #8, SOC 8/3/16, included a plan of care for the certification period of 3/3117 to 5/29/17, with orders for home health aide services up to 8 hours per day, 7 days a week. to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders, and light housekeeping per care plan. A. The home health aide written patient instructions included to assist the patient with bed, elimination, bed bath, skin inspection, nail care, clean dentures, transfers, inspect dressing, hair care, meal prep, medication reminder, oral care, positioning, peri care after incontinent episode, light housekeeping in the bathroom, kitchen, and bedroom, linen change, and wash clothes. The home health aide written instructions failed to be specific and include frequency and duration of visits, frequency of tasks to be performed. 5. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 6. Employee A, the Alternate Administrator, indicated at 12:00 p.m.,			

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	that she was aware of the specific information needed for the home health aide care plan. 7. An undated policy titled "Home Health Aide / Certified Nursing Assistant (HHA ...) Care Plan" C - 751, indicated " ... To provide a means of assigning duties to the HHA ... that are clear to the Nurse, HHA ..., and to the client / caregiver being served ... To provide documentation that the client's care is individualized to his / her specific needs.			
N 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency 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 record review and interview, the agency failed to ensure staff followed the plan of care in relation to frequency and duration of patient visits, personal care, and providing services without a physician's order in 3 of 4 active records reviewed of patients with skilled nursing in a sample of 10. (#3) Findings include: 1. The clinical record for patient #3, SOC 11/28/16, included a plan of care for the certification period of 03/28/17 to 5/26/17, with orders for skilled nursing	N 0537	Director of Nursing will in-service nurses on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and	08/25/2017

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	every 14 days for medication set up. Review of the skilled nursing visit notes in the electronic clinical record, the patient record contained a skilled nursing visit note on 03/29/17, 4/21/17, 5/5/17, 5/18/17, and 5/23/17. The clinical record failed to evidence a skilled nursing visit between 04/09/17 to 4/15/17. 2. Employee B, the Director of Clinical Services and Employee C, the Interim Alternate Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 3. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 4. An undated policy titled "Plan of Care" C - 580, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The individualized Plan of Care is based on a comprehensive assessment and information provided by the client / family and health team member ... The Plan of Care shall be completed in full to include ... Type, frequency, and duration of all visits / services, Medications, treatments, and procedures .... "		was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of nursing documentation weekly, until 100% compliance is achieved, to monitor compliance with following frequency and duration for disciplines ordered by MD as well MD ordered plan of care and that care provided follows the MD ordered Plan of Care. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of nursing documentation monthly to monitor for continued compliance. (To begin 8/25/17)	

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N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview, the agency failed to ensure that a Registered Nurse reassessed a patient following surgery in 1 out of 1 record reviewed of a patient who received surgical procedure during a certification period in a sample of 10. (#6) Findings include: 1. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 3 times a week. A. A Communication log dated 3/30/17, indicated the patient declined home health aide visit on 7/6/17 (verified by Director of Clinical Services as a typo and should read 4/6/17) due to having surgery. 1. A nursing visit note dated 4/7/17, indicated a LPN (Licensed Practical Nurse) conducted a visit, which	N 0541	Director of Nursing/designee will instruct staff on proofing documentation before submitting to ensure dates are correct. (To be done 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired staff are instructed on proofing documentation before submitting to ensure dates are correct. (To begin 8/25/17) Director of Nursing/designee will audit 100% of documentation weekly to ensure the dates on documentation are correct. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of documentation monthly to monitor for compliance. (To begin by 8/25/17). Director of Nursing/designee will in-service RN's on need to assess patient, before any other discipline makes visit, when they have had a hospital stay or a surgical procedure done to see if plan of care needs to be adjusted. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired RN's includes training on need to assess	08/25/2017

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	15K064	A. BUILDING 00 B. WING	06/05/2017

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	failed to evidence the surgical procedure the patient had on 4/6/17. Employee C, the Interim Assistant Director of Clinical Services made a supervisory visit on 4/21/17, but failed to assess the patient. B. A Communication log dated 5/3/17, indicated the patient declined a home health aide visit on 5/4/17, due to having surgery. 1. A nursing visit note dated 5/5/17, indicated a LPN conducted a visit, which failed to evidence the surgical procedure the patient had on 5/4/17. Employee C made a supervisory visit on 5/17/17, but failed to assess the patient. C. The next Registered Nurse recertification assessment visit was conducted on 5/29/17, by Employee C. Employee C failed to conduct the initial visit and reassess the patient after the patient had surgery. D. Employee C was unable to provide any further documentation when asked on 6/5/17 at 1:30 p.m. 2. An undated policy titled "Skilled Nursing Services" C - 200, indicated " ... The Registered Nurse ... Regularly reevaluates the clients needs, and		patient, before any other discipline makes visit, when they have had a hospital stay or a surgical procedure done to see if plan of care needs to be adjusted. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of documentation for patients who have had a hospital stay or a surgical procedure done to monitor for compliance with documentation they have been assessed by an RN before any other disciplines provide care. Once 100% compliance is achieved 25% of documentation will be audited monthly for those patients to ensure compliance. (To begin by 8/25/17) Director of Nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.08/25/2017	

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	coordinates the necessary services ... " 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 following: (C) Initiate the plan of care and necessary revisions.			
N 0542 Bldg. 00	Based on record review and interview, the agency failed to ensure the plan of care was updated to include the determination of duration of home health aide visits specific and pertinent to the patient's needs in 6 out of 7 active records reviewed (#2, 3, 4, 5, 7 and 8) of patients with home health aides in a sample of 10; failed to include parameters for skilled nursing to obtain oxygen saturations in 7 out of 8 active records reviewed (#2, 3, 4, 5, 6, 7 and 8) in a sample of 10; failed to update a patient's personal location of services to be provided on the plan of care in 1 of 5 home visits conducted (#2); failed to update a medication profile in 2 out of 8 active records reviewed (#3 and 6), failed to include g-tube site care, the amount and frequency of water flushes, the name, amount, and frequency of tube feedings, and instruction on the use of the Trilogy vent and bypap machine for oxygen rescue in 1 of 1 record reviewed of a patient with g-tube and a vent / bypap	N 0542	Director of Nursing/designee will instruct nurses when patient has order for home health aide to indicate who is responsible to determine how many hours patient needs when order says “up to” number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes instructing nurses when patient has order for home health aide to indicate who is responsible to determine how many hours patient needs when order says “up to” number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. (To begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of Plans of Care to monitor for compliance	08/25/2017

