STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	15K025		04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	This was a Federal Complaint Survey that was extended on 4/8/16. Survey Dates: April 6, 7, 8, 12, 13, 14, 15, and 18, 2016. Complaint number: IN00197325 Substantiated; Federal and state deficiencies were cited. Complaint number: IN00185401 Substantiated; Federal and state deficiencies were cited. Complaint number: IN00181930 Substantiated; Federal and state deficiencies were cited Complaint number: IN00181526 Substantiated; Federal and state deficiencies were cited Complaint number: IN00178606 Substantiated; Federal and state deficiencies were cited Facility Number: 011160 Medicaid Number: 200836920A Census: 659 Sample: 11 Individual Support Home Health Agency	G 0000	CORRECTED CITED DEFICIENCIES ARE COMPLETE WITH ADDITIONAL TRAINING, UPDATES, IMPROVEMENT, PREVENTION OF DEFICIENCY FROM OCCURRING IN THE FUTURE. ADMINISTRATOR AND DIRECTOR OF NURSING RESPONSIBLE.	

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

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

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	is precluded from providing its own training and competency evaluation program for a period of 2 years beginning April 13, 2016, to April 13, 2018, for being found out of compliance with the Conditions of Participation 42 CFR 484.14 Organization, Services and Administration, 484.18 Acceptance of Patients, Plan of Care, Medical Supervision, 484.30 Skilled Nursing Services, and 484.55 Comprehensive Assessment of Patients An Immediate Jeopardy was identified and began on 04/13/15 at 4:10 PM. The agency failed to ensure that measures was put into place immediately when learning that Employee F failed to work as scheduled from late evening on 3/28/16 to mid morning of 3/29/16. Employee F failed to report the absence to the agency. The patient who had gone without care / services was found dead the morning of 3/29/16. The Administrator was notified on 04/13/16 at 4:10 PM of the Immediate Jeopardy related to 484.10 Patient Rights, 484.18 Acceptance of Patients, Plan of Care, Medical Supervision, and 484.30 Skilled Nursing Services. The agency submitted a plan of action to remove the Immediate Jeopardy on 04/14/16 and again on 04/15/16. The Immediate Jeopardy was removed on 4/18/16 at 3:00 PM, after interviews with staff in regards			

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	to procedures to calling off, updating of the company policy, and verification of staff inservices with staff acknowledging they had read and understood company policy and patient rights.			
G 0100 Bldg. 00	Based on record review and interview, the agency failed to ensure that a patient had received the care and services that were to be provided and ordered by a physician (See G 101) and failed to ensure complaints made by patients / or caregivers were reported, documented and / or investigated with a resolution for 4 of 9 interviews (See G 107). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.10: Patient Rights and Immediate Jeopardy. The immediate Jeopardy was identified and began on 04/13/16. The Administrator was notified of the Immediate Jeopardy on 04/13/16 at 4:10 PM. The facility developed an acceptable plan for removal of the IJ on 4/15/16. Based on interviews and record reviews, the Immediate Jeopardy was removed on 04/18/16 at 3:00 PM.	G 0100	Toprevent the deficiency from recurring, on 3/29/16 the DON had a sign off sheetfor re-training on call off procedures, and started contacting staff on 3/29/16and writing their name on the sheet as she made contact. The staff that she made face to face contactwith she had them sign the sheet. There-training on call off procedures was completed prior to the surveyorsentrance to ensure the health and safety of our clients and was presented tothe surveyor. In the future the DON will put the procedure in writing andensure that each staff make notation of their understanding and put inpersonnel file rather than doing verbal. 1. On4/13/16 a full all staff (nurses, administration, HHA's, and ancillary staff,etc.) mandatory inservice was sent via e-mail (for all staff with emailaddresses), U.S. Post Office	04/15/2016

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	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.		mailing for those without emails, along with aphone call or text explaining the urgency and severity of the mandated trainingon 4/13/16 with a mandatory responsedead line of 4/15/16. Training includesPatient Rights (including patient and/or family responsibilities, Care Plansand Clinical Documentation, Attendance and Reporting (including specific calloff procedures for all staff) along with Progressive Disciplinary Action forfailure to comply. All staff mustrespond to the e-mail (with signed receipt indicator) or personally sign,acknowledging they received, state they have read and understand the ISHHA policyand procedures regarding the Mandated Training. All staff must be trained by 4/15/16 or will be removed from thescheduled (a suspended employee) until the Mandated Training is completed. Any staff on vacation, sick or unaware of theMandated Training will be suspended and not allowed to return to work until theMandated Training is completed. Anotification by email, text, mail or phone call has been given to allemployees. Effective immediately 4/13/16all staff will receive during orientation and annually every April specifictraining and understanding of Patient Rights (including patient and/or familyresponsibilities, Care Plans and Clinical Documentation,	

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			Attendance andReporting (including specific call off procedures for all staff) along withProgressive Disciplinary Action for failure to comply, with a signed trainingsheet. Copies of the Mandated TrainingSheets and Sign off sheets attached. Bi-weekly newsletters are submitted via QuickBooks for all staff with anemail address. We are currently investigatingQuickbooks addition of sending the agency a receipt when the email isopened. The newsletters will be send viaemail with a return receipt effective 4/15/16 until the agency investigatesQuickbooks version of acknowledgement of staff receiving agency information viaemail. A staff list is generated during payroll witha column added to indicate receipt of agency information submitted viaemail. Staff without emails will be sentcertified registered letters or will be required to come to office and pick upagency information and sign acknowledging receipt. This will be ongoing. Kimberly J Moore, Administrator & CathyYoung, DON & Payroll Coordinator 2. Effective4/13/16 and ongoing ISHHA will verbally notify each staff of their suspensionand follow up with a signed return receipt via email or a registered, certifiedsigned receipt letter via the U.S. Post Office and ongoing. On 4/14/16 an email	

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			was sent to the LPNregarding her termination and a return receipt was requested and a registered,certified signed receipt letter via the U.S. Post Office. A copy of the receipt from the post officewill be attached to the letter and filed in personnel file. Effective 4/13/16 this process will beenforced and be ongoing. Kimberly J Moore, Administrator Responsible & Cathy Young, DON &HR Director 3. Effective4/13/16 and ongoing. The Administratoror designee will make spontaneous checks on clients with staff present. This process will be done with a phone callby calling the clients phone and talking directly to the staff and drop invisits to the clients home. A clientlist has been generated with dates of visits. Special attention will be given to those clients and staff with ahistory of long term care together. Kimberly J Moore, Administrator & Justin Moore, AlternateAdministrator Responsible & Designee 4. Effective4/13/16 and ongoing ISHHA Admission Nurse will have the client and or familymembers sign the welcome letter and also the Patient Information Packet forreceipt and acknowledgement of the Call off Process. The forms are included in the Admission Packetto be taken to the admission. Kimberly JMoore, Administrator, Cathy Young, DON and Admission Nurses	

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			Responsible. 5. ISHHAhas full systems in place to ensure all clients are staffed at all times whennotified of the need for staff, either by the employee or by the client. ISHHA maintains a full staff of Float Nurses bothRN's and LPN's and Float HHA's at all times available to ensure clients arestaffed and nurses are replaced when they call off for any reason 24 hours aday 7 days a week. ISHHA provides company cars for the Float staff to ensurequick response to client coverage. ISHHAreviews, as needed the need to increase or decrease the float staffing pool toaccommodate the client base. The processfor the review to increase: 1) If anAdministrative Staff from the scheduling department is routinely sent to coveras an HHA for a two week period, an additional HHA float will be added. If a CM is routinely sent to cover for askilled nursing case for a two week period, an additional nurse float will beadded. This process has been effective and will continue ongoing. Kimberly J Moore, Administrator and CathyYoung, DON Responsible 4/13/16 and ongoing 6. Effective4/13/16 and ongoing the Attendance and Reporting Policy was updated to includespecific instructions for call offs. TheAttendance and Reporting Policy is part of the Mandated Training required. The updated Attendance and	

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			Reporting Policywill be replaced for orientation class and the April Annual Training andongoing. Kimberly J Moore, Administratorand Cathy Young, DON Responsible 7. Effective4/13/16 and ongoing the Nurse Scheduler and all staff on a “need to know basis”will receive a confidential email (blind copy) when the email is sent for thesuspension and/or termination. KimberlyJ Moore, Administrator and Cathy Young, DON Responsible 8. Effective4/14/16 and ongoing ISHHA will verballynotify each staff of their suspension and follow up with a signed returnreceipt via email or a registered, certified signed receipt letter via the U.S.Post Office and ongoing. A copy of thecertified receipt will be attached to the letter and placed in the personnel file. On 4/14/16 an email was sent to the LPNregarding her termination and a return receipt was requested and a registered,certified signed receipt letter via the U.S. Post Office. The certified receipt was attached to theletter and placed in the personnel file. Effective 4/14/16 this process will be enforced and be ongoing. Kimberly J Moore, Administrator & CathyYoung, DON & HR Director Responsible 9. Effective4/14/16 and ongoing the scheduling staff will communicate with all staff thecall off procedures and consequences weekly when	

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			review of their weeklyschedule. Effective 4/15/16 and ongoing the client monthly calendar hasbeen edited to add the staff call off procedure and client responsibility whenstaff does not show up. All clients arestaffed with permanent staff at all times when staff are hired and trained fora specific client. If the client doesnot have permanent staff float nurses or HHA's are assigned to staff theclient. ISHHA maintains a full staff of float nurses and float HHA's. ISHHAmaintains a schedule of all clients who require staffing. The open list of clients are reviewed by theManagement Team each Monday at 8:30 am and ongoing. The schedule is completed in advance, staffare notified of their staffing schedule in sufficient advanced notice that theyare given full opportunity to notify ISHHA of their inability to complete ashift, be at the client's home timely, or any other reason they may be unableto fulfill their staffing obligations. When a call in occurs replacement staff are scheduled and sent to theclients home immediately. This system ensure when staff do call-off schedulinghas ample time to replace them. KimberlyMoore, Administrator, Cathy Young, DON, Scheduling Staff Responsible. 10. Effective 4/14/16 and ongoing TheWelcome Letter was updated to include the clients acceptance	

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			of Float Staff by stating“yes” or “no” with the agencies ability to staff adequately. This form is signed by the client ordesignated individual and is be placed in the client chart. The Welcome Letter also includes instructionsfor staff not showing up or trying to make a deal about scheduled hours with theclient and/or designated individual. On4/15/16 a copy of the new Welcome letter will be mailed to all clients with aself-addressed letter for return to the office. The CM’s will follow-up on the letter for return. All letters will be completed in 30 days andplaced in client charts. A client listtracker will be in place to assure every client has a signed Welcome Letter intheir chart within 30 by 5/15/16 for completion. Kimberly J Moore, Administrator, Cathy Young,DON and Admission Nurse and Case Managers Responsible	
G 0101 Bldg. 00	484.10 PATIENT RIGHTS The patient has the right to be informed of his or her rights. The HHA must protect and promote the exercise of those rights. Based on record review and interview, the agency failed to ensure that a patient had received the care and services that were to be provided and ordered by a physician. (Patient#1) Findings include:	G 0101	G101 – PatientRights On4/13/16 a full all staff (nurses, administration, HHA’s, and ancillary staff,etc.) mandatory in-service was sent via e-mail (for all staff with emailaddresses), U.S. Post Office mailing for those without emails, along with aphone call or text explaining the urgency and severity of the mandated	06/10/2016

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	1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension. a. On 04/06/16 at 11:00 AM, the Administrator stated that the complaint visit must have been in regards to patient number 1. b. Review of patient number 1 clinical record on 04/06/16 at 12:40 PM, a discharge summary dated 03/29/16, indicated the patient had died at home.		trainingon 4/13/16 with a mandatory responsedead line of 4/15/16. Training includesPatient Rights (including patient and/or family responsibilities, Care Plansand Clinical Documentation, Attendance and Reporting (including specific calloff procedures for all staff) along with Progressive Disciplinary Action forfailure to comply. All staff mustrespond to the e-mail (with signed receipt indicator) or personally sign,acknowledging they received, state they have read and understand the ISHHApolicy and procedures regarding the Mandated Training. All staff completed the training prior tobeing put back on the schedule. Suspension letters were mailed certified/receipt on 4/15/16 to all staffthat had not completed the mandatory training. Any staff on vacation, sick or didnot respond to the Mandated Training weresuspended and not allowed to return to work until the Mandated Training wascompleted. Effective 4/13/16 all staff will receive duringorientation and annually every April specific training and understanding ofPatient Rights (including patient and/or family responsibilities, Care Plansand Clinical Documentation, Attendance and Reporting (including specific calloff procedures for all staff) along with Progressive Disciplinary Action	

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	c. Review of the OASIS discharge assessment dated 03/29/16, the summary indicated the patient was found dead at his home at 08:00 AM. The patient was in his wheelchair at the kitchen table. d. Review of the nursing visit notes on 04/06/16 at 12:40 PM, the clinical record failed to contain visit notes 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16. e. Review of the agency's investigative note dated 03/29/16 at 9:57 AM, indicated the Director of Clinical Services had taken a phone call from Employee F, LPN (Licensed Practical Nurse) at 9:30 AM. Employee F reported that he / she had developed a fever and did not feel that he / she should come to work. Employee F asked the patient if he / she would like for Employee F to notify the office and the patient replied that he / she did not want any of the nurses from the office because of previous issues. Employee F indicated he / she had spoken to the patient around midnight on the phone and messaged with him / her on facebook around 3:00 AM. Employee F indicated he / she had called the patient to let him / her know that he / she was coming to assist him / her around 7:00 AM but the employee got no answer. When Employee F arrived at the patient's		forfailure to comply, with a signed training sheet. Bi-weekly newsletters are submitted viaQuickBooks for all staff with an email address. A cell phone was purchased to send a text to all staff, as a reminder, to review their emailwhen newsletters and agency information is released via email. The cell phone will also provide staff, thatdon't have an email, a copy of the newsletter and all agency information. Those staff that can't receive through emailor cell phone will be mailed via US Post Office all newsletters and agencyinformation. Staff that pick upnewsletters and agency information bi-weekly will do so at the office or atdrop sites. Emails will request anacknowledging receipt. Text messageswill require a text back of receipt. USMail will be sent receipt return. Pickup will require a signed receipt. A bi-weeklystaff list is generated during payroll with a column added to indicate receiptof agency information. Newsletter andagency information will also be visually available to all staff at the officeand each drop site. On 4/18/16 and ongoing all nurses were notified, in theirmethod of communication, to submit nurse visit notes every Monday. Nurse visit notes are entered as receivedinto the tracker and tracked back to the schedule. A comparison report is generated	

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	home around 8:00 AM, he / she did not get an answer at the door and someone had to let him / her in and that was when Employee F found the patient sitting in his wheelchair at the kitchen table. Employee F called 911. Employee F indicated he / she was trying to follow the client's wishes. The Director of Clinical Services informed Employee F of the immediate suspension pending the investigation. f. The Administrator, Director of Clinical Services, and Assisting Director of Clinical Services was interviewed on 04/06/16 at 1:40 PM. The Director of Clinical Services stated Employee F had failed to return phone calls and text messages, so a letter of termination had gone out to him / her in the mail. At 3:40 PM, the Administrator, Director of Clinical Services, and Assisting Director of Clinical Services were interviewed again. To prevent this occurrence from happening again, measures that had been put into place included reiterating to patients to contact the office when staff fails to show up and there was a live person to take calls 24/7. Another measures included retraining the staff to notify the office for call offs. The Director of Clinical Services stated there was not a sign in sheet of the staff training. The Director of Nursing stated		on eachWednesday to determine if there are missing nurse visit notes. The staff, that have missing nursing notes,will be contacted on each Wednesday , in their method of communication and willhave until each Friday to submit. Stafffailing to submit timely will be suspended until nursing notes arereceived. Staff will be terminated afterthree untimely weeks. ISHHA will assiststaff in receiving nursing notes timely by means of gas cards, gift cards, kindwords, picking them up to ensure ISHHA stays in compliance and this deficiencywill not recur. Effective 4/13/16 policywas updated to add that any staff being suspended will be notified in theirmethod of communication and also a letter will be mailed via US Post Officecertified/receipt. After theinvestigation the staff will be notifiedin their method of communication and also a letter will be mailed via US PostOffice certified/receipt of the outcome (termination or return to work). All signed receipts will be put in staffpersonnel files. Effective 4/29/16 andongoing the call off procedure with repercussions will be in eachnewsletter. All staff will be in-servicedon Tag G101 (Patient Rights) by 6/10/16. Education on Patient Rights and Call Off Procedures will be the June2016 in home training with clients and staff during Supervised Visits and	