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	machine (#4); and failed to include other entities / agencies assisting with the patients care in 2 out of 4 active records of patients with more than one service in a sample of 10. (# 6 and 7) Findings include: 1. The clinical record for patient #2, SOC (start of care) 3/6/12, included a plan of care for the certification period of 4/9/17 to 6/7/17. A. The plan of care indicated home aide services up to 8 hours per day, 5 days per week. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. C. A home visit on 6/1/17 at 9:15 a.m., was conducted at the patient's daughters home where the patient had been residing. The new address of residence was not listed on the plan of		with indicating who is responsible to determine how many hours patient needs when order says "up to" number of hours. Nurses should indicate if patient is cognitive to make own personal care decisions. If not then indicate who determines time – caregiver, RN, etc. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of Plans of Care monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing/designee will instruct nurses to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). (To be completed by 8/25/17) Director of Nursing will be responsible to ensure newly hired nurses are trained to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). (To be begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of Plans of Care to monitor for compliance indicating the Plan of Care has the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). Once 100% compliance is achieved, Director of Nursing/designee will audit	

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	care. The plan of care included a former address where services were initially provided. During this time, the home health aide indicated the patient use to live with the son but moved in with the daughter and had been residing with the daughter for a long time and could not remember when the patient had moved. The home health aide also indicated that the daughter was disabled. 2. The clinical record for patient #3, SOC 11/28/16, included a plan of care with orders for skilled nursing every 14 days for medication set up, oxygen saturations as needed and home health aide services up to 8 hours per day, 7 days a week. A. On 5/31/17 at 3:00 p.m., Employee C, the Interim Assistant Director of Clinical Services, indicated she would make extra visits to the patient's home to fix the medication box due to medications not being refilled before her visit. B. On 5/31/17 at 4:10 p.m., Employee C indicated she was going to go to the patient's home that evening and make sure the patient had his / her medication for our home visit on 6/1/17. C. On 6/2/17 at 4:45 p.m., Employee		25% of Plans of Care monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing/designee will instruct nurses that a verbal order is needed from MD to make extra visits that fall outside the ordered visit frequency for that discipline of the Plan of Care and the nurse must complete documentation for all visits made. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on needing a verbal order from MD to make extra visits that fall outside the ordered visit frequency for that discipline of the Plan of Care and nurse must complete documentation for all visits made. (To begin by 8/25/17) Director of Nursing/designee will track all nursing visits for a month to monitor for compliance with following ordered frequency and if extra visits are noted there is a verbal order for that visit and that nurse has completed documentation for all visits. Once 100% compliance is achieved, Director of Nursing will track 25% of patients monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing will instruct nurses on including reason for doing pulse oximetry, if there is an order on Plan of Care to do one. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation	

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	C indicated she did not obtain orders nor did she complete nursing visit notes. D. Review of the home health aide visit notes dated 03/29, 4/4, 4/9, 4/21, 4/29, 5/5, 5/8, 5/18, and 5/23/17, the home health aide provided services approximately from 3 hours to 7 hours. The plan of care failed to be updated to include extra visits for skilled nursing in the management of the patient's medications in between scheduled visits, duration of home health aide hours failed to be patient specific to include the minimal hours per day for the home health aide to be in the home as well as who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours and when to obtain oxygen saturations. 3. The clinical record for patient #4, SOC 4/24/17, included a plan of care for the certification period of 4/24/17 to 6/22/17, with orders for a LPN (licensed practical nurse) up to 3 hours per day, 5 days a week to assist with personal care, transfers, medication reminders, meal preparation / setup, and light housekeeping. The plan of care also indicated for the skilled nurse to obtain oxygen saturations as needed.		of newly hired nurses includes training on including reason for doing pulse oximetry, if there is an order on Plan of Care to do one. (To begin by 8/25/17) Director of Nursing will in-service nurses on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions, resumptions and re-certifications to monitor for compliance of coordinating care with other medical agencies, if there are any. (To begin by 8/25/17) Director of Nursing is responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	A. During a home visit on 6/1/17 at 1:00 p.m., with Employee E, a LPN, was observed to administer liquid dilantin (anti-seizure medication), tylenol and ibuprofen (used for mild pain and / or fever) and approximately 100 ml (milliliters) of water flush through the patient's gastric tube (g-tube) before, during, and after medication administration. In the kitchen, a piece of paper that was secured to a cabinet door contained a list of medications and water flushes with times to administer. The Employee E indicated the spouse would sometimes have the medications administered prior to their arrival and sometimes the clinical staff would have to administer. Employee E indicated she would provide g-tube site care after the patient received a bath. Employee E and the patient discussed using the Trilogy vent and bypap machine for oxygen rescue. B. Review of the skilled nursing visit notes indicated the following: 1. On 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17,5/18, 5/22, 5/23, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered tube feedings and water flushes.			

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	2. On 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse provided g-tube site care. The plan of care failed to be updated to include g-tube site care, the amount and frequency of water flushes per g-tube, the name, amount, and frequency of tube feedings per g-tube, when to obtain oxygen saturations, and instruction on the use of the Trilogy vent and bypap machine for oxygen rescue. 4. The clinical record for patient #5, SOC 11/21/16, included a plan of care for the certification period of 3/19/17 to 5/19/17, with orders for home health aide services up to 6 hours per day, 5 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 1.25 to 3 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 6 hours. B. The plan of care indicated skilled nursing to obtain oxygen saturations as			

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	needed. The plan of care failed to indicate when to obtain oxygen saturations. 5. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week for the instillation of medication / irrigation solution via catheter into bladder every visit. The medication profile evidenced Clorpactin to be administered every Monday, Wednesday, and Friday via urostomy flush and order for skilled nursing to obtain oxygen saturations as needed. A. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/12, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes failed to evidence that the instillation of the medication / irrigation solution via catheter into the bladder had been provided B. The Director of Clinical Services was interviewed on 06/05/17 at 1:30 and indicated the patient's Clorpactin instillation into the bladder had been discontinued. The Director of Clinical Services provided a physician's script /			

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	order dated 3/2/17, indicated to discontinue the Clorpactin instillation. C. A. During a home visit on 6/2/17 at 9:30 a.m., the patient was observed to live in a group home. The plan of care failed to be updated to exclude the Clorpactin medication instillation / irrigation, failed to indicate when to obtain oxygen saturations and failed to include that the patient resided and received services within a group home. 6. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 3.5 to 6 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 6 hours.			

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	B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. C. Review of a recertification comprehensive assessment dated 4/7/17, the "Professional Services" narrative section indicated the patient was receiving home health services with a Medicare agency for wound treatments. The plan of care failed to evidence that the patient's wounds were being managed by a Medicare agency. 7. The clinical record for patient #8, SOC 8/3/16, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for home health aide services up to 8 hours per day, 7 days a week. A. Review of the home health aide visit notes during this certification period, the home health aide provided services approximately from 3.50 to 8 hours. The durations of hours failed to be patient specific and include the minimal hours per day for the home health aide to be in the home and who would determined the duration of hours in a day should the home health aide not be needed for the entire 8 hours.			