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	Employee F knew he / she needed to call in, for he / she had called off a few weeks ago. g. Employee F was interviewed on 04/06/16 at 4:30 PM. The employee stated he / she did not show up at the patient's home as scheduled and did not notify the office of his / her absence per patient wishes. Employee F stated he / she did notify the office and spoke with the Director of Clinical Services in regards to the absence and death. Employee F did confirmed the typed conversation with the Director of Clinical Services with the exception that he / she observed the patient's facebook as "active" at 3:00 AM, but did not speak with the patient at this time. The Employee also stated he / she was not placed on suspension, but was allowed time off to grieve due to the close relationship he / she had with the patient. The employee stated he / she had not received any text messages or phone calls from the Director of Clinical Services. Employee F stated he / she was contacted today by Employee R, a Registered Nurse / Case Manager, but also stated he / she had another death in the family and had been out of town where phone reception was poor. The employee stated that a scheduler had reached out to him / her on 03/31/16, about taking another case and		willbe documented on the ASV by 6/30/16. Acurrent Patient Rights form dated 5/27/16 will be signed by the patient andstaff and placed in client chart and personnel file. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly) to spontaneouslycheck on staff, to follow-up on each monthly inservice, call off process,organization chart, updates on client and staff paperwork, patient rights,etc. The committee member, when educating,will get signed documents of the training provided. Each document signed will be placed in thestaff personnel file and client chart. Thecommittee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. Thecommittee will meet the first Wednesday of each month to discuss findings andthe outcomes and to ensure that each finding was addressed and resolved anddocumented. The Quality AssuranceCommittee, Chart Audit Committee, RN Case Managers, Nurse Scheduler, OfficeManager, Compliance Officer, Administratorand Director of Nursing will be responsible for monitoring these	

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	was planning to send him / her the plan of care. h. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. The Administrator stated Employee F did notify the office the previous evening. The Administrator stated the employee was still fired. The Administrator provided an employee list of names that the Director of Clinical Services produced, of staff who had been in-serviced on call offs. At 10:30 AM, the Administrator provided Employee F's missing visit notes of patient number 1 and also provided a business news letter. The Administrator stated the news letter went out with payroll, which was within the same week of the patient's death. The news letter stressed the importance of calling the office for call offs and failure to follow the agency policy would result in termination. The 03/27 and 03/28/16 skilled nursing visit notes were not provided. i. On 04/08/16 at 3:00 PM, Employee F was interviewed in person. Employee F provided a text message between him / herself and the patient on 03/28/16, indicating that Employee F continued to be ill and the patient		correctiveactions to ensure that this deficiency is corrected and will not recur.	

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	declined to have a replacement nurse. Employee F stated the patient was able to take him / herself off the vent but felt better if someone was there due to random episodes of desaturate when removed and at times, would become unresponsive for a few minutes then return to normal. Both agreed for Employee F to follow up with the patient in the morning of 03/29/16. Employee F provided a text message between him / herself and the Administrator dated 04/07/16 at 5:15 PM. The message indicated "you are suspended pending investigation. Client died and you did not cover the shift or call the office as policy states." Employee F provided a text message dated 03/31/16, from an unknown scheduler in regards to taking on a new case and another text message dated 04/02/16, indicating the plan of care was going to be sent out. Employee F was questioning why he / she was asked to take on a new client if he / she was suspended. Employee F provided a text dated 04/04/16, where he / she had made contact with the office requesting information about the new case. Employee F also stated that when he / she met with the Alternate Administrator on 04/07/16, he had provided him / her with a $20 gift card for meeting with him. Employee F stated the missing 03/27 and 03/28/16 skilled nursing visit notes were			

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	not provided to the Alternate Administrator because the visit notes were to be turned in with the next payroll. Employee F stated he / she had thought he / she would have them to turn in with the new case. j. During a home visit with Employee P, home health aide, on 04/12/16 at 9:00 AM, Employee P was interviewed and had stated he / she had never seen a company newsletter, but then the agency did not have his / her correct address. Employee P also stated he / she had not been told or reminded about notifying the office about call offs and the repercussions. k. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 AM, Employee I was interviewed and had stated he / she had never seen a company newsletter, nor had he / she been told or reminded about notifying the office about calls offs and the repercussions. l. During a home visit with Employee J, a LPN, on 04/12/16 at 1:40 PM, Employee J was interviewed and stated he / she had not received a company newsletter, but did receive a text from the office the previous week about calls offs, but was unable to			

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	remember the specific details of the text nor the date received. m. During a home visit with Employee K, a Registered Nurse on 04/12/16 at 3:40 PM, Employee K was interviewed and stated that he / she would get a company newsletter in an email sometimes but had not received an email within the past few weeks. Employee K stated he / she did get a text the previous week to contact the Director of Nursing for call offs but unable to provide a specific date. n. During a home visit with Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H was interviewed. Employee H stated that he / she had not received a company newsletter and could not remember the last time he / she had received one. Employee H recalled hearing about call offs a few weeks prior, but don't recall specifics or repercussions. o. The Administrator was interviewed on 04/13/16 at 4:00 PM. The Administrator was in agreement that the text message to Employee F on 04/07/16 at 5:15 PM, had taken place. The Administrator stated she had did that because she had felt bad for the employee and wanted cooperation to get the visit			

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	notes. The Administrator had no explanation of the field staff interviews on 04/12/16 in regards to the newsletter and the lack of knowledge of the call off policy and repercussions. p. The detective involved in the patient's death investigation was interviewed on 04/18/16 at 10:16 AM. The Detective stated the initial findings was asphyxiation due to a mucous plug, but the final coroners report would take anywhere from 2 to 3 weeks. The time of death usually would be upon arrival of the coroner, but was unsure at this time. The projected time of death was anticipated between 6:00 AM to 7:00 AM. The Detective also stated that there was a video that put Employee F's arrival time to the patient's home at 8:35 AM on 03/29/16. The Detective stated Employee M, a home health aide / administrative assistant, came by the policy station the previous week and obtained a copy of the report. 2. A policy titled Scope of Services and Core Skilled Service Provided dated 07/10/15, indicated " ... The qualifications and competence of the individual(s) providing services are appropriate to patient needs and the required services and comply with applicable laws and regulations .... "			

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	3. A policy titled Standard of Practice dated 07/10/15, indicated ISHHA staff will deliver services based on each patent's unique and individual needs and clinical decisions will not be altered ... Patient care will be provided in a coordinated, effective, appropriate ... and safe manner in accordance with ISHHA goals, objectives, and philosophy." 4. A policy titled Tardiness and Unplanned Absence dated 07/10/15, indicated " ... f an employee is unable to report for work, he / she must notify his or her supervisor at least four (4) hours prior to the beginning of the work shift. The team member must personally contact the supervisor .... "			
G 0107 Bldg. 00	484.10(b)(5) EXERCISE OF RIGHTS AND RESPECT FOR PROP The HHA must investigate complaints made by a patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of the HHA, and must document both the existence of the complaint and the resolution of the complaint. Based on record review and interview,	G 0107	G107– Exercise of Rights and	06/10/2016

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	the agency failed to ensure complaints made by patients / or caregivers were reported, documented and / or investigated with a resolution for 4 of 9 interviews. (#1, 4, 8, and 11) Findings include: 1. Employee F, LPN (Licensed Practical Nurse), was interviewed on 04/08/16 at 3:00 PM. A text message was observed on Employee F phone dating 10/05/15. The text message was a conversation between the employee and the Director of Nursing. The text message indicated a confirmation of the Director of Clinical Services visiting patient number 1 on 10/05/15. The employee indicated the patient was having problems with Employee O, a LPN, and the Director of Clinical Services was meeting with the patient to discuss the problems. a. Review of the complaint book failed to include an investigation of the patient's problems with Employee O. b. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated the patient was complaining about Employee O being bossy, telling him what to do, and speaking for him. The Director of		Respect for Property Allstaff will be in-serviced on Tag G107 (Exercise of Rights and Respect forProperty) by 6/10/16. Effective 4/18/16and ongoing Management personnel were instructed to transfer all complaints frompatients or caregivers (including, but not limited to lack of respect for thepatient's property) to the Administrator or Director of Nursing or designee. All complaints will be investigated anddocumented with a resolution. Ifresolution of the complaint was not possible, the actions that were attemptedand the outcomes will be documented. On5/27/16 policy was updated to include a letter will be sent to the patient/caregiverupon resolution (will include the actions that were attempted and the outcomes). A copy of the letter will accompany the ISHHAinvestigation and attached to the complaint investigation and maintained in theComplaint Book. On 5/25/16 and ongoing InHome Quality Assurance Committee was developed to make home visits on 10% ofclients monthly (until all clients have been seen) (the committee will continueto make home visits 10% quarterly). During home visits, thecommittee members will ask patients how they would express a grievance orproblem should one occur. If one had already occurred, they	

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	Clinical Services stated Employee O had taken care of the patient for many years and she had spoken with Employee O about professional boundaries. The Director of Clinical Services stated the patient reported he / she felt safe with Employee O. The Director of Clinical Services did not provide any documentation in regards to the investigation. 2. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week. a. The clinical record contained a letter dated 08/21/15, that was sent to the patient informing him / her a notice of discharge on 08/31/15, due to the patient continuing to refuse home health aides. b. Patient number 4 was interviewed on 04/12/16 at 7:30 PM. The patient indicated he / she had received two letters of discharge. The patient stated he / she did not refuse nursing nor did he / she refused home health aides. The patient stated he / she		are to ask how itwas handled and what were the results or outcomes. If they have not reported one, but discusseda complaint, a report from the member will be given to the Administrator orDirector of Nursing or designee within 24 hours to investigate. The committee member will re-educate thepatient on the complaint/grievance process and organization chart.The committee member, when educating, will get signed documents of the trainingprovided. Each document signed will beplaced in the staff personnel file and client chart. The committee willmeet the first Wednesday of each month to discuss findings and the outcomes andto ensure that each finding was addressed and resolved and located in theComplaint Book. The Quality Assurance Committee, ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur.	

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	did not like the team leaders that came into his / her home and his / her last complaint was over a home health aide that spit over his / her food when he / she spoke. The patient stated he / she had to be fed and he / she would lose his / her appetite and couldn't eat. The patient stated he / she was falsely being accused of refusing visits. c. Review of the complaint book, the complaint book failed to include an investigation of the patient's complaint. d. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated she investigated the nursing complaints and the Administrator or local coordinators would investigate the home health aide complaints. The Director of Clinical Services stated if it was a staffing issue such as scheduling, the local coordinators were closer to the source. e. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator stated the patient constantly wanted team leaders and refused the home health aides. The Administrator. The Administrator was not able to provide any further of documentation of the patient's history of			

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	complaints. 3. During a home visit with Employee K, a Registered Nurse, on 04/12/16 at 3:40 PM, a parent for patient number 8 was interviewed. The parent had stated he / she had contacted the office several times to ask for a back up nurse. The parent stated that he / she was very particular in who was allowed in the home and wanted the nurse to meet the patient prior to providing care. Employee K stated there had been no back up nurse since May, 2015. a. The Administrator was interviewed on 04/14/16 at 12:15 PM. The Administrator stated every patient has a back up person and also stated it was difficult to train a back up person due to no reimbursement. By 5:00 PM, the Administrator did not provide any further documentation in relation to the parent's concern / complaint. b. Review of the complaint book, the complaint book failed to include an investigation of the parent's complaint. 3. The clinical record for patient number 11 was reviewed on 04/15/16 at 11:56 AM. The clinical record evidenced multiple missed visit reports. A parent for patient number 11 was interviewed on			

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	04/15/16 at 12:05 PM. The parent had stated he / she was having problems with Employee V, a home health aide. The parent stated Employee V was "more of a hassle and did cancel visits" with Employee V. The parent stated the employee refused to use equipment such as the hoyer lift and felt the employee was not adequately trained to be a home health aide. The parent stated he / she had informed Employee W of his / her concern. The parent also stated he / she would call the Middletown branch and would get told he / she needed to call the Noblesville office and the other office would tell him / her to contact Middletown. The parent stated he / she kept getting the "run around." a. Review of the complaint book, the complaint book failed to include an investigation of the parent's complaint. b. The Administrator was interviewed on 04/18/16 at 2:55 PM. The Administrator stated she was not made aware of the parent's concern and the parent's call should have stayed within the Middletown office and not referred to the other office. 4. A policy titled Bill of Rights / Grievance Procedure dated 07/10/15, indicated " ... ISHHA will investigate			

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	complaints made by a patient / family member or guardian regarding care or treatment furnished or that was not furnished. ISHHA will investigate complaints made identifying a lack of respect for patient property by anyone providing services on behalf of ISHHA. ISHHA will document the existence of a complaint and the resolution. The documentation will be placed in a confidential 'Patient Complaint' filed. If the patient verbalizes a complaint to ISHHA staff in the home the complaint will be communicated to the Supervising Nurse or designee who will ensure that the complaint will be handled, investigated and documented in a manner consistent with the nature of the complaint. The Patient or Responsible party will be informed of the progress of the investigation and proposed action plan .... "			
G 0122 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Based on record review and interview, the Administrator failed to ensure there was delineation of agencies between Individual Support Home Health Agency and with the personal care service agency, Individual Support Services and failed to ensure that lines of authority	G 0122	G122– Organization, Services and Administration Allstaff will be in-serviced on Tag G122 (Organization, Services andAdministration) by 6/10/16. The 5/27/16newsletter included pictures, names and titles to ensure the delineation ofagencies. The 5/27/16	06/10/2016

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	were clearly defined for delegation of responsibility down to the patient care level (See G 123), failed to ensure supervisory functions were not delegated to another agency or organization (See G 124), and failed to ensure that 60 day summaries were individualized and had a clearly written synopsis of the patient's course of treatment, including all services provided for 9 of 9 records reviewed of patients recertified in a sample of 11 (See G 145). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.14 Organization, Services, and Administration. 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.		newsletterincluded clear lines of authority/supervision along with the organizationchart. In addition to the in-service,individual training sessions to train on 60 day summaries to ensure they areindividualized and have clearly written synopsis of the patient's course oftreatment, including all services provided and goals and update records to removeinformation to ensure the delineation of agencies with Case Managers started on5/24/16 and to be completed by 6/30/16 with the Director of Nursing, AlternateDirector of Nursing/Compliance Officer. Anall Case Manager training session has been scheduled for Friday, June 17, 2016to train again on 60 day summaries toensure they are individualized and have clearly written synopsis of thepatient's course of treatment, including all services provided and goals andupdate records to remove information to ensure the delineation of agencies. Updates to the Case Manager training manualon 60 day summaries to ensure the clinical summaries are individualized andhave clearly written synopsis of the patient's course of treatment, includingall services provided and goals (eliminating any information to ensure thedelineation of agencies) will be completed by 6/2/16. Effective 4/17/16 and ongoing 10% of allclinical records	