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	B. The plan of care indicated skilled nursing to obtain oxygen saturations as needed. The plan of care failed to indicate when to obtain oxygen saturations. 8. Employee B, the Director of Clinical Services and Employee C, the Interim Alternate Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 9. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 10. An undated policy titled "Plan of Care" C - 580, indicated " ... Communication with a patient's physician is required in the following cases: Upon admission, recertification or discharge ... change in the plan of The individualized Plan of Care is based on a comprehensive assessment and information provided by the client / family and health team member ... The Plan of Care shall be completed in full to include ... Type, frequency, and duration of all visits / services, Medications, treatments, and procedures .... "			

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	11. An undated policy titled "Skilled Nursing Services" C - 200, indicated " ... The Registered Nurse ... Regularly reevaluates the clients needs, and coordinates the necessary services ... "			
N 0545 Bldg. 00	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on record review and interview, the agency failed to ensure that their efforts were coordinated effectively with other health providers serving their patients in 5 out of 5 records reviewed of patients receiving outside services in a sample of 10. (#5, 6, 7, 8 and 10). Findings include: 1. The clinical record of patient #5, SOC 11/21/16, was reviewed and included a plan of care for the certification period of 5/20/17 to 7/18/17. The plan of care indicated the patient was receiving physical, occupational, and speech therapy with a Medicare agency and that the patient resided in a group home with 24 hour supervision. The clinical record failed to evidence that the agency had coordinated services with the Medicare agency and failed to evidence	N 0545	Director of Nursing will in-service nurses on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions, resumptions and re-certifications to monitor for compliance of coordinating care with other medical agencies, if there are any. (To begin by 8/25/17)	08/25/2017

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	15K064	A. BUILDING 00 B. WING	06/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AT HOME HEALTH SERVICES LLC	6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	coordination with the group home of its expectations / delineation of duties with the home health agency. 2. The clinical record of patient #6, SOC 1/30/17, was reviewed and included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 3 times a week and home health aide services 7 days a week. A. During a home visit on 6/2/17 at 9:30 a.m., the patient was observed to live in a group home. The clinical record failed to evidence that the agency had coordinated services with the group home of its expectations / delineation of duties with the home health agency. 3. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. A. Review of a recertification comprehensive assessment dated 4/7/17, the "Professional Services" narrative section indicated the patient was receiving home health services with a Medicare agency for wound treatments. The comprehensive assessment failed to evidence an complete skin assessment,		Director of Nursing will in-service nursing staff on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to notify MD of a patient's discharge, notify patient/caregiver of discharge at least fifteen (15) days before discharge and notifying any other agency involved in patient's care of upcoming discharge of patient from agency. Nurses to document these conversations in patient's chart. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of discharges to ensure compliance with notifying MD of upcoming discharge, notifying patient of discharge at least fifteen (15) days before discharge and notifying other agencies involved in patient's care of patient's upcoming discharge from agency. (To begin 8/25/17) The Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	including visual site, of the patient's wounds. The clinical record failed to evidence the attempted coordination with the Medicare agency. B. A communication log dated 5/2/17, indicated that the patient was receiving home health services with a different Medicare agency for the treatment of wounds. The clinical record failed to evidence that the agency had coordinated services with the correct Medicare agency. 4. The clinical record for patient #8, SOC 8/3/16, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for a home health aide up to 8 hours a day, 7 days a week. The plan of care indicated the patient was receiving skilled nursing and home health aide services with a Medicare agency. A. Review of the OASIS start of care comprehensive assessment dated 8/3/16, the "Professional Services" narrative indicated the patient was receiving home health services 3 times a week through a Medicare agency for management of pressure wounds to the patient's right arm and buttocks. B. Review of the OASIS comprehensive recertification assessment			

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	dated 1/25 and 3/30/17, the "Professional Services" narrative indicated the patient was receiving skilled nursing and home health aide services through a Medicare agency. The clinical record failed to evidence that the agency had coordinated services with the Medicare agency. 5. The clinical record for #10, SOC (start of care) 5/11/16, was reviewed and included a plan of care for the certification of 3/7/17 to 5/5/17, with orders for home health aide services up to 1 hour a day, 7 days a week to assist with personal care, bathing, dressing, activities of daily living, meal prep, medication reminders and light housekeeping per care plan. A. The clinical record evidenced a discharge OASIS discharge assessment dated 4/2/17. The clinical record failed to evidenced that the attending physician had been notified in advance of the patient's unscheduled discharge, the patient had been informed in advance of the discharge and failed to provide documentation in regards notifying the other home health agency and verifying the type of services being provided . B. An interview with the Employee C, Interim Assistant Director of Clinical Services, on 5/31/17 at 2:30 p.m., the			

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	employee indicated the patient notified the agency and indicated another home health agency was in the home. At Home Health Services decided to discharge the patient. The employee indicated a 15 day notice was not provided. C. On 5/31/17 at 2:30 p.m., Employee C was not unable to provide any further documentation upon request. 6. An interview with Employee B, the Director of Clinical Services and Employee C indicated they are aware of the care coordination component and acknowledged the agency had a problem with documentation of all conversations and coordinations. 7. An undated policy titled "Coordination of Client Services" C - 360, indicated "It shall be the policy of this agency to ensure effective interchange, reporting and coordination of care and information provided by ... other providers of care .... "			
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. Based on record review and interview, the agency failed to ensure the Licensed	N 0554	Director of Nursing will in-service nurses on requirement to follow	08/25/2017

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	Practical Nurse (LPN) documented on a patient's urostomy care and bowel program in 1 of 4 active records reviewed of patients with skillned nursing in a sample of 10. (#6) Findings include: 1. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week to remove and apply a urostomy wafer one day per week and for the instillation of medication / irrigation solution via catheter into bladder every visit. The medication profile evidenced Clorpactin to be administered every Monday, Wednesday, and Friday via urostomy flush and order for skilled nursing to obtain oxygen saturations as needed. A. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, failed to evidence that the patient's urostomy wafer had been changed weekly. B. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/14,		Plan of Care which includes tasks nurse is to provide. Care documented must follow orders on Plan of Care. Nurses to document how patient tolerated the procedure being done. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to follow Plan of Care. Care documented must follow orders on Plan of Care. Nurses to document how patient tolerated the procedure being done. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of nursing documentation weekly, until 100% compliance is achieved, to monitor compliance with following MD ordered plan of care and that care provided follows the MD ordered Plan of Care and that nurses document how patient tolerated the procedure being done. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of nursing documentation monthly to monitor for continued compliance. (To begin by 8/25/17) Director of Nursing will be responsible for monitoring these corrective changes to ensure this deficiency is corrected and does not recur.	