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			will be audited quarterly for evidence that 60 day summariesare individualized and have clearly written synopsis of the patient's course oftreatment, including all services provided and goals and update records toremove information to ensure the delineation of agencies. On 5/25/16 and ongoing an In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all clients have been seen) (the committee will continue to make homevisits 10% quarterly). During the homevisit the committee member will ensure that an organizational chart is in theiryellow folder in their home and their understanding of the delineation of theagencies and the lines of authority with a signed form for the clientchart. The committee member, wheneducating, will get signed documents of the training provided. Each document signed will be placed in thestaff personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesdayof each month to discuss findings and the outcomes and to ensure that eachfinding was addressed and resolved and placed in the Complaint Book. The Quality Assurance Committee,	

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			ComplianceOfficer, Administrator and Director of Nursing will be responsible for monitoringthese corrective actions to ensure that this deficiency is corrected and willnot recur.	
G 0123 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level are clearly set forth in writing and are readily identifiable. Based on record review and interview, the Administrator failed to ensure there was delineation of agencies between Individual Support Home Health Agency and with the personal care service agency, and failed to ensure that lines of authority were clearly defined for delegation of responsibility down to the patient care level. Findings include: 1. During the entrance conference on 04/06/16 at 10:30 AM, the Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services, indicated there were drop sites in Martinsville and Noblesville. The drop sites were located within the personal service agency that was also owned by the Administrator.	G 0123	G123– Organization, Services and Administration Allstaff will be in-serviced on Tag G123 (Organization, Services andAdministration) by 6/10/16. The 5/27/16newsletter included pictures, names and titles to ensure the delineation ofagencies. The 5/27/16 newsletterincluded clear lines of authority/supervision along with the organizationchart. Staff are assigned the closestdrop site based on their location for their convenience for paperwork needs andsupplies. Staff are assigned a “Point ofContact” person based on their location for scheduling and otherneeds/information. Phones areestablished at the drop sites for the convenience of the staff and clients. Phone calls received at drop sites aretransferred to the Middletown Office in relationship to the need. The drop site phones also rings directly tothe Middletown Office	06/10/2016

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	2. On 04/06/16 at 11:15 AM, an employee list was provided by the Administrator. The employee list indicated Employee L was an ADM [administrator] and Employee M was AADM [assistant administrator]. The Administrator had stated Employee L managed the personal service branch in Martinsville. 3. On 04/11/16 at 10:30 AM, the personal service branch was visited. The doors were locked and a sign on the back door provided Employee L and the Administrator's name and phone number as well as the Middletown office phone number. There were 7 company vehicles in the parking lot. Six (6) of the 7 vehicles had Individual Support Home Health Agency advertisement on the vehicles. 4. During a home visit with patient number 5 on 04/12/16 at 9:00 AM, Employee P, a home health aide, stated he / she works from the "Martinsville office" and he / she provided both attendant care and home health aide services from both [name of personal service agency] and Individual Support Home Health Agency. Employee P stated Employee L was the supervisor for both companies. Patient number 5 stated when he / she needs to contact the office,		as needed. Thedrop sites are not staffed by ISHHA staff and signs are left (for theconvenience of staff) to make contact with the "Point of Contact" person or theAdministrator when no staff is available to assist them. Phone numbers of "Point of Contact" andadditional numbers or cell numbers are for the convenience of our staff toensure they can get their needs met without making unnecessary trips and cannotaccess the drop site or making a trip to the Middletown Office. ISHHA provides transportation to staff whenstaff are in need (car problems, financial problems or simply helping) it's only logical to advertise on the cars,as they move about and parking them at drop sites so they are safe and keys arelocked at the drop site for insurance purposes and safety. The cars are another assurance for ourclients to be served when their regular staff call off – we can very quicklysend a staff in a company car, much easier than asking them to drive their owncar. Paperwork training/correction orcompletion for staff at drop sites is for staff convenience. ISHHA provides a "yellow" folder in clienthomes for distinct delineation. Employees are instructed not to take cell phonesin to client homes when they are providing services. Notes on drop sites doors indicated to callthe Administrator when "Point of	

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	he / she starts with Employee L and would go down the list of phone numbers. The patient also stated he / she would text Employee L as well. The patient stated he / she received services from both the home health agency and personal service agency. a. Review of the patient's agency folder during the home visit, a form titled "Emergency Back Up Plans" listed Middletown / Noblesville with the phone numbers of the Administrator, Employee M, and the office number. The next paragraph listed Martinsville area and the name of Employee L and Employee U with their phone numbers, then provided an on-call line. b. Another form in the patient's agency folder titled "Welcome to ISHHA ... If you have any questions or concerns please call us. Martinsville Workstation," Name of Employee L, Program Director, office number and cell number, on call line for after hours, home office number, the Administrator's name and cell number, Employee M as the VP [vice president] with cell number, followed by a title of "Supervisor" and Employee L signature. c. There was another form in the patient's agency folder that indicated		Contact" staff not available. Both employees that were contacted bysurveyor were staffing clients. Oneemployee was staffing from 8a to 6pm, the other staff was staffing 9:30a to5:30p. An allCase Manager training session has been scheduled for Friday, June 17, 2016 toreview and train on the clear lines of authority/supervision for a distinctdelineation of agencies. On 4/20/16 trainingwas provided to the Human Resources Director on employee titles for theemployees. The HR Director wasinstructed not to title staff as Administration and abbreviate as ADM and theAdministrations Assistants as AADM. On4/20/16 policy was updated with title abbreviations per position and theemployee list was corrected. On 5/27/16The HR Director reviewed completed personnel files for accurate jobdescriptions. Staff that were theAlternate Administrator or other positions (job description remains in thepersonnel file) also have a Home Health Aide Job Description and appropriatejob description for their position. On5/27/16 the tracker for the employee list was corrected with the employeetitles to match the policy. On5/25/16 and ongoing an In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all clients have been seen) (the committee	

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	[name of personal service agency] with the Administrator and Employee M listed with phone numbers to contact first followed by "Martinsville area" with the name of Employee L and Employee U with phone numbers, followed by an on call number. The form was signed with Employee L signature. 5. During a home visit with patient number 6 on 04/12/16 at 10:30 AM, Employee I, a home health aide, stated he / she reported to Employee Q, the Administrator with the Noblesville office. The employee stated he / she had orientation in Middletown but had paperwork orientation in Noblesville. According to Employee I and patient number 6, they don't know who the Administrator, Alternate Administrator, Assistant Director of Clinical Services, or Employee M were. Both stated they had just recently met the Director of Clinical Services a few weeks ago. The patient stated he / she received services from both the home health agency and personal service agency. 6. During a home visit with patient number 7 on 04/12/16 at 12:20 PM, the patient's spouse stated he / she contacted the "Martinsville" office when there was a need. The patient stated he / she only received services from the home health		will continue to make homevisits 10% quarterly). During the homevisit the committee member will update, review and ensure that anorganizational chart is explained and in their yellow folder in their home andtheir understanding of the delineation of the agencies and the lines ofauthority/supervision with a signed form for the client chart. The committee member, when educating, willget signed documents of the training provided. Each document signed will be placed in the staff personnel file andclient chart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved. The QualityAssurance Committee, Compliance Officer, HR Director, Administrator andDirector of Nursing will be responsible for monitoring these corrective actionsto ensure that this deficiency is corrected and will not recur.	

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	agency. 7. During a home visit to patient number 8 with Employee K on 04/12/16 at 3:40 PM, the patient's parent stated he / she contacted Employee L at the Martinsville office when he / she needed anything. a. The patient's agency folder was reviewed. A business card with Employee R's name and discipline was observed in the folder with an address of 1920 Old State Rd 44, Martinsville, IN [address on the card was that of a branch to the sister agency / name of personal service agency]. Employee K, a Registered Nurse for patient number 7, stated Employee R had recently been transferred to the Noblesville office, which was also a branch of the sister agency. b. Employee K stated he / she did not go to the Middletown office for anything, that he / she did everything from the Martinsville office. The employee stated the last time he / she was in the Middletown office, was upon hire and he / she had been with the company for a few years. 8. The Quality Assessment Performance Improvement was reviewed on 04/15/16 at 1:15 PM. The notes reviewed			

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	indicated the last two meetings dated 09/23/15 and 12/2015, combined both Individual Support Home Health Agency and [name of personal service agency] discussion of hired employees in the Middletown, Martinsville, and Noblesville offices. The notes also included a notation about how to track the attendant care and homemakers. 9. Review of the personnel files on 04/15/16 at 1:30 PM, Employee L job title / job description indicated he / she was a Program Coodinator for the personal service agency. Employee M job title / job description indicated he / she was the Alternate Administrator. 10. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated she would meet with staff operating from the drop site / personal service agency branch during annual meetings and that staff were asked to come to Middletown for those meetings. The Director of Clinical services also stated other forms of communication with the staff was through text messaging or phone calls. The Director of Clinical Services stated she investigated the nursing complaints and the Administrator or local coordinators would investigate the home health aide complaints. The Director of			

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	Clinical Services stated if it was a staffing issue such as scheduling, the local coordinators were closer to the source. 11. The Administrator and Employee M was interviewed on 04/18/16 at 2:25 PM. Employee M stated he /she was a home health aide and did not hold an administrative title. The Administrator stated Employee M was an administrative assistant and helped out in the office occasionally. The Administrator stated the vehicles in Martinsville were for the employees to drive. 12. Employee L and Q was contacted and messages left for return call on 04/18/16 between 10:30 AM and 10:38 AM. Neither employees returned the calls by exit conference on 04/18/16 at 3:10 PM.			
G 0124 Bldg. 00	484.14 ORGANIZATION, SERVICES & ADMINISTRATION Administrative and supervisory functions are not delegated to another agency or organization. Based on record review and interview, the Administrator failed to ensure supervisory functions were not delegated to another agency or organization.	G 0124	G124- Organization, Services and Administration Allstaff will be in-serviced on Tag G124 (Organization, Services andAdministration) by 6/10/16. The 5/27/16newsletter included	06/10/2016

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	Findings include: 1. During the entrance conference on 04/06/16 at 10:30 AM, the Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services, indicated there was a drop site in Martinsville and Noblesville. The drop sites were located within the personal service agency that was also owned by the Administrator. 2. On 04/06/16 at 11:15 AM, an employee list was provided by the Administrator. The employee list indicated Employee L was an ADM [administrator] and Employee M was AADM [assistant administrator]. The Administrator had stated Employee L managed the personal service branch in Martinsville. 3. On 04/11/16 at 10:30 AM, the personal service branch was visited. The doors were locked and a sign on the back door provided Employee L and the Administrator's name and phone number as well as the Middletown office phone number. There were 7 company vehicles in the parking lot. Six (6) of the 7 vehicles had Individual Support Home Health Agency advertisement on the vehicles.		pictures, names and titles to ensure the delineation ofagencies. The 5/27/16 newsletterincluded clear lines of authority/supervision along with the organizationchart. Staff are assigned the closestdrop site based on location for their convenience for paperwork needs andsupplies. Staff are assigned a “Point ofContact” person based on their location for scheduling and otherneeds/information. Phones areestablished at the drop sites for the convenience of the staff andclients. Phone calls received at dropsites are transferred to the Middletown Office in relationship to theneed. The drop site phones also ringsdirectly to the Middletown Office as needed. The drop sites are not staffed by ISHHA staff and signs are left (forthe convenience of staff) to make contact with the “Point of Contact” person orthe Administrator when no staff is available to assist them. Phone numbers of “Point of Contact” andadditional numbers or cell numbers are for the convenience of our staff toensure they can get their needs met without making an unnecessary trip andcannot access the drop site or making a trip to the Middletown Office. ISHHA provides transportation to staff whenstaff are in need (car problems, financial problems or simply helping) it’s only logical to advertise on the cars,as they	

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	4. During a home visit with patient number 5 on 04/12/16 at 9:00 AM, Employee P, a home health aide, stated he / she worked from the "Martinsville office" and he / she provided both attendant care and home health aide services from both [name of personal service agency]and Individual Support Home Health Agency. Employee P stated Employee L was the supervisor for both companies. Patient number 5 stated when he / she needed to contact the office, he / she would start with Employee L and would go down the list of phone numbers until he / she reached someone. The patient also stated he / she would text Employee L as well. The patient stated he / she received services from both the home health agency and personal service agency. a. Review of the patient's agency folder during the home visit, a form titled "Emergency Back Up Plans" listed Middletown / Noblesville with the phone numbers of the Administrator, Employee M, and the office number. The next paragraph listed Martinsville area and the name of Employee L and Employee U with their phone numbers, then provided an on-call line. b. Another form in the patient's agency folder titled "Welcome to ISHHA		move about and parking them at drop sites so they are safe and keys arelocked at the drop site for insurance purposes and safety. The cars are another assurance for ourclients to be served when their regular staff call off. Paperwork training, correction andcompletion for staff at drop sites is for staff convenience. ISHHA provides a “yellow” folder in clienthomes for distinct delineation. An allCase Manager training session has been scheduled for Friday, June 17, 2016 toreview and train on the clear lines of authority/supervision for a distinctdelineation of agencies. On 4/20/16training was provided to the Human Resources Director on employee titles forthe employees. The HR Director wasinstructed not to title staff as Administration and abbreviate as ADM and theAdministrations Assistants as AADM. On4/20/16 policy was updated with title abbreviations per position and theemployee list was corrected. On 5/27/16The HR Director reviewed personnel files and completed for accurate jobdescriptions. Staff that were theAlternate Administrator or other positions (job description remains in thepersonnel file) also have a Home Health Aide Job Description and appropriatejob description for their position. On5/27/16 the data base for the employee list was corrected with the employeetitles to match the	

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	... If you have any questions or concerns please call us. Martinsville Workstation," Name of Employee L, Program Director, office number and cell number, on call line for after hours, home office number, Administrator name and cell number, Employee M as the VP [vice president] with cell number, followed by a title of "Supervisor" and Employee L signature. c. There was another form in the patient's agency folder that indicated Individual Support Services with the Administrator and Employee M listed with phone numbers to contact first followed by "Martinsville area" with the name of Employee L and Employee U with phone numbers, followed by on call number. The form was signed with Employee L signature. 5. During a home visit with patient number 6 on 04/12/16 at 10:30 AM, Employee I, a home health aide, stated he / she reported to Employee Q, the Administrator with the Noblesville office. The employee stated he / she had orientation in Middletown but had paperwork orientation in Noblesville. According to Employee I and patient number 6, they don't know who the Administrator, Alternate Administrator, Assistant Director of Clinical Services, or		policy. On 5/25/16 andongoing an In Home Quality Assurance Committee was developed to make homevisits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill review, update and ensure that that the yellow client folder has cleardelineation of the agencies and an organizational chart is explained and intheir yellow folder in their home and their understanding of the delineation ofthe agencies and the lines of authority with a signed form for the clientchart. The committee member, wheneducating, will get signed documents of the training provided. Each document signed will be placed in thestaff personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesdayof each month to discuss findings and the outcomes and to ensure that eachfinding was addressed and resolved. The Quality Assurance Committee, Compliance Officer, HR Director, Administratorand Director of Nursing will be responsible for monitoring these correctiveactions to ensure that this deficiency is corrected and will not recur.	