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	4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes indicated an 18 Fr foley catheter had been inserted with urine return. The notes failed to include where and why the double lumen foley catheter insertion. C. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/10, 4/14, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, failed to evidence that the patient's bowel program had been conducted, the outcome of the bowel program, and the patient's tolerance of the procedures. D. The Director of Clinical Services was interviewed on 06/05/17 at 1:30 and indicated the patient's Clorpactin instillation into the bladder had been discontinued. The Director of Clinical Services provided a physician's script / order dated 3/2/17, indicated to discontinue the Clorpactin instillation. E. The Alternate Administrator and the Director of Clinical Services had not further information or documentation by the exit conference on 06/05/17 at 3:50 p.m. 2. An undated policy titled "Skilled			

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	Nursing Services" C - 200, indicated " ... The Licensed Practical Nurse ... Assists the regisered nurse to complete the physician plan of care for skilled services ... Prepares clinical and progress notes .... "			
N 0555 Bldg. 00	410 IAC 17-14-1(a)(2)(C) Scope of Services Rule 14 Sec. 1(a) (2)(C) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (C) Assist the physician and/or registered nurse in performing specialized procedures. Based on record review and interview, the agency failed to ensure the Licensed Practical Nurse (LPN) followed the plan of care in relation to frequency and duration of patient visits, personal care, and providing services without a physician's order in 2 out of 4 active records reviewed of patients with skilled nursing in a sample of 10. (#4 and 6) Findings include: 1. The clinical record for patient #4, SOC 4/24/17, included a plan of care for the certification period of 4/24/17 to 6/22/17, with orders for a licensed practical nurse (LPN) up to 3 hours per day, 5 days a week to assist with personal care, transfers, medication reminders, meal preparation / setup, and light housekeeping.	N 0555	Director of Nursing will in-service nurses on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to follow Plan of Care which includes	08/25/2017

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	A. During a home visit on 6/1/17 at 1:00 p.m., Employee E, LPN was observed to administer liquid dilantin (anti-seizure medication), tylenol and ibuprofen (used for mild pain and / or fever) and approximately 100 ml (milliliters) of water flush through the patient's gastric tube (g-tube) before, during, and after medication administration. In the kitchen, a piece of paper that was secured to a cabinet door contained a list of medications and water flushes with times to administer. Employee E indicated the spouse would sometimes have the medications administered prior to their arrival and sometimes the clinical staff would have to administer. Employee E indicated she would provide g-tube site care after the patient received a bath. B. Review of the skilled nursing visit notes indicated the following: 1. On 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered tube feedings. 2. On 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/24, 5/25, 5/30, 5/31, 6/1 and		frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of nursing documentation weekly, until 100% compliance is achieved, to monitor compliance with following frequency and duration for disciplines ordered by MD as well MD ordered plan of care and that care provided follows the MD ordered Plan of Care. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of nursing documentation monthly to monitor for continued compliance. (To begin by 8/25/17) Director of Nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

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	6/2/17, the visit notes indicated the skilled nurse administered water flushes. 3. On 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse provided g-tube site care. 4. On 5/4, 5/17, 5/25, 5/31, 6/1, and 6/4/17, the visit notes indicated the skilled nurse was in the home for 4 hours and for 10 hours on 5/23/17. 5. Three (3) skilled nursing visits were made week 1 and 4 of the certification period and 4 skilled nursing visits were made week 2, 3, 5, and 6 of the certification period. 6. On 4/25, 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23 and 5/24/17, failed to evidence if personal care had been provided. The skilled nurses failed to follow the plan of care in regards to frequency and duration of visits, providing personal care, as well as providing services without a physician's order. 3. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1			

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	visit per day, up to 2 hours per visit, 3 times per week to remove and apply a urostomy wafer one day per week. A. Review of the LPN visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/17, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes failed to evidence that the patient's urostomy wafer had been changed weekly. The skilled nurse failed to follow the plan of care. 4. Employee B, the Director of Clinical Services and Employee C, the Interim Alternate Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 5. Employee A, the Alternate Administrator and Employee B, indicated on 6/5/17 at 3:50 p.m., that the overage of hours may be due to waiver hours being included in the Medicaid Prior Authorization hours. Both indicated there is no delineation on notes. 6. An undated policy titled "Plan of Care" C - 580, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The individualized Plan of			

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	Care is based on a comprehensive assessment and information provided by the client / family and health team member ... The Plan of Care shall be completed in full to include ... Type, frequency, and duration of all visits / services, Medications, treatments, and procedures .... " 7. An undated policy titled "Skilled Nursing Services" C - 200, indicated " ... The Licensed Practical Nurse ... Assists the regisered nurse to complete the physician plan of care for skilled services ... Prepares clinical and progress notes .... "			
N 0557 Bldg. 00	410 IAC 17-14-1(a)(2)(E) Scope of Services Rule 14 Sec. 1(a) (2)(E) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (E) Assist the patient in learning appropriate self-care techniques. Based on record review and interview, the Licensed Practical Nurse (LPN) to document in the skilled nursing visit notes the tube feeding administered, outcome of the fluid intake, specific the medication that was taught to the patient, specific diet teaching, disease process teaching, reason for physician notification as well as the follow up on the material educated with the patient and physician notification in 1 of 10 records	N 0557	Director of Nursing/designee will in-service nursing staff on accurately documenting care provided specifically indicating what education was done and patient/caregiver response, if MD was notified of changes or concerns what changes if any were ordered, explaining tasks that were done in detail – i.e. tube feedings to include type of solution and amount administered, assessment as ordered on Plan of Care. Nurses	08/25/2017

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	reviewed. (#4) Findings include: 1. The clinical record for patient #4 SOC (start of care) 4/ 26/17, was reviewed. The skilled nursing visit notes indicated the following: A. On 4/27/17, the visit note indicated the interventions provided were teaching on new medication, diet teaching, disease process teaching and administered tube feedings. The visit note failed to evidence the medications, diet, and disease process that were taught and patient's understanding as well as the type and amount of tube feeding administered. B. On 4/28, 5/2, 5/17, 5/19, 5/22 and 5/23/17, the visit note indicated the interventions provided were the administration of tube feedings. The visit note failed to evidence the type and amount of tube feedings administered. C. On 5/3, 5/4 and 5/5/17, the visit notes indicated the interventions provided were education and administration of tube feedings. The visit notes failed to evidence what was educated in regards to tube feedings, the patient's understanding of tube feedings,		to sign documentation. (To be completed by 8/25/17) Director of Nursing is responsible to ensure orientation of newly hired nurses includes training on accurately documenting care provided specifically indicating what education was done and patient/caregiver response, if MD was notified of changes or concerns what changes if any were ordered, explaining tasks that were done in detail – i.e. tube feedings to include type of solution and amount administered, assessment as ordered on Plan of Care. Nurses to sign documentation. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of visit notes weekly to monitor for compliance. Once 100% compliance has been achieved, 25% of visit notes will be audited monthly to monitor for compliance. (To begin by 8/25/17). Director of Nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

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AT HOME HEALTH SERVICES LLC	6525 E 82ND ST STE 216 INDIANAPOLIS, IN 46250

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	and the type and amount of tube feedings administered. D. On 5/8/17, the visit note indicated the interventions provided were education and administration of tube feedings as well indicated that there were significant changes and the physician was notified after the case manager was informed. The visit notes failed to evidence what was educated in regards to tube feedings, the patient's understanding of tube feedings, type of tube feedings administered, what the specific changes in condition was, and physician response to notification of said change. The visit note also failed to evidence a blood pressure, temperature, heart rate, respirations, and pain assessment. E. On 5/9, 5/10 and 5/11/17, the visit notes indicated the interventions provided were education and administration of tube feedings as well indicated that there were significant changes and the physician was notified after the case manager was informed. The visit notes failed to evidence what was educated in regards to tube feedings, the patient's understanding of tube feedings, the type of tube feedings provided, what the specific changes in condition were, and physician response to notification of said change.			

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	F. On 5/16 and 5/24/17, the visit note indicated the interventions provided were administration of tube feedings. The visit note failed to evidence the type of tube feeding administered. G. On 5/25 and 5/30/17, the visit notes indicated the interventions provided were education of g-tube feedings, medication instruction, signs and symptoms of disease process, and g-tube site care. The visit note failed to evidence what was educated in regards to tube feedings, medications, and signs / symptoms of the disease process, the patient's understanding of the education provided, and an assessment of the g-tube site and the specific "care" provided. H. A visit note on 5/26/17, was provided on 6/2/17. The visit note was incomplete and failed to include cardiovascular, gastrointestinal, neurological / mental status, genitourinary, pulmonary, musculoskeletal, integumentary assessments, interventions, and professional services provided. The note also failed to include a signature with date. On 6/5/17, the agency provided another visit note that evidenced an assessment of the cardiovascular, gastrointestinal, neurological / mental			

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	status, genitourinary, pulmonary, musculoskeletal, integumentary systems but failed to evidence a pain assessment, interventions, and professional services provided. I. On 5/31 and 6/1/17, the visit note indicated the interventions provided was education of g-tube feedings, medication instruction, signs and symptoms of disease process, and g-tube site care. The visit note also indicated the patient's medications were reconciled per phone with the physician. The visit note failed to evidence what was educated in regards to tube feedings, medications, and signs / symptoms of the disease process, the patient's understanding of the education provided, and an assessment of the g-tube site and the specific "care" provided as well as the medications that were reconciled with the physician. J. On 6/2/17, the visit note indicated the interventions provided was education of g-tube feedings, medication instruction, signs and symptoms of disease process, and g-tube site care. The note also indicated the spouse notified the physician and to "see narrative." The visit note failed to evidence what was educated in regards to tube feedings, medications, and signs / symptoms of the disease process, the patient's			

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	understanding of the education provided, and an assessment of the g-tube site and the specific "care" provided as well as the "narrative" in regards to the patient's spouse physician notification. 2. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 3. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m. 4. An undated policy titled "Skilled Nursing Services" C - 200, indicated " ... The Registered Nurse ... Regularly reevaluates the clients needs, and coordinates the necessary services ... "			
N 0558 Bldg. 00	410 IAC 17-14-1(a)(2)(F) Scope of Services Rule 14 Sec. 1(a) (2)(F) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (F) Accept and carry out physician, dentist, chiropractor, podiatrist, or optometrist orders (oral and written). Based on record review and interview, the agency failed to ensure clinical staff followed the plan of care in relation to	N 0558	Director of Nursing will in-service nurses on requirement to follow Plan of Care which includes frequency and duration for	08/25/2017

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	frequency and duration of patient visits, personal care, and providing services without a physician's order in 2 of 4 active records reviewed of patients with skilled nursing services in a sample of 10. (#4 and 6) Findings include: 1. The clinical record for patient #4, SOC 4/24/17, included a plan of care for the certification period of 4/24/17 to 6/22/17, with orders for a licensed practical nurse (LPN) up to 3 hours per day, 5 days a week to assist with personal care, transfers, medication reminders, meal preparation / setup, and light housekeeping. A. During a home visit on 6/1/17 at 1:00 p.m., the LPN was observed to administer liquid dilantin (anti-seizure medication), tylenol and ibuprofen (used for mild pain and / or fever) and approximately 100 ml (milliliters) of water flush through the patient's gastric tube (g-tube) before, during, and after medication administration. In the kitchen, a piece of paper that was secured to a cabinet door contained a list of medications and water flushes with times to administer. The LPN indicated the spouse would sometimes have the medications administered prior to their		disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on requirement to follow Plan of Care which includes frequency and duration for disciplines ordered by MD and was tasks nurse is to provide. If a visit is not made, nurse will document reason, complete a missed visit report and notify MD of missed visit. If patient requires a task that is not listed on the Plan of care, nurse will contact MD and obtain an order for the needed task. If LPN notes there is something needed that is not on the Plan of Care, LPN will contact he RN case manager or Director of Nursing to discuss patient's need before MD is contacted. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of nursing documentation weekly, until	

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	arrival and sometimes the clinical staff would have to administer. The LPN indicated she would provide g-tube site care after the patient received a bath. B. Review of the skilled nursing visit notes indicated the following: 1. On 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered tube feedings. 2. On 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/24, 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse administered water flushes. 3. On 5/25, 5/30, 5/31, 6/1 and 6/2/17, the visit notes indicated the skilled nurse provided g-tube site care. 4. On 5/4, 5/17, 5/25, 5/31, 6/1, and 6/4/17, the visit notes indicated the skilled nurse was in the home for 4 hours and 10 hours on 5/23/17. 5. Three (3) skilled nursing visits were made week 1 and 4 of the certification period and 4 skilled nursing visits were made week 2, 3, 5, and 6 of the certification period.		100% compliance is achieved, to monitor compliance with following frequency and duration for disciplines ordered by MD as well MD ordered plan of care and that care provided follows the MD ordered Plan of Care. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of nursing documentation monthly to monitor for continued compliance. (To begin by 8/25/17) Director of Nursing will be responsible for monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

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6. On 4/25, 4/27, 4/28, 5/2, 5/3, 5/4, 5/5, 5/8, 5/9, 5/10, 5/11, 5/15, 5/16, 5/17, 5/18, 5/22, 5/23 and 5/24/17, failed to evidence if personal care had been provided.

The skilled nurses failed to follow the plan of care in regards to frequency and duration of visits, providing personal care, as well as providing services without a physician's order.

2. The clinical record for patient #6, SOC 1/30/17, included a plan of care for the certification period of 3/31/17 to 5/29/17, with orders for skilled nursing 1 visit per day, up to 2 hours per visit, 3 times per week to remove and apply a urostomy wafer one day per week.