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	Employee M were. Both stated they had just recently met the Director of Clinical Services a few weeks ago. The patient stated he / she received services from both the home health agency and personal service agency. 6. During a home visit with patient number 7 on 04/12/16 at 12:20 PM, the patient's spouse stated he / she contacted the "Martinsville" office when there was a need. The patient stated he / she only received services from the home health agency. 7. During a home visit with patient number 8 on 04/12/16 at 3:40 PM, the patient's parent stated he / she contacts Employee L at the Martinsville office when he / she needed anything. a. The patient's agency folder was reviewed. A business card with Employee R's name and discipline was observed in the folder with an address of 1920 Old State Rd 44, Martinsville, IN [address on the card was that of a branch to the sister agency Individual Support Services). Employee K, a Registered Nurse for patient number 7, stated Employee R had recently been transferred to the Noblesville office, which was also a branch of the sister agency.			

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	b. During the home visit, Employee K stated he / she did not go to the Middletown office for anything, that he / she did everything from the Martinsville office. The employee stated the last time he / she was in the Middletown office, was upon hire and he / she had been with the company for a few years. 8. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated she would meet with staff operating from the personal service agency branch during annual meetings and that staff were asked to come to Middletown for annual meetings. The Director of Clinical Services also stated other forms of communication with the staff was through text messaging or phone calls. The Director of Clinical Services stated she investigated the nursing complaints and the Administrator or local coordinators would investigate the home health aide complaints. The Director of Clinical Services stated if it was a staffing issue such as scheduling, the local coordinators were closer to the source. 9. The Administrator and Employee M was interviewed on 04/18/16 at 2:25 PM. Employee M stated he /she was a home			

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	health aide and did not hold an administrative title. The Administrator stated Employee M was an administrative assistant and helped out in the office occasionally. The Administrator stated the vehicles in Martinsville were for the employees to drive. 10. Employee L and Q was contacted and messages left for return call on 04/18/16 between 10:30 AM and 10:38 AM. Neither employees returned the calls by exit conference on 04/18/16 at 3:10 PM.			
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 that 60 day summaries were individualized and had a clearly written synopsis of the patient's course of treatment, including all services provided for 9 of 9 records reviewed of patients recertified in a sample of 11. (#1, 2, 4, 5, 7, 8, 9, 10, and 11) Findings include: 1. The clinical record for patient number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician	G 0145	G145– Coordination of Patient Services Allstaff will be in-serviced on Tag G145 (Organization, Services andAdministration) by 6/10/16. Individualtraining sessions with Case Managers to train on 60 day summaries to ensurethey are individualized and have clearly written synopsis of the patient'scourse of treatment, including all services provided, and the removal of allservices indicated on "other" (HMK, ATTC, PAC, etc.) started on 5/24/16 andongoing with the Director of Nursing, Alternate Director of Nursing/ComplianceOfficer. An	06/10/2016

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	for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. Review of a form titled Clinical Summary / Case Conference dated 03/22/16, the form indicated the services provided were skilled nursing and attendant care services with [name of outside agency]. The form indicated to continue goals / care, response of current treatment / medications, summary of patients conditions / changes in patient condition was left blank, indication to problems / needs / goals were left blank, caregiver support system / home environment indicated the patient "lives		all Case Manager trainingsession has been scheduled for Friday, June 17, 2016 to train on 60 daysummaries to ensure they are individualized and have clearly written synopsisof the patient's course of treatment, including all services provided and theremoval of all services indicated on "other" (HMK, ATTC, PAC, etc.). Updates to the Case Manager training manualon 60 day summaries to ensure the clinical summaries are individualized andhave clearly written synopsis of the patient's course of treatment, includingall services provided, and the removal of all services indicated on "other"(HMK, ATTC, PAC, etc.) will be completed by 6/2/16. Effective 4/17/16 10% of all clinical recordswill be audited quarterly for evidence that 60 day summaries are individualizedand have clearly written synopsis of the patient's course of treatment,including all services provided and the removal of all services indicated on"other" (HMK, ATTC, PAC, etc.). The ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur.	

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	with" but was left blank, and no anticipated discharge plans. The new certification order indicated skilled nursing 1 - 13 hour visit a day for 7 days, 1 to 3 hour visits for 5 days a week for 9 weeks and attendant care services with [name of agency] for the certification period of 03/23/16 to 05/21/16. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment. 2. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to evaluate cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / falls prevention, medication teaching, evaluate med effects / compliance, administer suppository per MD orders, teach bowel regimen, and provide pericare. The patient was also receiving home health aide services (3) 2 hour visits per day 7 days a week to assist with bathing and hygiene, light housekeeping, transfer or positioning, encourage fluids, incontinent care of			

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	urine, check pressure areas, skin care, and range of motion to all extremities. Goals indicated the patient would maintain good hygiene and comfort, safety would be maintained, demonstrates compliance with medications, Stabilization of cardiovascular pulmonary condition, demonstrates competence in following medical regimen, and verbalized pain controlled at acceptable level. a. Review of a form titled Clinical Summary / Case Conference dated 08/18/15, the form indicated the services provided were home health aide and attendant care services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective, summary of patients conditions / changes in patient condition was left blank, no new problems had been identified, lived alone, no indication for anticipated discharge plan, and recertification order indicated skilled nursing 1 to 2 hour visit a day for 2 days a week for 9 weeks, home health aide services (3) 2 hour visits a day 7 days a week for 9 weeks, and attendant care services 58 - 62 hours a month through Medicaid Waiver, for the certification period 08/18/15 to 10/16/15. b. On 08/21/15, the patient was			

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	sent a letter for discharge by the agency due to the patient's frequent refusal of staff. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment, including all services provided, progress toward goals, and the anticipated plan for discharge. The summary included attendant care order / information which was not a part of a service that was provided by the home health agency. 3. The clinical record for patient number 5, SOC 03/01/10, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16 with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing and hygiene, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, and light housekeeping. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. Review of the home health aide visit notes during the certification period indicated the home health aides was not breaking up their visits as ordered and was staying with the patient			

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	from 9:00 AM to 3:00 PM, then immediately providing attendant care services through a sister company from 3:00 PM to 4:45 PM. b. Review of the comprehensive recertification assessment dated 03/23/16, indicated the patient's oxygen saturation was 94% percent, patient was incontinent of bladder only, and no assessment of the nutritional status. c. A form titled Clinical Summary / Case Conference dated 03/23/16, the form indicated the services being provided were home health aide services and attendant care services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective, summary of patients conditions / changes in patient condition indicated the patient's oxygen saturations was 93%, nutrition and hydration was adequate, bowel and bladder incontinence, problems / needs / concerns indicated no new problems had been identified, caregiver support / system / home environment indicated the patient lived alone, no planned discharge at the present time, and no change in the plan of treatment / plan of care goals. The recertification order indicated home health aide services (2) 2 hour and (2) 1			

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	hour visits a day 7 days a week for 9 weeks and attendant care services 24 - 28 hours a month for the certification period from 03/27/16 to 05/25/16. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment. The summary included attendant care order / information which was not a part of a service that was provided by the home health agency. 4. The clinical record for patient number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. During a home visit on 04/12/16 at 12:20 PM, a skilled nurse was observed to clean the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD			

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	pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. The patient was observed to have a wound to the right outer leg between the knee and ankle. b. Review of a form titled Clinical Summary / Case Conference dated 01/06/16 and 03/04/16, the form indicated the services provided were skilled nursing services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective, summary of patients conditions / changes in patient condition was reflected from the recertification reassessments which indicated the patient was alert and oriented, vital signs within normal limits, breath sounds clear, skin warm / dry with good turgor, abdomen soft with bowel sounds x 4 quads, nutrition and hydration adequate, lower extremity cellulitis continues with skilled nursing and daily dressing changes, no new problems had been identified, lived with a disabled wife, no planned discharge, and no change in plans of treatment / plan of care goals. The new certification indicated to continue skilled nursing 1 hour a day 7 days a week. The summary failed to be individualized and include a clearly written synopsis of the patient's			

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	course of treatment with adequate plan of care goals for the correct certification period. 5. The clinical record for patient number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. The patient also had respite nursing 1 - 30 hours for 12 months. a. Review of the skilled nursing visit notes, the skilled nurse provided 1 hour on 2/22; 3 consecutive hours on 03/08, 03/09, 03/16 (PM), 03/30 (PM); 4 consecutive hours on 03/10, 03/23, 03/30 (AM); 5 consecutive hours on 2/25, 03/03, 03/04, 03/28; 9 consecutive hours on 2/29, 03/22; 6 consecutive hours on 03/17 (PM); 7 consecutive hours on 2/23, 2/24, 03/02; 8 consecutive hours on 2/15, 2/18, 2/19, 2/25, 03/01, 02/21, 03/31, 04/01; 10 consecutive hours on 02/29; and 12 consecutive hours on 04/08/16. During week 6 (03/20 to 03/26/16), the skilled nurse only provided services for 3 days. b. Review of a form titled Clinical Summary / Case Conference dated 10/14/15 and 12/11/15, indicated			

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	the services provided were skilled nursing services and respite nursing, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition was reflected from the recertification reassessments which indicated indicated the patient was alert and oriented, vital signs within normal limits, breath sounds clear, skin warm / dry with good turgor, gastric tube intact and patent, abdomen soft with bowel sounds x4 quads, no signs and symptoms of distress or pain, no new problems had been identified, lived with parents, no planned discharge, and no change in plans of treatment / plan of care goals. The summaries failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care goals for the correct certification period. c. Review of a form titled Clinical Summary / Case Conference dated 02/13/16 and 04/13/16, indicated the services provided were skilled nursing services and respite nursing, continue goals / care, appeared complementary with no duplication, response to current treatment / medications were effective. The			

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	summary of patients conditions / changes in patient condition indicated the patient was alert and oriented, vital signs within normal limits, breath sounds clear, skin warm / dry with good turgor, gastric tube intact and patent, abdomen soft with bowel sounds x4 quads, and both forms also indicated the patient suffered a broken right femur shaft on 02/04/16 and underwent internal fixation device open approach on 02/05/16. Surgical incision was clean, dry, no drainage or odor, edges were approximated without signs and symptoms of infections, no new problems were identified, lived with parents, no planned discharge, and no change in plans of treatment / plan of care goals. The new certification indicated to continue skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days and respite nursing 1 - 30 hours for 12 months. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care goals for the correct certification period. The 04/13/16 summary failed to include the patient's return to surgery for removal of appliances on 02/16/16. 6. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the			

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	certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week and respite nursing up to 40 hours a month for 12 months to evaluate cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate and teach for signs and symptoms of infections and standard precautions, teach diet, teach home safety / fall prevention, and oxygen at 2 liters per trach at bedtime. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. Review of a form titled Clinical Summary / Case Conference dated 11/18/15 and two undated clinical summaries for the certification periods 11/22/15 to 01/20/16 and 01/21/16 to 03/20/16, indicated the services provided were skilled nursing services and respite nursing, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition indicated the patent was very stable and seems quite happy surrounded by her family. Problems / Needs / Concerns indicated in all 3 summaries that the patient seemed to have been suffering from a mild stomach flu, no			

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	new problems were identified, lived with parent, no planned discharge, and no change in plans of treatment / plan of care goals. b. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H stated the patient attended an adult day care 3 days a week and would sometimes go with a parent to work. Employee H stated he / she provides services to the patient on Tuesday from 3:45 to 9:00 PM and 10:00 AM to 9:00 PM on Thursday, Friday, and Saturday. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care goals for the correct certification period. 7. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care, foot care, ambulation assist / mobility in			

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	wheelchair, skin care, check pressure ulcers, and make bed / straighten patient areas. a. Review of a form titled Clinical Summary / Case Conference dated 09/23/15, indicated the services provided were home health aide services, attendant care services and homemaker services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition was left blank, Problems / Needs / Concerns was left blank, caregiver support system was left blank, no planned discharge, and no indication of changes in plans of treatment / plan of care goals. The new certification indicated home health aide services to continue 1 hour a day 7 days a week and continue 30 hours of attendant care services and 21 - 23 hours of homemaker services for the certification period from 09/23/15 to 11/21/15. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment. The summary included attendant care and homemaker orders / information which was not a part of the services that was provided by the home health agency.			

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	8. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health aide services 3 hours per day 5 days a week to assist with bathing and hygiene, ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and light housekeeping, and range of motion exercises (all extremities). Goals indicated the patient would maintain good hygiene, comfort, and safety will be maintained. a. Review of a form titled Clinical Summary / Case Conference dated 10/18/15, indicated the services provided were home health aide services and PAC services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition was left blank, no new problems identified, caregiver support system indicated the patient lived with parents, no planned discharge, and "NA" (not applicable) to changes in plans of treatment / plan of care goals. The new certification indicated home health			

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	aide services to continue (1) 3 hour / day for 5 days a week and PAC 15 hours per week through medicaid waiver for the certification period from 10/18/15 to 12/16/15. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment. The summary included PAC orders / information which was not a part of the services that was provided by the home health agency. 9. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 10. A policy titled Medical Supervision dated 07/10/15, indicated " ... Written reports on the patient's condition are provided to the physician at least every sixth [sic] [60] days. 11. A policy titled Clinical Summary to Physician dated 07/10/15, indicated " ... The summary note will include: a. Clinical summary of the care, treatment and services provided during the previous sixty [60] day episode of care. b. Patient response to the services and progress toward established goals. Summary of current needs and involvement of other			

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	community / family caregivers or services .... "			
G 0156 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Based on record review and interview, the agency failed to ensure the skilled nurse and the home health aide followed the plan of care for 11 of 11 records reviewed in a sample of 11 (See G158); failed to ensure that the plan of care was supported by the comprehensive assessment for 5 of 11 records reviewed, failed to update and revise the plan of care to include specific instructions for a bowel program for 1 of 1 record reviewed of patients with bowel program, failed to include the type, frequency and duration of services to be provided, ventilator settings, size of trach, frequency and instruction of trach care to be provided in 3 of 3 records reviewed of patients with trach's, failed to include directions for application of braces in 1 of 1 record reviewed of patients with braces, failed to include the type of feeding, rate, and frequency of gastrointestinal tube feedings in 2 of 2 records reviewed of patients with tube feedings, failed to include the size of foley catheters for in out catheterizations in 2 of 2 records reviewed with patients receiving in and	G 0156	G156– Acceptance of Patients, POC, Med Super Allstaff will be in-serviced on Tag G156 (Acceptance of Patients, POC, Med Super)by 6/10/16. Individual trainingsessions with Case Managers to train on POC, comprehensive assessment, type,frequency and duration, ventilator, trach, tube feedings, assistive devises,catheters, suctioning, wounds, size, measurements, instructions specific forservices, charting, documentation and notification of physician for alltreatments and discharges started on 5/24/16 and ongoing with the Director ofNursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC, comprehensive assessment,type, frequency and duration, ventilator, trach, tube feedings, assistivedevises, catheters, suctioning, wounds, size, measurements, instructions for specificservices, charting, documentation and notification of physician for alltreatments and discharges. Updates to the Case Manager training manual on	06/10/2016