A. Review of the skilled nursing visit notes on 3/31, 4/3, 4/5, 4/7, 4/10, 4/12, 4/14, 4/12, 4/19, 4/21, 4/24, 4/26, 4/28, 5/1, 5/3, 5/5, 5/8, 5/10, 5/12, 5/15, 5/17, 5/19, 5/22, 5/24, 5/26, and 5/29/17, the visit notes failed to evidence that the patient's urostomy wafer had been changed weekly. The skilled nurse failed to follow the plan of care.

3. Employee B, the Director of Clinical Services and Employee C, the Interim Alternate Director of Clinical Services,

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	had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 4. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m.			
N 0563 Bldg. 00	410 IAC 17-14-1(c)(2) Scope of Services Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (2) review the plan of care as often as the severity of the patient's condition requires, but at least every two (2) months; Based on record review and interview, the agency failed to ensure that the Registered Nurse conducted a complete skin assessment in 2 of 2 active records reviewed of a patient receiving wound treatments with a Medicare agency in a sample of 10. (#7 and 8) Findings include: 1. The clinical record for patient #7, SOC 12/31/16, included a plan of care for the certification period of 4/9/17 to 6/7/17, with orders for home health aide services up to 6 hours per day, 7 days a week. A. Review of a recertification comprehensive assessment dated 4/7/17,	N 0563	Director of Nursing/designee will in-service nurses on conducting a complete assessment at start of care, recertification – this is to include a complete skin assessment. If patient has skin impairments, including wounds, nurse will assess those areas and document findings. If it is documented patient has a wound then all documentation for that patient for that time needs to reflect the same thing. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on conducting a complete assessment at start of care, recertification – this is to include a complete skin assessment. If patient has skin impairments, including wounds, nurse will assess those areas and	08/25/2017

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	the "Professional Services" narrative section indicated the patient was receiving home health services with a Medicare agency for wound treatments. The comprehensive assessment failed to evidence an complete skin assessment, including visual site, of the patient's wounds. The clinical record failed to evidence the attempted coordination with the Medicare agency. B. A communication log dated 5/2/17, indicated that the patient was receiving home health services with a different Medicare agency for the treatment of wounds. C. An interview with the Director of Clinical Services on 5/31/17 at 11:00 a.m., the Director of Clinical Services indicated that she was not able to set up a joint visit with the Medicare agency, but did not indicate which agency the patient was with. The Director of Clinical Services indicated she did not want to disrupt the patient's dressing to assess the patient's skin. 2. The clinical record for patient #8, SOC 8/3/16, included a plan of care for the certification period of 3/31/17 to 5/29/17. The plan of care indicated the patient was receiving skilled nursing and		document findings. If it is documented patient has a wound then all documentation for that patient for that time needs to reflect the same thing. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admission and re-certifications to monitor for compliance with documenting a complete assessment, to include skin. Once 100% compliance is achieved 25% of admissions, re-certifications will be audited monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing will in-service nurses on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To be done by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on coordinating care with all medical agencies involved with patient. Training will include documenting name of agency, name/title of person spoke with, payer, discipline(s), frequency, duration and tasks to be provided. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of admissions, resumptions and re-certifications to monitor for compliance of coordinating	

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	home health aide services with a Medicare agency. A. Review of the OASIS start of care comprehensive assessment dated 8/3/16, the "Professional Services" narrative indicated the patient was receiving home health services 3 times a week through a Medicare agency for management of pressure wounds to the patient's right arm and buttocks. B. Review of the OASIS comprehensive recertification assessment dated 1/25 and 3/30/17, the "Professional Services" narrative indicated the patient was receiving skilled nursing and home health aide services through a Medicare agency. The skin assessments indicated the patient did not have a wound. C. The home health aide written patient instructions dated 3/30/17, indicated for the home health aide to inspect the patient's dressing. The clinical record failed to be consistent in relation to the patient's wound status, failed to evidence an assessment of the wound, and failed to evidence communication / narrative notes related to the error. 3. Employee B, the Director of Clinical		care with other medical agencies, if there are any. (To begin by 8/25/17)	

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	Services indicated on 6/2/17 at 4:15 p.m., that the agency was having issues with their computer program and she had notified the company on the problem. Employee B indicated in the meantime, the nursing staff was to write a communication note / narrative indicating the problem and correctly identifying the questions with the correct answers. Employee B was not able to provide evidence of her communication with the computer software company.			
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 that a Registered Nurse conducted a home health aide supervisory visit every 14 days in 3 out of 3 active records reviewed (#3, 6 and 9) of patients receiving a home health aide with skilled nursing services and failed to conduct a home health aide supervisory visit every 30 days in 2 out of 5 active records reviewed of home health aide only services in a sample of 10. (# 2 and 5)	N 0606	Director of Nursing/designee will in-service nurses on supervising aide at least every fourteen (14) days in cases where patient is receiving skilled nurse and aide services. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired nurses includes training on supervising aide at least every fourteen (14) days in cases where patient is receiving skilled nurse and aide services. (To begin by 8/25/17) Director of Nursing/designee will	08/25/2017

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	Findings include: 1. The clinical record for patient #2, SOC (start of care) 3/6/12, was reviewed. The clinical record failed to evidence a 30 day home health aide supervisory visit between 1/5/17 to 5/3/17. 2. The clinical record for patient #3, SOC 11/28/16, was reviewed and included orders for skilled nursing and home health aide. Review of the patient's clinical record, a supervisory visit was conducted on 03/24/17 and 5/23/17. The clinical record failed to evidence a home health aide supervisory visit every 14 days. 3. The clinical record for patient #5, SOC 11/21/16, was reviewed. The clinical record failed to evidence a 30 day home health aide supervisory visit between 1/26/17 to 6/2/17. 4. The clinical record for patient #6, SOC 1/30/17, was reviewed and included orders for skilled nursing 3 times a week and home health aide services 7 days a week. Review of the patient's clinical record, a supervisory visit was conducted on 4/21 to 5/17/17. The clinical record failed to evidence a home health aide supervisory visit every 14 days.		audit 100% of aide supervisory notes weekly until 100% compliance is achieved. Once 100% compliance is achieved, 25% of aide supervisory notes will be audited monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing/designee will in-service nurses on requirement to supervise aide at least every thirty (30) days in cases where patient has aide only services. (To be completed by 8/25/17) Director of Nursing will be responsible to ensure newly hired nurse are trained on requirement to supervise aide at least every thirty (30) days in cases where patient has aide only services. (To begin by 8/25/17) Director of Nursing/designee will audit 100% of aide supervisory notes weekly until 100% compliance is achieved. Once 100% compliance is achieved, 25% of aide supervisory notes will be audited monthly to monitor for compliance. (To begin by 8/25/17) Director of Nursing is responsible for monitoring corrective actions to this deficiency is corrected and will not recur.	

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	5. The clinical record for patient #9, SOC 7/8/16, was reviewed and included orders for skilled nursing and home health aide. The clinical record failed to evidenced home health aide supervisory visit on 1/2/17, 3/1/17 and 4/28/17. The clinical record failed to evidence a home health aide supervisory visit every 14 days.			
N 0608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review, the agency failed to ensure that visit notes were accessible in an electronic medical record in 1 of 2 closed records reviewed (#1) in a sample	N 0608	Director of Nursing/designee will instruct nurses to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be	08/25/2017

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	of 10, failed to update a clinical record with a correct address location of a patient receiving services in 1 out of 5 home visits conducted (#2), failed to physician orders were written for prn (as needed) visits and that those prn skilled nursing visits were documented in 1 out of 4 records reviewed (#3) of patients with skilled nursing in a sample of 10; failed to ensure electronic medical records identified an employee as a LPN and not an RN in 2 out of 2 records reviewed (#4 and 6) of patients receiving skilled nursing services from Employee E in a sample of 10; failed to ensure visit notes were completed and signed / dated by the clinican in a timely manner in 1 of 8 active records reviewed (#4) in a sample of 10; failed to ensure that the physician signed the initial plan of care orders within a timely manner in 1 out of 8 active records reviewed (#5) in a sample of 10; and failed to evidence a plan of care in 1 out of 8 active records reviewed (#9) in a sample of 10. Findings include: 1. The clinical record for patient #1, Start of Care (SOC) 03/10/15, was reviewed on 05/31/17. The electronic medical record system provided visit dates and times but did not provide access to the actual visit notes. At 2:30		provided by staff and when(nursing/aide). (To be completed by 8/25/17) Director of Nursing will be responsible to ensure newly hired nurses are trained to indicate on Plan of Care the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). (To be begin by 8/25/17) Director of Nursing/designee will audit, weekly, 100% of Plans of Care to monitor for compliance indicating the Plan of Care has the following: the correct address, status of others living in the home, what tasks are to be provided by staff and when(nursing/aide). Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of Plans of Care monthly to monitor for compliance. (To begin by 8/25/17) Administrator/designee will ensure that if agency changes electronic records vendor agency has copies, either paper or electronic, of all patient records before changing vendor. (To be done by 8/25/2017) Director of Nursing/designee will ensure there is someone available, in office or by phone, who can assist with computer issues when staff is unable to access patient electronic records. There will be a list posted in office, in a central location, indicating who to contact and how	

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	15K064	A. BUILDING 00 B. WING	06/05/2017

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	p.m., Employee B, the Director of Clinical Services, was requested to provide home health aide visit notes. A. On 06/01/17 at 3:20 p.m., Employee B was requested again to provide copies of home health aide visit notes. B. On 06/02/17 at 11:50 a.m., Employee B the provided a print out of home health aide visits of recorded time in and time out between 04/12/15 to 06/12/15. Employee B indicated she was not able to provide any information after 06/12/17. C. On 06/05/17 at 9:45 a.m., Employee A, the Alternate Administrator, was requested to provide patient #1 home health supervisory visit records. At 12:00 p.m., Employee A indicated the company had changed software and she was not able to obtain the visit notes and would contact the Administrator to see if the agency would pay the former software company to get into the clinical record and obtain the information. D. On 06/05/17 at 3:40 p.m., Employee A was only able to provide nursing visit records 04/21, 04/23 - 4/28/15 and 06/30 - 06/17/15, 07/20 -		to contact them. During staff meetings Director of Nursing/designee will remind staff of who to contact when having issues retrieving patient's electronic records. This will be documented in the meeting notes. (To begin by 8/25/17) Director of Nursing/designee will instruct staff on proofing documentation before submitting to ensure signature is present. (To be done 8/25/17) Director of Nursing will be responsible to ensure orientation of newly hired staff are instructed on proofing documentation before submitting to ensure signature is presntt. (To begin 8/25/17) Director of Nursing/designee will audit 100% of documentation weekly to ensure the dates on documentation are correct. Once 100% compliance is achieved, Director of Nursing/designee will audit 25% of documentation monthly to monitor for compliance. (To begin by 8/25/17). The nurse who signed her electronic notes as "RN" when she only had an Indiana license was an oversight when putting her credentials in the system. That has been corrected and she is listed and signs as an "LPN." She is an "RN" in Illinois and has an "LPN" license in Indiana. She is working as an LPN for the agency and follows the Nurse Practice Act standards for LPN. She has not functioned in the	

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	07/31/15, and 08/18 - 08/19/15. Employee A indicated she kept getting an "error" and was not able to access the home health aide visit notes. 2. The clinical record for patient #2, SOC (start of care) 03/06/12, was reviewed on 6/2/17. The plan of care included a former address where services were initially provided. A. A home visit on 6/1/17 at 9:00 a.m., was conducted at the patient's daughters home where the patient had been residing. During this time, the home health aide indicated the patient use to live with the son but moved in with the daughter and had been residing with the daughter for a long time and could not remember when the patient had moved. The plan of care failed to be updated with accurate information of the patient's residence to where services were to be provided. 3. The clinical record for patient #3, SOC 11/28/16, was reviewed on 5/31/17. The plan of care included orders for skilled nursing every 14 days for medication set up. A. On 5/31/17 at 3:00 p.m., Employee C, the Interim Assistant Director of Clinical Services, indicated		capacity of an RN while employed by this agency.	

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	she would make extra visits to the patient's home to fix the medication box due to medications not being refilled before her visit. The clinical record failed to evidence physician orders and visit notes for the extra visits made. B. On 5/31/17 at 4:10 p.m., Employee C indicated she was going to go to the patient's home that evening and make sure the patient had his / her medication for our home visit on 6/1/17. C. On 6/2/17 at 4:45 p.m., Employee C indicated she did not obtain orders nor did she complete nursing visit notes. 4. The clinical record for patient #4 SOC 4/26/17, was reviewed. The skilled nursing visit notes indicated the following: A. A visit note on 5/26/17, was provided on 6/2/17. The visit note was incomplete and failed to include cardiovascular, gastrointestinal, neurological / mental status, genitourinary, pulmonary, musculoskeletal, integumentary assessments, interventions, and professional services provided. The note also failed to include a signature with date.			