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	out catheterizations, failed to include the size / frequency of changes for suprapubic catheter in 1 of 1 record reviewed for patients with suprapubic catheters, failed to include instructions for foley catheter flushes in 1 of 1 record reviewed of patients with foley catheter irrigations, failed to include instructions for wound treatments in 1 of 1 records reviewed of patients with wound treatments, failed to include the location for the application of powder and ointments in 1 of 1 records reviewed of patients receiving medicated powder and ointments, and failed to include instruction for bathing and meal preps in 1 of 11 records reviewed of patients receiving assistance with bathing and meal prep (See G 159), failed to notify the primary care physician in relation to a patient's discharge for 1 of 5 records reviewed of patients discharged by the agency, failed to notify the physician of missed visits in 1 of 6 active / current records reviewed, failed to notify the primary care physician of a patient's elevated blood pressures for 1 of 6 records reviewed of active / current patients, and failed to notify the primary care physician for a patient with no urinary output for 1 of 2 patients reviewed with in and out catheterizations in a sample of 11 (See G164), and failed to ensure that all treatments provided had		POC,comprehensive assessment, type, frequency and duration, ventilator, trach, tubefeedings, assistive devises, catheters, suctioning, wounds, size, measurements,instructions for specific services, charting, documentation and notification ofphysician for all treatments and discharges will be completed by 6/2/16. All Home Health Aides will be in-serviced onfollowing the POC by 6/10/16. On 5/25/16and ongoing an In Home Quality Assurance Committee was developed to make homevisits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill ensure that the POC is being followed by review of POC, patient interviewand documentation/nursing notes. Thecommittee member, when educating, will get signed documents of the trainingprovided. Each document signed will beplaced in the staff personnel file and client chart. The committee members will provide a writtenreport of the visit to the Administrator and Director of Nursing within 24hours. The committee will meet the firstWednesday of each month to discuss findings and the outcomes and to ensure thateach finding was addressed and resolved. Effective 4/17/16 and	

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	a physician's order for 2 of 2 records reviewed of patients with wounds and 1 of 1 records reviewed of patients receiving a bowel program in a sample of 11 (See G 165). 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 and Immediate Jeopardy. The immediate Jeopardy was identified and began on 04/13/16. The Administrator was notified of the Immediate Jeopardy on 04/13/16 at 4:10 PM. The facility developed an acceptable plan for removal of the IJ on 4/15/16. Based on interviews and record reviews, the Immediate Jeopardy was removed on 04/18/16 at 3:00 PM. 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.		ongoing 10% of all clinical records will beaudited quarterly for evidence that POC, comprehensive assessment, type,frequency and duration, ventilator, trach, tube feedings, assistive devises,catheters, suctioning, wounds, size, measurements, instructions for services, charting,documentation and notification of physician for all treatments and dischargesare evident, along with the Skilled Nurse (notes) and Home Health Aide(documentation sheets) following the POC. Staff failing to follow POC will receiveadditional training with corrective action up to termination. The QualityAssurance Committee, Compliance Officer, Administrator and Director of Nursingwill be responsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	
G 0158	484.18 ACCEPTANCE OF PATIENTS, POC, MED			

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Bldg. 00	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 the skilled nurse and the home health aide followed the plan of care for 11 of 11 records reviewed in a sample of 11. (# 1 to 11) Findings include: 1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and	G 0158	G158- Acceptance of Patients, POC, Med Super Allstaff will be in-serviced on Tag G158 (Acceptance of Patients, POC, Med Super)by 6/10/16. On 4/13/16 a full all staff (nurses, administration, HHA's, andancillary staff, etc.) mandatory in-service was sent via e-mail (for all staffwith email addresses), U.S. Post Office mailing for those without emails, alongwith a phone call or text explaining the urgency and severity of the mandatedtraining on 4/13/16 with a mandatoryresponse dead line of 4/15/16. Traininginclude Patient Rights (including patient and/or family responsibilities, CarePlans and Clinical Documentation, Attendance and Reporting (including specificcall off procedures for all staff) along with Progressive Disciplinary Actionfor failure to comply. All staff mustrespond to the e-mail (with signed receipt indicator) or personally sign,acknowledging they received, state they have read and understand the ISHHApolicy and procedures regarding the Mandated Training. All staff completed the training prior tobeing put back on the schedule. Suspension letters were mailed certified/receipt on 4/15/16 to all staffthat had not	06/10/2016

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	hypertension. a. The clinical record of patient number 1 was reviewed on 04/06/16 at 12:40 PM and indicated the following: 1. The OASIS discharge assessment dated 03/29/16, the summary indicated the patient was found dead at his / her home at 08:00 AM. The patient was in his wheelchair at the kitchen table. 2. Review of the nursing visit notes on 04/06/16 at 12:40 PM, the clinical record failed to contain visit notes 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16. b. An agency investigation note dated 03/29/16 at 9:57 AM, was reviewed and indicated the Director of Clinical Services had taken a phone call from Employee F, LPN (Licensed Practical Nurse) at 9:30 AM. Employee F reported that he / she had developed a fever and did not feel that he / she should come to work. Employee F asked the patient if he / she would like for Employee F to notify the office and the patient replied that he / she did not want any of the nurses from the office because of previous issues. Employee F indicated he / she had spoken to the patient around midnight on the phone and messaged		completed the mandatory training. Any staff on vacation, sick or didnot respond to the Mandated Training weresuspended and not allowed to return to work until the Mandated Training wascompleted. Effective 4/13/16 all staff will receive duringorientation and annually every April specific training and understanding ofPatient Rights (including patient and/or family responsibilities, Care Plansand Clinical Documentation, Attendance and Reporting (including specific calloff procedures for all staff) along with Progressive Disciplinary Action forfailure to comply, with a signed training sheet. Bi-weekly newsletters are submitted viaQuickBooks for all staff with an email address. A cell phone was purchased to send a text to all staff, as a reminder, to review their emailwhen newsletters and agency information is released via email. The cell phone will also provide staff, thatdon't have an email, a copy of the newsletter and all agency information. Those staff that can't receive through emailor cell phone will be mailed via US Post Office all newsletters and agencyinformation. Staff that pick upnewsletters and agency information bi-weekly will do so at the office or atdrop sites. Emails will request anacknowledging receipt. Text messageswill	

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	with him / her on facebook around 3:00 AM. Employee F indicated he / she had called the patient to let him / her know that he / she was coming to assist him / her around 7:00 AM but the employee got no answer. When Employee F arrived at the patient's home around 8:00 AM, he / she did not get an answer at the door and someone had to let him / her in and that was when Employee F found the patient sitting in his wheelchair at the kitchen table. Employee F called 911. Employee F indicated he / she was trying to follow the client's wishes. The Director of Clinical Services informed Employee F of the immediate suspension pending the investigation. c. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was interviewed on 04/06/16 at 1:40 PM. The Director of Clinical Services stated Employee F had failed to return phone calls and text messages, so a letter of termination had gone out to him / her in the mail. At 3:40 PM, the Administrator, Director of Clinical Services, and Assistant Director of Clinical Services were interviewed again. To prevent this occurrence from happening again, measures that had been put into place included reiterating to patients to contact the office when staff fails to show up and there was a live		require a text back of receipt. USMail will be sent receipt return. Pickup will require a signed receipt. A bi-weeklystaff list is generated during payroll with a column added to indicate receiptof agency information. Newsletter andagency information will also be visually available to all staff at the officeand each drop site. On 4/18/16 allnurses were notified, in their method of communication, to submit nurse visitnotes every Monday. Nurse visit notesare entered as received into the tracker and tracked back to the schedule. A comparison report is generated on each Wednesday to determine if there aremissing nurse visit notes. The staff,that have missing nursing notes, will be contacted on each Wednesday , in theirmethod of communication and will have until each Friday to submit. Staff failing to submit timely will besuspended until nursing notes are received. Staff will be terminated after three untimely weeks. ISHHA will assist staff in receiving nursingnotes by means of gas cards, gift cards, kind words, picking them up to ensureISHHA stays in compliance and this deficiency will not recur. Effective 4/13/16 policy was updated to addthat any staff being suspended will be notified in their method of communicationand also a letter will be mailed via US Post Office	

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	person to take calls 24/7. Another measure included retraining the staff to notify the office for call offs. The Director of Clinical Services stated there was not a sign-in sheet of the staff training. The Director of Nursing stated Employee F knew he / she needed to call in, for he / she had called off a few weeks ago. d. Employee F was interviewed on 04/06/16 at 4:30 PM. The employee stated he / she did not show up at the patient's home as scheduled and did not notify the office of his / her absence per patient wishes. Employee F stated he / she did notify the office and spoke with the Director of Clinical Services in regards to the absence and death. Employee F did confirmed the typed conversation with the Director of Clinical Services with the exception that he / she observed the patient's facebook as "active" at 3:00 AM, but did not speak with the patient at this time. The Employee also stated he / she was not placed on suspension, but was allowed time off to grieve due to the close relationship he / she had with the patient. The employee stated he / she had not received any text messages or phone calls from the Director of Clinical Services. Employee F stated he / she was contacted today by Employee R, a Registered Nurse		certified/receipt. After the investigation the staff will be notified in their method ofcommunication and also a letter will be mailed via US Post Office certified/receiptof the outcome (termination or return to work). All signed receipts will be put in staff personnel files. Effective 4/29/16 and ongoing the call offprocedure with repercussions will be in each newsletter. Individual training sessions with CaseManagers to train on POC, comprehensive assessment, type, frequency andduration, ventilator, trach, tube feedings, assistive devises, catheters, suctioning,wounds, size, measurements, instructions for specific services, charting, documentationand notification of physician for all treatments and discharges started on 5/24/16and ongoing with the Director of Nursing, Alternate Director ofNursing/Compliance Officer. An all CaseManager training session has been scheduled for Friday, June 17, 2016 to trainon POC, comprehensive assessment, type, frequency and duration, ventilator,trach, tube feedings, assistive devises, catheters, suctioning wounds, size,measurements, instructions for specific services,documentation and notification of physician for all treatments and discharges, Updatesto the Case Manager training manual on POC, comprehensive assessment,	

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	/ Case Manager, but also stated he / she had another death in the family and had been out of town where phone reception was poor. The employee stated that a scheduler had reached out to him / her on 03/31/16, about taking another case and was planning to send him / her the plan of care. e. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. The Administrator stated Employee F did notify the office the previous evening. The Administrator stated the employee was still fired. The Administrator provided an employee list of names that the Director of Clinical Services produced, of staff who had been in-serviced on call offs. At 10:30 AM, the Administrator provided Employee F's missing visit notes of patient number 1 and also provided a business news letter. The Administrator stated the news letter went out with payroll, which was within the same week of the patient's death. The news letter stressed the importance of calling the office for call offs and failure to follow the agency policy would result in termination. The 03/27 and 03/28/16 skilled nursing visit notes were not provided.		type,frequency and duration, ventilator, trach, tube feedings, assistive devises,catheters, suctioning, wounds, size, measurements, instructions for specificservices, charting, documentation and notification of physician for alltreatments and discharges will be completed by 6/2/16. All Home Health Aides will be in-serviced onfollowing the POC, visit notes, documentation, tardiness and unplanned absencesby 6/10/16. On 5/28/16 The "Welcome Letter" was updated to include astatement "Will you accept a Float Staff to start your servicesand fill in when your permanent staff calls off." The "Welcome Letter" willrequire client/family signature and will be filed in client chart and a copy inyellow folder. On5/25/16 and ongoing an In Home Quality Assurance Committee was developed tomake home visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill review, update and ensure that the "Welcome Letter" is explained,understood and signed (a copy will be filed in client chart and a copy inyellow folder), POC is followed, follow-up on each monthly inservice, call offprocess, organization chart, updates on client and staff paperwork, patientrights, etc. The committee member, wheneducating, will get signed documents of the training	

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	f. On 04/08/16 at 3:00 PM, Employee F was interviewed in person. Employee F provided a text message between him / herself and the patient on 03/28/16, indicating that Employee F continued to be ill and the patient declined to have a replacement nurse. Employee F stated the patient was able to take him / herself off the vent but felt better if someone was there due to random episodes of desaturation when removed and at times, would become unresponsive for a few minutes then return to normal. Both agreed for Employee F to follow up with the patient in the morning of 03/29/16. Employee F provided a text message between him / herself and the Administrator dated 04/07/16 at 5:15 PM. The message indicated "you are suspended pending investigation. Client died and you did not cover the shift or call the office as policy states." Employee F provided a text message dated 03/31/16, from an unknown scheduler in regards to taking on a new case and another text message dated 04/02/16, indicating the plan of care was going to be sent out. Employee F was questioning why he / she was asked to take on a new client if he / she was suspended. Employee F provided a text dated 04/04/16, where he / she had made contact with the office requesting information about the new case.		provided. Each document signed will be placed in thestaff personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesdayof each month to discuss findings and the outcomes and to ensure that eachfinding was addressed and resolved. On5/27/16 policy was updated to include a letter will be sent to the patient uponresolution (will include the actions that were attempted and the outcomes.) A copy of the letter will accompany the ISHHAinvestigation. Effective 4/17/16 andongoing 10% of all clinical records will be audited quarterly for evidence thatPOC, comprehensive assessment, type, frequency and duration, ventilator, trach,tube feedings, assistive devises, catheters, suctioning, wounds, size,measurements, specific instructions for services, charting, documentation andnotification of physician for all treatments and discharges are evident,updated “Welcome Letter”, along with the Skilled Nurse (notes) and Home HealthAide (documentation) following the POC. Stafffailing to follow POC will receive additional training with corrective actionup to termination. The Quality AssuranceCommittee, Compliance Office, Administrator and Director of Nursing will	

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	Employee F also stated that when he / she met with the Alternate Administrator on 04/07/16, he had provided him / her with a $20 gift card for meeting with him. Employee F stated the missing 03/27 and 03/28/16 skilled nursing visit notes were not provided to the Alternate Administrator because the visit notes were to be turned in with the next payroll. Employee F stated he / she had thought he / she would have them to turn in with the new case. g. During a home visit with Employee P, home health aide, on 04/12/16 at 9:00 AM, Employee P was interviewed and had stated he / she had never seen a company newsletter, but then the agency did not have his / her correct address. Employee P also stated he / she had not been told or reminded about notifying the office about call offs and the repercussions. h. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 AM, Employee I was interviewed and had stated he / she had never seen a company newsletter, nor had he / she been told or reminded about notifying the office about calls offs and the repercussions. i. During a home visit with		beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

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	Employee J, a LPN, on 04/12/16 at 1:40 PM, Employee J was interviewed and stated he / she had not received a company newsletter, but did receive a text from the office the previous week about calls offs, but was unable to remember the specific details of the text nor the date received. j. During a home visit with Employee K, a Registered Nurse on 04/12/16 at 3:40 PM, Employee K was interviewed and stated that he / she would get a company newsletter in an email sometimes but had not received an email within the past few weeks. Employee K stated he / she did get a text the previous week to contact the Director of Nursing for call offs but unable to provide a specific date. k. During a home visit with Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H was interviewed. Employee H stated that he / she had not received a company newsletter and could not remember the last time he / she had received one. Employee H recalled hearing about call offs a few weeks prior, but don't recall specifics or repercussions. l. The Administrator was interviewed on 04/13/16 at 4:00 PM.			

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	The Administrator was in agreement that the text message to Employee F on 04/07/16 at 5:15 PM, had taken place. The Administrator stated she had did that because she had felt bad for the employee and wanted cooperation to get the visit notes. The Administrator had no explanation of the field staff interviews on 04/12/16 in regards to the newsletter and the lack of knowledge of the call off policy and repercussions. m. The detective involved in the patient's death investigation was interviewed on 04/18/16 at 10:16 AM. The Detective stated the initial findings was asphyxiation due to a mucous plug, but the final coroners report would take anywhere from 2 to 3 weeks. The time of death usually would be upon arrival of the coroner, but was unsure at this time. The projected time of death was anticipated between 6:00 AM to 7:00 AM. The Detective also stated that there was a video that put Employee F's arrival time to the patient's home at 8:35 AM on 03/29/16. The Detective stated Employee M, a home health aide / administrative assistant, came by the police station the previous week and obtained a copy of the report. 2. The clinical record for number 2, SOC 02/11/16, included a plan of care			

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	established by a physician for the certification period of 02/11/16 to 04/10/16, with orders for skilled nursing. The patient's diagnoses included RSV (Respiratory Syncytial Virus), Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance. a. A "Notification of Client Status" dated 02/11/16, indicated the patient had been admitted for respite nursing and "PA" (meaning prior authorization from Medicaid to provide ongoing nursing services on a routine basis). The note also indicated the parents wanted a routine nurse for overnights and no float nurses. b. The initial plan of care (undated) had orders for skilled nursing to evaluate but failed to include a nursing frequency / duration. The agency provided respite nursing visits on 02/24, 02/26, 03/01, and 03/03/16. The plan of care also indicated the patient was to receive 1 liter of oxygen during naps / bedtime. A respite nursing notes dated 03/01/16 and 03/03/16, indicated the patient had received 3 liters of oxygen per the trach tube. The nurse failed to follow the plan of care.			

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	c. The second plan of care dated 03/22/16, had orders for skilled nursing 8 hours per day, 5 days a week for 9 weeks and respite nursing up to 60 hours per month for 12 months. Review of the clinical record, the agency failed to provide skilled nursing visits 8 hours a day, 5 days a week. d. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was interviewed on 04/07/16 at 12:30 PM. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services stated that the initial plan of care was developed upon admission and the agency were to provide respite nursing services. The patient was transferred into the hospital and returned home on 3/22/16. The Administrator and Assistant Director of Clinical Services stated that Medicaid had instructed the agency to develop a new plan of care versus writing orders and updating the current plan of care. The Assistant Director of Clinical Services stated there was a delay in routine nursing services due to the father's lack of ability to provide job information. The Director of Clinical Services stated the PA (Prior Authorization) came on 3/25/16, but the mother did not want floating nurses in the			

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	home and requested that the patient be staffed with a permanent nurse. The Assistant Director of Clinical Services stated the requested visit notes may have been in the patient's home. At 1:00 PM, missed visit notes were provided and the Director of Clinical Services stated she had been interviewing for a permanent nurse and a nurse had been hired and was due to start "today." e. The parent of patient number 2 was interviewed on 04/07/16 at 3:50 PM. The parent had stated that he / she did not recall telling the agency that he / she wanted to hold services or refused services until a permanent nurse was available. The parent stated he / she preferred a permanent nurse but would have taken anyone due to the exhaustion between him / her and their spouse, need for rest during the night due to pregnancy / work, and how the patient needed constant supervision during the night due to getting the trach tubing around his / her neck. The parent indicated the patient had respite nursing a few times prior to his / her hospitalization, but when the patient came out of the hospital, his / her respite nurse was in the hospital his / herself and that a replacement respite nurse had not been provided. 3. The clinical record for number 3, SOC			

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	06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health aide services 14 hours per week, 1 - 2 hours per day, 7 days a week for 9 weeks. The patient diagnoses included, but limited to arthritis, coronary artery bypass graft, coronary artery disease, diabetes, and autonomic instability. a. The clinical record was reviewed on 04/07/16 at 1:54 PM, and failed to evidence home health aide visits from 06/22/15 to 07/14/15, 07/15/15, 07/16/15, and 07/18/16 to 07/27/15. b. The Administrator provided a typed statement on 04/07/16 at 4:00 PM, indicating Employee E, a Registered Nurse / Case Manager, had reported that the patient was complaining about not getting all of his / her hours. The statement indicated the Administrator had spoken to employee L, a Home Health Aide and Manager of a Personal Service Agency owned by the Administrator. The statement indicated Employee L had spoken with the patient and the patient was not satisfied with the staff Employee L was sending, the patient wanted the agency to hire a family member, and was holding the agency off. The statement indicated the			

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	Administrator had left a message on the patient's phone on 7/23, 7/24, 7/27, and 7/28/15. On 7/25/15, the statement indicated the patient had emailed Employee M, also a home health aide and coordinator for both the home health agency and personal services agency, and had asked about hiring the patient's sister [name of sister was included]. The statement indicated Employee M had informed the patient that he / she was unaware of the request and would investigate it. The statement indicated the Administrator and Employee M had talked with the patient and the patient indicated "it didn't matter he / she fired us and was going with an agency that would hire his / her sister in one day." During this time, the Administrator stated new staff must have orientation for approximately 1 week. c. Patient number 3 was interviewed on 04/07/16 at 7:00 PM. The patient had stated that the named sister in the statement, was a patient of the agency's and had been for many years. The patient stated he / she used to work for the agency and took care of the named sister until he / she had their own surgery in 2009. The patient stated that his / her niece currently works for the agency and was taking care of the mentioned sister. The patient stated he / she would never			

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	ask to have his / her niece removed from the sister's care. The patient stated that he / she did not want weekend staff, but wanted to take the weekend hours and apply it to the week day hours. The patient stated he / she had never canceled or refused a visit, but complained to the agency about not having home health aides to his / her home as ordered. The patient stated on one occasion, a home health aide was in an accident on his / her way to the patient's home, but the home health aide was not replaced. The patient stated the agency told him / her would need to find another agency. d. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 PM. The Director of Clinical Services stated she was not aware of the missing home health aide visits. The Director of Clinical Services stated she mostly manages the nursing and the Administrator, Employee L and Employee M managed the home health aides. e. Employee M and the Administrator were interviewed on 4/18/16 at 2:25 PM. Employee M stated he / she was a home health aide and nothing further. The Administrator stated Employee M did helped with coordination as well. Employee M was			

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	not able to recall the event nor conversation with the patient. After the statement was read, Employee M was not able to add any further information and indicated the statement summed up the situation. The Administrator stated the name mentioned in the statement must have been wrong. 4. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis. a. Review of the skilled nursing visit notes, the skilled nurse failed to provide 2 visits during the week of 07/19 to 07/25/15 and during the week of 07/26 to 08/01/15. The skilled nurse failed to provide a 2nd visit during the week of 08/09 to 08/15/15. The skilled nurse failed to follow the plan of care. b. Review of the home health aide visit notes indicated the following: 1. The home health aide provided (4) 2 hour visits on 07/19,			

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	07/20, 07/22, 07/23, 08/04, and 08/30/15. 2. The home health aide provided a 4 plus hour visits on 07/24, 08/10, and 08/17 (6:30 PM to 10:30 PM), 07/27, 07/31, 08/18 (6:00 PM to 10:15 PM), 07/28, 07/30, 08/11, 08/16, 08/20, 08/25, 08/27 (6:00 PM to 10:00 PM), 08/21/15 (6:20 PM - 10:20 PM), and 08/10 and 08/17/15 (6:00 PM to 10:30 PM). 3. The home health aide provided a 6 plus hour visit on 08/30/15 (9:00 AM to 3:15 PM). 4. The home health aide provided (2) 3 hour visits on 09/01 to 09/08/15 (6:00 PM to 9:00 PM / 8:00 PM to 11:00 PM) and a single 3 hour visit on 07/25/15 (8:00 PM to 11:00 PM). 5. The home health aide provided (2) visits on 07/21, 07/25, 07/31, 08/03, 08/10, 08/11, 08/14, 08/17, 08/25, 08/27, 08/29, and 09/01 to 09/08/15. The home health aides failed to follow the plan of care. c. The plan of care indicated the home health aide was to provide assistance with tub / shower, assist bath - chair, pericare, nail care - file only, foot care, ambulation assist / mobility to			

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	commode and with wheelchair, transfer or positioning, encourage fluids, incontinent care of urine, check pressure areas, skin care with lotion, make bed / straighten patient areas, and range of motion to all extremities. 1. Review of the home health aide visits notes dated 07/19 to 07/24/15, 07/27 to 07/29, 08/02, 08/04 to 08/07, 08/10, 08/12, 08/14, 08/16, 08/17, 08/18, 08/19, 08/20, 08/24, 08/27, 08/28, 08/30, 08/31, and 09/01 to 09/08, 2015, failed to evidence that tub / shower, assist bath - chair, pericare, nail care - file only, foot care, ambulation assist / mobility to commode and with wheelchair, transfer or positioning, encourage fluids, incontinent care of urine, check pressure areas, skin care with lotion, make bed / straighten patient areas, and / or range of motion to all extremities had been provided. The home health aide failed to follow the plan of care. 5. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with			

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	feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. a. Review of the home health aide notes dated 02/15, 02/19, 02/20, 02/21, 02/22, 02/26, 02/29, 03/04, 03/05, 03/06, 03/07, 03/11, 03/14, 03/17, 03/18, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, and 03/28/16, the home health aide documented "NN" (Not Needed) for bathing, pericare, nail care, foot care, pm care, ambulation assist / mobility, assist with feeding, incontinent care, checking pressure areas, skin care, medication assistance, and / or making the bed / straighten patient area. The home health aide failed to follow the plan of care. b. Review of the home health aide visit notes dated 02/14/16 to 02/17/16, 02/19/16 to 03/16/16, 03/18/16 to 03/21/16, 03/23 to 03/25/16, 03/17/16, and 04/02/16, the home health aide indicated he / she had provided services to the patient from the hours of 9:00 AM. to 3:00 PM. On 02/18/16 and 03/26/16, the home health aide indicated he / she had provided services from 10:30 AM to 3:30 PM. On 03/17/16, the home health aide indicated he / she had provided			

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	services from 12:00 PM to 4:00 PM. On 03/22/16, the home health aide indicated he / she had provided services from 9:00 AM to 11:50 AM. On 03/28/16, the home health aide indicated he / she provided services from 9:00 AM to 7:25 PM. The home health aide failed to follow the plan of care. c. During a home visit on 04/12/16 at 9:00 AM., the patient's agency binder was reviewed. The binder included a page of a breakdown of home health aide and attendant care hours through the personal services agency owned by the Administrator. The page indicated 9:00 AM to 11:00 AM, 11:30 AM to 12:30 PM, 1:00 PM to 2:00 PM, and 2:15 PM to 4:15 PM, and weekends 9:00 AM to 3:00 PM services were to be home health aide hours through the home health agency. The other times 11:00 AM to 11:30 AM, 12:30 PM to 1:00 PM, and 2:00 PM to 2:15 PM, services were to be provided with the personal services agency. d. The home health aide, Employee P, was interviewed during this time. The employee stated that he / she was unfamiliar with the breakdown of time sheet and pulled the sheet from the binder. Employee P stated she works from 9:00 AM to 3:00 PM and does the			

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	personal care services from 3:00 PM to 4:45 PM. e. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 p.m. The Director of Nursing stated the home health aides should have been following the plan of care. 6. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and home health aide services (2) 2 hour visits and (1) 1 hour visits per day 7 days a week. a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The skilled nurse failed to follow the plan of care. b. Review of the home health aide visit notes dated 03/17, 03/18, 03/21 to 03/25/16, the home health aide provided services from 9:00 AM to 3:45 PM. Review of the home health aide visit notes dated 03/19, /03/20, and 03/26/16, the home health aide provided			

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	services from 9:00 AM to 2:00 PM. The home health aide failed to follow the plan of care. c. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 a.m., the employee stated he / she did not have a written plan of care to follow and did not know his / her hours of care between the home health agency and the personal service agency that was also owned by the Administrator. The patient stated that he / she had to cancel a few nursing visits due to a nurse who caused him / her pain during a catheterization and he / she wanted to get rid of the pain before the next catheterization. The patient also stated that he / she had a problem with nurses not coming as scheduled and would not call to let her know that they would be late. The patient stated the times should be 9:00 to 10:00 AM, 1:00 to 2:00 PM, and 5:00 to 6:00 PM. The patient stated that he / she had things to do and can't wait all day for the nurses to come. d. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 p.m. The Director of Clinical Services stated the home health aide new his / her schedule and a written plan of care was put in the patient's home a few			

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	weeks prior. The Director of Clinical Services also stated the patient had the tendency to not be home when nurses arrived even when the visits were prescheduled. 7. The clinical record for patient number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. The LPN failed to follow the plan of care. b. Review of the skilled nursing visit notes dated 03/01, 03/02, 03/07,			

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	03/09, and 03/12/16, the skilled nurses failed to assess the cardiovascular system, respiratory system, and / or failed to obtain vital signs. 8. The clinical record for patient number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. The patient also had respite nursing 1 - 30 hours for 12 months. a. Review of the skilled nursing visit notes, the skilled nurse provided 1 hour on 2/22; 3 consecutive hours on 03/08, 03/09, 03/16 (PM), 03/30 (PM); 4 consecutive hours on 03/10, 03/23, 03/30 (AM); 5 consecutive hours on 2/25, 03/03, 03/04, 03/28; 9 consecutive hours on 2/29, 03/22; 6 consecutive hours on 03/17 (PM); 7 consecutive hours on 2/23, 2/24, 03/02; 8 consecutive hours on 2/15, 2/18, 2/19, 2/25, 03/01, 02/21, 03/31, 04/01; 10 consecutive hours on 02/29; and 12 consecutive hours on 04/08/16. During week 6 (03/20 to 03/26/16), the skilled nurse only provided services for 3 days. The skilled nurse failed to follow the plan of care. 9. The clinical record for patient number			

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	9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month for 12 months. a. Review of the skilled nursing visit notes, the skilled nurse provided 3 of 5 visits each week between the dates of 02/14 to 03/12/16. b. During a home visit with the patient and Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H stated the patient attended an adult day care 3 days a week and would sometimes go with a parent to work. Employee H also stated he / she provides services to the patient on Tuesday from 3:45 to 9:00 PM and 10:00 AM to 9:00 PM on Thursday, Friday, and Saturday. The skilled nurse failed to follow the plan of care. 10. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care,			

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	foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and make bed / straighten patient areas. a. Review of the home health aide visit notes, the record failed to evidence a home health aide visit on 10/5/15 and 10/25. The home health aide failed to follow the plan of care. b. Review of the home health aide notes dated 10/01, 10/02, 10/06, 10/07, 10/08, 10/09, 10/12, 10/14, 10/15, 10/17, 10/18, 10/23, and 10/24/16, the home health aide documented "NN" (Not Needed) for shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and / or make bed / straighten patient areas. The home health aide failed to follow the plan of care. 11. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health aide services 3 hours per day 5 days a w eek to assist with bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair),			

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	transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). a. Review of the home health aide visit notes during the certification period of 08/19/15 to 10/17/15, the home health aide failed to evidence 5 visits during week 1, 1 visit during week 2, 5, and 7, and 2 visits during week 3, 4, and 6. The home health aide failed to follow the plan of care. The home health aide provided 2 extra visits during week 8 and 9. b. Review of the home health aide visit notes dated 08/27, 08/28, and 08/31/15, the home health aid provided 6 hour visits. The home health aide failed to follow the plan of care. c. Review of the home health aide notes dated 08/25 to 08/27, 09/02, 09/04, 09/09, 09/14 to 09/17, 09/22 to 09/24, 09/28 to 09/30, 10/04 to 10/17/15, the home health aide documented "NN" (Not Needed) for bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care,			

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	encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). The home health aide failed to follow the plan of care. 12. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all patient visit notes had been provided. 13. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 14. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... " 15. A policy titled Tardiness and Unplanned Absence dated 07/10/15, indicated " ... f an employee is unable to report for work, he / she must notify his or her supervisor at least four (4) hours prior to the beginning of the work shift.			