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	B. On 6/5/17, the agency provided another visit note dated 5/26/17 that evidenced an assessment of the cardiovascular, gastrointestinal, neurological / mental status, genitourinary, pulmonary, musculoskeletal, integumentary systems but failed to evidence a pain assessment, interventions, and professional services provided. At the top of the visit note, it is indicated that the LPN signed the visit note on 6/4/17 and at the bottom of the page, the note indicated the LPN signed the visit note on 5/26/17. C. The first page of the skilled nursing visit notes dated 4/25, 5/2, 5/8, 5/9, 5/15, 5/16, 5/22, 5/23, 5/25, 6/1, and 6/2/17, indicated the notes were completed by Employee E, a Registered Nurse but the last page of the visit notes were electronically signed by Employee E, a Licensed Practical Nurse. 1. The Indiana Professional Licensing website was reviewed and indicated that Employee E was a LPN only. The only Registered Nurses with Employee E name were licensed in Illinois. 2. The Employee A, the Alternate Administrator, and Employee B, the Director of Clinical Services, were			

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	intereviewed on 6/5/17 at 3:45 p.m. Employee A and B indicated that the discrepancy was a computor error and that Employee E worked for a local hospital with his / her RN license and worked for the home health agency under his / her LPN license due to a contract with the hospital. 5. The clinical record for patient #5 SOC 11/21/16, was reviewed. The initial plan of care dated 11/21/16 to 1/20/17, evidenced that the physician signed the plan of care on 1/13/17. The agency failed to ensure that the physician signed the initial plan of care orders within a timely manner. 6. The clinical record for patient #6, SOC 1/30/17, was reviewed. A. Skilled nursing visit notes dated 4/12, 4/17, 4/19, 4/24, 5/1 and 5/17/17, indicated the notes were completed by Employee E, a Registered Nurse but the visit notes were electronically signed by Employee E, a Licensed Practical Nurse. 1. The Indiana Professional Licensing website was reviewed and indicated that Employee E was a LPN only. The only Registered Nurses with Employee E name were licensed in Illinois.			

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	2. The Alternate Administrator and Director of Clinical Services were intereviewed on 6/5/17 at 3:45 p.m., and they indicated that the discrepancy was a computor error and that Employee E worked for a local hospital with his / her RN license and worked for the home health agency under his / her LPN license due to a contract with the hospital. The agency did not verify if Employee E was truly a registered nurse. 7. The clinical record for patient #9, SOC 7/8/16, was reviewed. A request for physician orders and the plan of care for the current certification period was requested on 5/30/17 and again on 6/2/17. The agency failed to evidence patient #9's physician orders and plan of care. 9. Employee B, the Director of Clinical Services and Employee C, the Interim Assistant Director of Clinical Services, had no further information or documentation in relation to the above findings on 6/2/17 at 4:00 p.m. 10. Employee A, the Alternate Administrator and Employee B, had no further information or documentation by the exit conference on 6/5/17 at 3:50 p.m.			

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N 0610 Bldg. 00	410 IAC 17-15-1(a)(7) Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview, the agency failed to ensure that all the contents of a patient's clinical record was retained and accessible in 1 of 1 record reviewed in a sample of 10. (#1) Findings include: 1. The clinical record for patient # 1, Start of Care (SOC) 03/10/15, was reviewed on 05/31/17. The electronic medical record system provided visit dates and times but did not provide access to the actual visit notes. At 2:30 p.m., Employee B, the Director of Clinical Services, was requested to provide home health aide visit notes. 2. On 06/01/17 at 3:20 p.m., Employee B was requested again to provide copies of home health aide visit notes. 3. On 06/02/17 at 11:50 a.m., Employee B provided a print out of home health aide visits of recorded time in and time out between 04/12/15 to 06/12/15. Employee B indicated she was not able to provide any information after 06/12/17.	N 0610	Administrator/designee will ensure that if agency changes electronic records vendor agency has copies, either paper or electronic, of all patient records before changing vendor. (To be done by 8/25/2017) Director of Nursing/designee will ensure there is someone available, in office or by phone, who can assist with computer issues when staff is unable to access patient electronic records. There will be a list posted in office, in a central location, indicating who to contact and how to contact them. During staff meetings Director of Nursing/designee will remind staff of who to contact when having issues retrieving patient's electronic records. This will be documented in the meeting notes. (To begin by 8/25/17)	08/25/2017

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	4. On 06/05/17 at 9:45 a.m., Employee A, the Alternate Administrator, was requested to provide patient #1 home health supervisory visit records. At 12:00 p.m., Employee A indicated the company had changed software and she was not able to obtain the visit notes and would contact the Administrator to see if the agency would pay the former software company to get into the clinical record and obtain the information. 5. On 06/05/17 at 3:40 p.m., Employee A was only able to provide nursing visit records 04/21, 04/23 -4/28/15 and 06/30 - 06/17/15, 07/20 - 07/31/15, and 08/18 - 08/19/15. Employee A indicated she kept getting an "error" and was not able to access the home health aide visit notes.			
N 0612 Bldg. 00	410 IAC 17-15-1(b) Clinical Records Rule 15 Sec. 1(b) Original clinical records shall be retained for the length of time as required by IC 16-39-7 after home health services are terminated by the home health agency. Policies shall provide for retention even if the home health agency discontinues operations. Based on record review and interview, the agency failed to ensure that all the contents of a patient's clinical record was retained and accessible in 1 of 1 record reviewed in a sample of 10. (#1)	N 0612	Administrator/designee will ensure that if agency changes electronic records vendor agency has copies, either paper or electronic, of all patient records before changing vendor. (To be	08/25/2017

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	Findings include: 1. The clinical record for patient # 1, Start of Care (SOC) 03/10/15, was reviewed on 05/31/17. The electronic medical record system provided visit dates and times but did not provide access to the actual visit notes. At 2:30 p.m., Employee B, the Director of Clinical Services, was requested to provide home health aide visit notes. 2. On 06/01/17 at 3:20 p.m., Employee B was requested again to provide copies of home health aide visit notes. 3. On 06/02/17 at 11:50 a.m., Employee B provided a print out of home health aide visits of recorded time in and time out between 04/12/15 to 06/12/15. Employee B indicated she was not able to provide any information after 06/12/17. 4. On 06/05/17 at 9:45 a.m., Employee A, the Alternate Administrator, was requested to provide patient #1 home health supervisory visit records. At 12:00 p.m., Employee A indicated the company had changed software and she was not able to obtain the visit notes and would contact the Administrator to see if the agency would pay the former software company to get into the clinical		done by 8/25/2017) Director of Nursing/designee will ensure there is someone available, in office or by phone, who can assist with computer issues when staff is unable to access patient electronic records. There will be a list posted in office, in a central location, indicating who to contact and how to contact them. During staff meetings Director of Nursing/designee will remind staff of who to contact when having issues retrieving patient's electronic records. This will be documented in the meeting notes. (To begin by 8/25/17)	

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	record and obtain the information. 5. On 06/05/17 at 3:40 p.m., Employee A was only able to provide nursing visit records 04/21, 04/23 -4/28/15 and 06/30 - 06/17/15, 07/20 - 07/31/15, and 08/18 - 08/19/15. Employee A indicated she kept getting an "error" and was not able to access the home health aide visit notes.			