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	The team member must personally contact the supervisor .... "			
G 0159 Bldg. 00	484.18(a) PLAN OF CARE 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 that the plan of care was supported by the comprehensive assessment for 5 of 11 records reviewed (#5, 6, 7, 9, and 10), failed to update and revise the plan of care to include specific instructions for a bowel program for 1 of 1 record reviewed of patients with bowel program (#4), failed to include the type, frequency and duration of services to be provided (#2), ventilator settings, size of trach, frequency and instruction of trach care to be provided in 3 of 3 records reviewed of patients with trach's (#1, 2, and 9), failed to include directions for application of braces in 1 of 1 record reviewed of patients with braces (#2), failed to include the type of feeding, rate, and frequency of gastrointestinal tube	G 0159	G159– Plan of Care Allstaff will be in-serviced on Tag G159 (Plan of Care) by 6/10/16. Individual training sessions with CaseManagers to train on POC which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulseoximetry– measurements and sizes) any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items started on 5/24/16 and ongoing with the	06/10/2016

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	feedings in 2 of 2 records reviewed of patients with tube feedings (#2 and 8), failed to include the size of foley catheters for in out catheterizations in 2 of 2 records reviewed with patients receiving in and out catheterizations (#1 and 6), failed to include the size / frequency of changes for suprapubic catheter in 1 of 1 record reviewed for patients with suprapubic catheters (#9), failed to include instructions for foley catheter flushes in 1 of 1 record reviewed of patients with foley catheter irrigations (#1), failed to include instructions for wound treatments in 1 of 1 records reviewed of patients with wound treatments (#7), failed to include the location for the application of powder and ointments in 1 of 1 records reviewed of patients receiving medicated powder and ointments, and failed to include instruction for bathing and meal preps in 1 of 11 records reviewed of patients receiving assistance with bathing and meal prep. (# 1) Findings include: 1. The clinical record for patient number 1, SOC 01/20/15, included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing " to ... O2 [oxygen] at 0.5 - 6 liters 1		Director of Nursing,Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions (including but not limited to: trach, vents, cathes, g and j tubes, oxygen,suctioning, wounds, pulse oximetry–measurements and sizes), any safetymeasures to protect against injury, instructions for timely discharges orreferral, and any other appropriate items. On 5/25/16 and ongoing an In Home Quality Assurance Committee wasdeveloped to make home visits on 10% of clients monthly (until all clients havebeen seen) (the committee will continue to make home visits 10% quarterly). During the home visit the committee memberwill ensure that POC is being followed and documented by reviewing the POC,interview of patient and notes and documentation sheets. The committee member,when educating, will get signed documents of the training provided. Each document signed will be placed in thestaff	

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	minute [per minute] ... administer trach [sic] care, change trach collar QD [every day], suction trach ... I & O cath [in and out catheter] TID [three times a day] and prn [as needed]. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. A skilled nursing visit note dated 03/23/16 and 03/24/16 from 12:00 AM to 10:00 AM, indicated the skilled nurse changed out filters and tubing to the patient's vent, trach collar and canula changed out, used a 14 Fr catheter to catheterize the patient, irrigated the patient's catheter with 60 cc of unknown solution, applied Nystatin powder to the folds of the peri area and 40% zinc oxide applied to the patients buttocks. b. A skilled nursing visit note dated 03/24/16 from 4:00 PM to 7:00 PM, indicated the skilled nurse used a 16 Fr catheter to catheterize the patient and irrigated the patient's catheter with 60 cc of saline. c. A skilled nursing visit note dated 03/25/16, indicated the skilled nurse provided stand by assistance with bathing, shampooed the patient's hair, and assisted with meal prep.		personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesdayof each month to discuss findings and the outcomes and to ensure that eachfinding was addressed and resolved. Effective 4/17/16 and ongoing 10% of allclinical records will be audited quarterly for evidence that POC which coversall pertinent diagnoses, including mental status, types of services andequipment required, frequency of visits, prognosis, rehabilitation potential,functional limitations, activities permitted, nutritional requirements,medications and treatments w/specific instructions (including but not limitedto: trach, vents, cathes, g and j tubes,oxygen, suctioning, wounds, pulse oximetry–measurements and sizes), any safetymeasures to protect against injury, instructions for timely discharges orreferral, and any other appropriate items. Staff failing to follow POC will receive additional training withcorrective action up to termination. TheQuality Assurance Committee, Compliance Officer, Administrator and Director ofNursing will be responsible for monitoring these corrective actions to ensurethat this deficiency is corrected and will	

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	d. Employee E, a Registered Nurse / Case Manager, was interviewed on 04/06/16 at 3:10 PM. Employee E confirmed the patient had a ventilator but did not know the settings nor did he / she try to obtain those settings from a physician. The employee stated that he / she had tried to obtain the settings from Employee K, but never did receive them. The employee also was not able to indicate what size or type of trach the patient had. e. Employee F, a Licensed Practical Nurse, was interviewed on 04/06/16 at 4:30 PM. The employee stated the patient had to be catheterized, had to be placed on the vent at night, needed suction, and assisted the patient with AM care and meals. Employee F stated he / she did not know the patient's vent settings for it was programmed on a SD (scan disk card) by the hospital during the patient's last hospitalization. The employee stated he / she had received a call from Employee E prior to surveyor's call asking about the patient's ventilator settings. The plan of care failed to include instructions for trach care, size of foley catheter to use for catheterizations, instructions for foley catheter irrigation, vent settings, specific treatment areas for		not recur.	

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	the application of zinc oxide and Nystatin powder, and instructions for assistance with bathing and meal preps. The goals on the plan of care failed to be reflective of the patient's current status and treatment. 2. The clinical record for patient number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders for skilled nursing to" ... administer flushes as ordered, O2 [oxygen] during naps / bedtime, administer trach care ... administer feedings." The patient's diagnoses included Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance. a. A start of care comprehensive assessment dated 02/11/16, indicated Pediasure 1.0, 720 milliliters through out the night, Pediasure 410 [sic] milliliters per hour, and Pediasure 1.5, 4 ounce bolus 4 times a day, the patient had both a gastric and jejunostomy feeding tubes, the patient was receiving bolus and continuous feedings, with 35 milliliter flushes of water to the gastric feeding tube and 10 milliliter flushes of water to the jejunostomy feeding tube after night feedings, NPO (nothing by mouth) a 4 x			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

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	4 dressing under the patient's trach with 1 liter of oxygen via concentrator when sleeping, the patient had a trach, humidifier for oxygen, ventilator, pulse oximetry to be done every visit and "AFO in progress." b. Section 16 of the initial plan of care titled "Nutritional Req [requirements]" indicated Pediasure 1.0, 720 milliliters overnight. c. Section 18 of the initial plan of care titled "Activities Permitted" indicated AFOs [braces] were in progress. 1. The plan of care failed to be updated and revised to include the type, amount, and frequency of "flushes", failed to include the route of oxygen usage, failed to include the type of trach and frequency of trach care [including suctioning protocols], failed to include ventilator settings and management of the ventilator, failed to include the management of the humidifier, failed to include pulse oximetry, failed to include the amount of flushes and frequency to both gastric and jejunostomy feeding tubes, failed to include both types of Pediasure feedings along with the the specific tube used for feedings, the amount and rate of all tube feedings,			

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	failed to include that the patient was NPO, and failed to indicate the location and frequency of the AFOs to be placed and worn by the patient. 3. The clinical record for patient number 4, SOC 06/19/15, included a plan of care established by a physician for the certification period of 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis and constipation. a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The plan of care failed to be updated and revised to specifically indicate skilled nursing to perform a digital stimulation / bowel program as well as failed to include measurable goals for the program. b. Review of the comprehensive reassessment for recertification dated 08/17/15, indicated the patient was incontinent of bowel on a daily basis. The plan of care failed to be supported by			

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	the comprehensive assessment. 4. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. The patient diagnoses include chronic obstructive pulmonary disease, congestive heart failure, and rheumatoid arthritis. a. During a home visit on 04/12/16 from 9:00 to 9:45 AM, at an Independent Living Apartments, the patient's room was observed to have a large bed in the living quarters with a kitchenette and bathroom. The living space was cluttered with oxygen concentrator (not in use) and other durable medical equipment between the patient bed and entry / door. The patient was observed sitting up in her bed eating a bowel of cereal while the home health aide was sitting in a chair conversing with the patient. After the patient ate, the			

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	home health aide took the bowel into the kitchenette and went into the bathroom and picked up the area. The home health aide indicated that the patient has home health aide services from 9:00 AM to 3:00 PM then personal care services from 3:00 PM to 4:45 PM. The home health aide stated that he / she assists the patient with her bathing, picks up around the apartment, runs errands, and provide companionship. b. Review of the comprehensive reassessment for recertification dated 01/21/16, indicated the patient had some dyspnea with exertion. The Nutritional Status assessment was left blank and did not specify if the patient has physically able to shop, cook, and or feed him / herself. The reassessment indicated the patient was continent of bowel and bladder. The fall risk assessment was left blank. The reassessment indicated the patient was able to participate in bathing self in shower or tub but required presence of another person for assistance or supervision, able to get to and from the toilet and transfer independently with or without device. The reassessment indicated the patient was able to transfer with minimal human assistance or with use of an assistive device, able to ambulate with use of a one - handed device, able to to independently walk on			

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	even and uneven surfaces and negotiate stairs with or without railings. The plan of care failed to be supported by the comprehensive assessment. c. The Administrator, Director of Nursing, and Assistant Director of Nursing was unable to provide any further information regarding the findings referenced above when asked on 04/18/16 at 3:45 PM. 6. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterizations and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to assist with bed bath, assist with bath chair, pericare, nail care, foot care, pm care, assist with feeding, ambulation assist / mobility, commode, wheelchair, transfer / positioning, feeding, meal set up, oral care, encourage fluids, urine incontinence, check pressure areas, skin care, medication reminders, blood sugar reminders, make bed, and straighten patient area. The patient primary diagnoses was Rheumatoid Arthritis and Fibromyalgia. Secondary diagnoses listed in order were Bipolar Disorder,			

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	Diabetes, Sleep Apnea, Hypertension, and Urinary Retention. a. During a home visit on 04/12/16 at 10:30 AM, the patient stated that his / her daughter lived in the home but the daughter attended college during the day and provided the in and out catheterization at bedtime. The patient was then observed to transfer herself from the bed to a motorized wheelchair, from the motorized wheelchair to the toilet, from the toilet to the shower chair with stand by assistance from the home health aide. After the shower, the patient transferred herself from the shower chair to the toilet and dried herself off to the upper portion of the body and the home health aide dried the lower extremities. The patient transferred herself to the motorized wheelchair and was observed to dress herself with a sun dress type gown. After getting dressed, the patient operated her motorized wheelchair in the bedroom. An oxygen concentrator was observed in the room. b. Review of the start of care comprehensive assessment dated 03/17/16, the primary diagnosis was rheumatoid arthritis followed by secondary diagnoses of fibromyalgia, bipolar, diabetes mellitus, sleep apnea, hypertension, asthma, and urinary			

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	retention. The assessment did not indicate the patient had respiratory treatments used in the home. The assessment indicated the patient received meals from a community delivery service, able to take oral and injection medications independently, chairfast, unable to ambulate and is unable to wheel self, able to feed self independently, patient depends entirely upon another person to dress the upper body, unable to get to and from the toilet but is able to use a bedside commode with or without assistance, the nutritional assessment was left blank and did not specify if the patient was physically able to shop, cook, and or feed him / herself, and the summary indicated the patient must be catheterized 4 times a day, but 3 of the 4 catheterizations were to be provided by the agency nurses. The comprehensive assessment did not include the size of the pediatric catheter. The plan of care failed to be supported by the comprehensive assessment. The plan of care failed to include the size of the pediatric foley catheter to be used for in and out catheterizations and failed to include coordination with Mom's meals. 7. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to			

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	05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. The goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. Review of the comprehensive reassessment for recertification dated 03/02/16, the reassessment failed to provide a complete pain assessment, failed to include measurements to the lower extremity edema due to cellulitis, failed to provide wound bed assessment and measurement of the venous stasis ulcer to the right lower extremity, failed to complete the nutritional assessment, failed to document the fall risk assessment, failed to document the psychosocial assessment, failed to answer M1840 Toilet transferring assessment, failed to document patient / caregiver / family education, and failed to document a summary / progress of the past 60 days in the summary section. The comprehensive reassessment for recertification was incomplete and failed to support the services provided as written in the plan of care. The plan of care failed to be supported by the			

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	comprehensive assessment. b. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. c. The plan of care failed to be updated and revised to include type of solution to cleanse the lower extremities and the location of wounds to be treated. The goals on the plan of care failed to be reflective of the patient's current status and treatment. 8. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days to to administer medication as ordered, administer gastric tube feedings / flushes as ordered. a. The plan of care failed to be			

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	updated and revised to include the amount of tube feeding to be provided, as well as the amount and frequency of flushes. 9. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month to assess cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / fall prevention, and Oxygen at 2 liters per trach at night. The patient primary diagnosis was Cerebral Palsy, sleep apnea, cerebral vascular accident, coarotation of aorta, and urinary incontinence. a. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H was observed cooking dinner for the patient. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a			

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	day and as needed. The plan of care failed to be updated and revised to include trach care, ventilator settings / management, preparing meals, supra pubic catheter care, and suctioning as needed. b. Review of the comprehensive reassessment for recertification dated 03/18/16, the reassessment failed to provide a complete cardiopulmonary assessment, failed to complete the nutritional status, failed to provide an assessment of the suprapubic catheter / insertion site, failed to complete the assessment to the neurological and musculoskeletal system, failed to complete patient / caregiver / family education, and failed to complete a summary of the past 60 days. The plan of care failed to be supported by the comprehensive assessment. 10. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week, to provide a shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, make bed / straighten patient areas. The primary diagnosis indicated			

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	carbon monoxide poisoning, followed by secondary diagnoses of lumbago, esophageal reflux, hypothyroidism, and coronary artery disease. a. A form titled "Intake / Referral" dated 03/27/15, indicated the patient was a self referral and the patient had carbon monoxide poisoning in 2011. b. A physician visit note dated 03/03/15, indicated the physician would not diagnose the patient with carbon monoxide poisoning due to the patient had been moved out of the environment and there was no labs to prove the patient had the poisoning although the patient symptom complex was similar to carbon monoxide poisoning. c. A comprehensive reassessment for recertification dated 09/22/15, indicated the patient was not short of breath, continent of both bowel and bladder, failed to complete the musculoskeletal system and functional limitations, failed to complete the neurological assessment, and failed to complete the summary of care (including progress toward goals to date. The primary diagnosis and plan of care failed to be supported by the comprehensive assessment and physician visit note			

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	11. The Administrator, Alternate Administrator, Director of Nursing, and Assistant Director of Nursing was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 12. A policy titled Plan of Care dated 08/15/15, indicated " ... The Plan of Care is based on a comprehensive assessment and information provided the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The Plan of Care shall be completed in full to include ... All pertinent diagnosis (es), principle and secondary ... Medications, treatments, and procedures, Medical supplies and equipment required .... "			
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 notify the primary care physician in relation to a patient's discharge for 1 of 5 records reviewed of patients discharged by the agencyn(# 4) , failed to notify the physician of missed	G 0164	G164– Periodic Review of Plan of Care Allstaff will be in-serviced on Tag G164 (Periodic Review of Plan of Care) by6/10/16. Individual training sessionswith Case Managers to train on Periodic Review of POC which covers	06/10/2016

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	visits in 1 of 6 active / current records reviewed (# 6), failed to notify the primary care physician of a patient's elevated blood pressures for 1 of 6 records reviewed of active / current patients (# 6), and failed to notify the primary care physician for a patient with no urinary output for 1 of 2 patients reviewed with in and out catheterizations in a sample of 11. (# 6) Findings include: 1. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week. a. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15. b. Review of skilled nursing visit notes, a discharge comprehensive assessment was made on 08/26/15, but the last skilled nursing visit note was		allpertinent diagnoses, including mental status, types of services and equipmentrequired, frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning,wounds, pulse oximetry– measurements and sizes) any safety measures to protectagainst injury, instructions for timely discharges or referral, and any otherappropriate items and promptly report any changes to the physician that suggesta need to alter the POC started on 5/24/16 and ongoing with the Director ofNursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions (including but not limited to: trach, vents, cathes, g and j tubes, oxygen,suctioning, wounds, pulse oximetry– measurements and sizes), any	

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	dated 09/15/15. c. Review of the home health aide visit notes, the last home health aide visit note was dated 09/08/15. d. The clinical record failed to evidence a physician's order to discontinue services on 08/31/15 as anticipated in the patient's discharge letter, failed to evidence an order to stopped home health aide services on 09/08/15, and failed to evidence an order to discharge skilled nursing services on 09/15/15. 2. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention. a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and		safetymeasures to protect against injury, instructions for timely discharges orreferral, and any other appropriate items and promptly report any changes tothe physician that suggest a need to alter the POC. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill ensure that POC is being followed and documented by interview withpatient, review of POC, review of notes and documentation sheets. The committeemember, when educating, will get signed documents of the trainingprovided. Each document signed will beplaced in the staff personnel file and client chart. The committee members will provide a writtenreport of the visit to the Administrator and Director of Nursing within 24hours. The committee will meet thefirst Wednesday of each month to discuss findings and the outcomes and toensure that each finding was addressed and resolved., Effective 4/17/16 andongoing 10% of all clinical records will be audited quarterly for evidence thatPOC which covers all pertinent diagnoses, including mental status, types	

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356	

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	03/26/16. The agency failed to provide documentation that the physician had been notified of the missed visits. b. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified. c. Review of a skilled nursing visit note on 03/22/16 at 6:00 PM, the skilled nurse documented no urine output after 2 attempts of catheterizations. The clinical record failed to evidence that the physician had been notified. d. Review of a skilled nursing visit note on 03/23/16 at 10:00 AM, the skilled nurse documented the patient had a blood pressure of 149/101. The clinical record failed to evidence that the physician had been notified. e. Review of a skilled nursing visit note on 03/25/16 at 9:00 PM, the skilled nurse documented no urine output. The clinical record failed to evidence that the physician had been notified. 3. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM.		ofservices and equipment required, frequency of visits, prognosis, rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements, medications and treatments w/specific instructions (including butnot limited to: trach, vents, cathes, gand j tubes, oxygen, suctioning, wounds, pulse oximetry– measurements and sizes),any safety measures to protect against injury, instructions for timelydischarges or referral, and any other appropriate items and promptly report anychanges to the physician that suggest a need to alter the POC. Staff failing to follow POC will receiveadditional training with corrective action up to termination. The Quality Assurance Committee, ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur.	

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	The Director of Clinical Services did not have any further information or documentation. 4. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator did not provided further information or documentation in regards to notifying the physician of an impending discharges. 5. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse informs the physician and other personnel of changes in the patient condition of needs ... The Licensed Practical Nurse ... Reports findings and observations to the Registered Nurse and other members of the team to assure coordination and timely response to client changes or needs .... "			
G 0165 Bldg. 00	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. Based on record review and interview, the agency failed to ensure that all treatments provided had a physician's order in 2 of 2 records reviewed of patients with wounds (#7 and 8) and 1 of 1 records reviewed of patients receiving a	G 0165	All staff will be in-serviced on Tag G165(Conformance with Physician Orders) by 6/10/16. Individual training sessions with CaseManagers to train on Conformance with Physician Orders which include allmedications, treatments and	06/10/2016

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	bowel program in a sample of 11. (# 4) Findings include: 1. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The agency failed to ensure physician orders had been obtained prior to digital stimulation / conducting a bowel program. 2. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze		services provided to patients must be ordered by aphysician started on 5/24/16 and ongoing with the Director of Nursing,Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on Conformance with PhysicianOrders which all medications, treatments and services provided to patients mustbe ordered by a physician. On5/25/16 and ongoing an In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all clients have been seen) (the committee will continue to make homevisits 10% quarterly). During the homevisit the committee member will ensure that POC is being followed anddocumented by interview with patient, review of POC, notes and documentationsheets that conform to Physician Orders. The committee member, when educating,will get signed documents of the training provided. Each document signed will be placed in thestaff personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesdayof each month to discuss findings and the outcomes and to ensure that eachfinding was addressed and resolved., Effective	

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	dressing. a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. The clinical record failed to include a physician's order for the treatment that had been provided. 3. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. a. A skilled nursing visit note dated 02/18/16, indicated the patient recently had surgery to remove two loose pins and replaced it with a rod from the hip to knee in the right leg. Skilled nursing visit notes dated 03/09 and 03/10/16, indicated that the patient's surgical incision dressing had been changed. The clinical record failed to		4/17/16 and ongoing 10% of allclinical records will be audited quarterly for evidence that Conformance withPhysician Orders which include all medications, treatments and servicesprovided to patients must be ordered by a physician. Staff failing to follow POC will receiveadditional training with corrective action up to termination. The Quality Assurance Committee, ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur.	

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	include a physician's order for the treatment to be provided. 4. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services did not have any further information or documentation in relation to physician orders for wound treatments. 5. A policy titled Physician Orders dated 07/10/15, indicated "All medications, treatments and services provided to patients must be ordered by a physician.			
G 0168 Bldg. 00	484.30 SKILLED NURSING SERVICES Based on record review and interview, the Registered Nurse failed to followed the plan of care for 6 of 6 records reviewed of patients receiving services from a registered nurse in a sample of 11 (See G 170), failed to ensure the comprehensive reassessments were accurate and / or completed to support the services provided as written in the plan of care for 7 of 9 records reviewed of patients recertified for another 60 days in a sample of 11 (See G 172), failed to ensure that the plan of care was supported by the comprehensive assessment for 5 of 11 records reviewed,	G 0168	G168– Skilled Nursing Services Allskilled nurses will be in-serviced on Tag G168 (Skilled Nursing Services) by6/10/16. Individual training sessions with SkilledNurses to train on POC, Periodic Review of POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen,	06/10/2016

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	failed to update and revise the plan of care to include specific instructions for a bowel program for 1 of 1 record reviewed of patients with bowel program, failed to include the type, frequency and duration of services to be provided, ventilator settings, size of trach, frequency and instruction of trach care to be provided in 3 of 3 records reviewed of patients with trach's, failed to include directions for application of braces in 1 of 1 record reviewed of patients with braces, failed to include the type of feeding, rate, and frequency of gastrointestinal tube feedings in 2 of 2 records reviewed of patients with tube feedings, failed to include the size of foley catheters for in out catheterizations in 2 of 2 records reviewed with patients receiving in and out catheterizations, failed to include the size / frequency of changes for suprapubic catheter in 1 of 1 record reviewed for patients with suprapubic catheters, failed to include instructions for foley catheter flushes in 1 of 1 record reviewed of patients with foley catheter irrigations, failed to include instructions for wound treatments in 1 of 1 records reviewed of patients with wound treatments, failed to include the location for the application of powder and ointments in 1 of 1 records reviewed of patients receiving medicated powder and ointments, and failed to include		suctioning,wounds, pulse oximetry– measurements and sizes) any safety measures to protectagainst injury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Training on Conformance with PhysicianOrders which include all medications, treatments and services provided topatients must be ordered by a physician started on 5/24/16 and ongoing with theDirector of Nursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC, Periodic Review of POCwhich covers all pertinent diagnoses, including mental status, types ofservices and equipment required, frequency of visits, prognosis, rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements, medications and treatments w/specific instructions, (includingbut not limited to: trach, vents,cathes, g and j tubes, oxygen, suctioning, wounds, pulse oximetry– measurementsand sizes) any safety measures to protect against injury, instructions fortimely discharges or referral, and any other appropriate items; and promptlyreport any changes	

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	instruction for bathing and meal preps in 1 of 11 records reviewed of patients receiving assistance with bathing and meal prep (See G 173), failed to document a description / assessment of wounds being treated and failed to document the treatment provided for 2 of 2 records reviewed and 1 of 1 home visit of patients with wounds in a sample of 11 (See G 174), failed to notify the primary care physician in relation to a patient's discharge for 1 of 5 records reviewed of patients discharged by the agency, failed to notify the physician of missed visits in 1 of 6 active / current records reviewed, failed to notify the primary care physician of a patient's elevated blood pressures for 1 of 6 records reviewed of active / current patients, and failed to notify the primary care physician for a patient with no urinary output for 1 of 2 patients reviewed with in and out catheterizations, failed to ensure that all treatments provided had a physician's order for 2 of 2 records reviewed of patients with wounds and 1 of 1 records reviewed of patients receiving a bowel program in a sample of 11 (See G 176), the Licensed Practical Nurse (Licensed Practical Nurse) failed to ensure assessments / visit notes were clear, complete and accurate for 3 of 5 records reviewed with LPN providing services in a sample of 11 (See G 180), and failed to ensure that all		to the physician that suggest a need to alter the POC ; andTraining on Conformance with Physician Orders which include all medications,treatments and services provided to patients must be ordered by a physician. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill ensure that POC is being followed and documented by interview withpatient, review of POC, Physician Orders, notes and documentation sheets. The committee member, when educating, will getsigned documents of the training provided. Each document signed will be placed in the staff personnel file andclient chart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved., Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence on POC, Periodic Review of POC which covers all pertinent diagnoses,including	

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	treatments provided had a physician's order for 2 of 2 records reviewed of patients with wounds in a sample of 11 (See G 181). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 484.30: Skilled Nursing Services. The immediate Jeopardy was identified and began on 04/13/16. The Administrator was notified of the Immediate Jeopardy on 04/13/16 at 4:10 PM. The facility developed an acceptable plan for removal of the IJ on 4/15/16. Based on interviews and record reviews, the Immediate Jeopardy was removed on 04/18/16 at 3:00 PM. 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.		mental status, types of services and equipment required, frequency ofvisits, prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulseoximetry– measurements and sizes) any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Training on Conformance with PhysicianOrders which include all medications, treatments and services provided topatients must be ordered by a physician. Staff failing to follow POC will receiveadditional training with corrective action up to termination. The QualityAssurance Committee, Compliance Officer, Administrator and Director of Nursingwill be responsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	
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,	G 0170	G170– Skilled Nursing Services	06/10/2016

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	the Registered Nurse failed to followed the plan of care for 6 of 6 records reviewed of patients receiving services from a registered nurse in a sample of 11. (#2, 4, 6, 7, 8, 9,) Findings include: 1. The clinical record for number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders for skilled nursing. The patient's diagnoses included RSV (Respiratory Syncytial Virus), Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance. a. A "Notification of Client Status" dated 02/11/16, indicated the patient had been admitted for respite nursing and "PA" (meaning prior authorization from Medicaid to provide ongoing nursing services on a routine basis). The note also indicated the parents wanted a routine nurse for overnights and no float nurses. b. The initial plan of care (undated) had orders for skilled nursing to evaluate but failed to include a nursing frequency / duration. The agency		Allskilled nurses will be in-serviced on Tag G170 (Skilled Nursing Services) by6/10/16. Individual training sessionswith Skilled Nurses to train on furnishing services in accordance with the POCwhich covers all pertinent diagnoses, including mental status, types ofservices and equipment required, frequency of visits, prognosis, rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements, medications and treatments w/specific instructions, (includingbut not limited to: trach, vents,cathes, g and j tubes, oxygen, suctioning, wounds, pulse oximetry–measurementsand sizes) any safety measures to protect against injury, instructions fortimely discharges or referral, and any other appropriate items; and promptlyreport any changes to the physician that suggest a need to alter the POC ; andConformance with Physician Orders which include all medications, treatments andservices provided to patients must be ordered by a physician started on 5/24/16and ongoing with the Director of Nursing, Alternate Director ofNursing/Compliance Officer. An all CaseManager training session has been scheduled for Friday, June 17, 2016 to trainon furnishing services in accordance with the POC which covers POC	

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	provided respite nursing visits on 02/24/16 and 02/26/16. The nurse failed to follow the plan of care. c. The second plan of care dated 03/22/16, had orders for skilled nursing 8 hours per day, 5 days a week for 9 weeks and respite nursing up to 60 hours per month for 12 months. Review of the clinical record, the agency failed to provide skilled nursing visits 8 hours a day, 5 days a week. d. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was interviewed on 04/07/16 at 12:30 PM. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services stated that the initial plan of care was developed upon admission and the agency were to provide respite nursing services. The patient was transferred into the hospital and returned home on 3/22/16. The Administrator and Assistant Director of Clinical Services stated that Medicaid had instructed the agency to develop a new plan of care versus writing orders and updating the current plan of care. The Assistant Director of Clinical Services stated there was a delay in routine nursing services due to the father's lack of ability to provide job		which allpertinent diagnoses, including mental status, types of services and equipmentrequired, frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning,wounds, pulse oximetry– measurements and sizes) any safety measures to protectagainst injury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. On 5/28/16 andongoing The "Welcome Letter" was updated to include a statement "Willyou accept a Float Staff to start your services and fill in when your permanentstaff calls off." The "Welcome Letter" will require client/family signature andwill be filed in client chart and a copy in yellow folder. On 5/25/16 and ongoing an In Home Quality AssuranceCommittee was developed to make home visits on 10% of clients monthly (untilall clients have been seen) (the committee will continue to make home visits10% quarterly). During the home visitthe	

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	information. The Director of Clinical Services stated the PA (Prior Authorization) came on 3/25/16, but the mother did not want floating nurses in the home and requested that the patient be staffed with a permanent nurse. The Assistant Director of Clinical Services stated the requested visit notes may have been in the patient's home. At 1:00 PM, missed visit notes were provided and the Director of Clinical Services stated she had been interviewing for a permanent nurse and a nurse had been hired and was due to start "today." e. The parent of patient number 2 was interviewed on 04/07/16 at 3:50 PM. The parent had stated that he / she did not recall telling the agency that he / she wanted to hold services or refused services until a permanent nurse was available. The parent stated he / she preferred a permanent nurse but would have taken anyone due to the exhaustion between him / her and their spouse, need for rest during the night due to pregnancy / work, and how the patient needed constant supervision during the night due to getting the trach tubing around his / her neck. The parent indicated the patient had respite nursing a few times prior to his / her hospitalization, but when the patient came out of the hospital, his / her respite nurse was in the hospital		committee member will ensure that the "Welcome Letter" is explained,understood and signed (a copy will be filed in client chart and a copy inyellow folder), POC is followed, follow-up on each monthly inservice, call offprocess, organization chart, updates on client and staff paperwork, patientrights, etc. The committee member, wheneducating, will get signed documents of the training provided. Each document signed will be placed in thestaff personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesday ofeach month to discuss findings and the outcomes and to ensure that each findingwas addressed and resolved., Effective 4/17/16 and ongoing 10% of all clinicalrecords will be audited quarterly for evidence furnishing services inaccordance with the POC which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulseoximetry– measurements	

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	his / herself and that a replacement respite nurse had not been provided. 2. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week. The patient diagnoses included, but limited to Multiple Sclerosis. a. Review of the skilled nursing visit notes, the skilled nurse failed to provide 2 visits during the week of 07/19 to 07/25/15 and during the week of 07/26 to 08/01/15. The skilled nurse failed to provide a 2nd visit during the week of 08/09 to 08/15/15. The skilled nurse failed to follow the plan of care. 3. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and home health aide services (2) 2 hour visits and (1) 1 hour visits per day 7 days a week. a. Review of the skilled nursing visit notes, the skilled nurse failed to		and sizes) any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. Staff failing tofollow POC will receive additional training with corrective action up totermination. The Quality Assurance Committee, Compliance Officer, Administratorand Director of Nursing will be responsible for monitoring these correctiveactions to ensure that this deficiency is corrected and will not recur.	

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	make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The skilled nurse failed to follow the plan of care. b. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 a.m., the employee stated he / she did not have a written plan of care to follow and did not know his / her hours of care between the home health agency and the personal service agency that was also owned by the Administrator. The patient stated that he / she had to cancel a few nursing visits due to a nurse who caused him / her pain during a catheterization and he / she wanted to get rid of the pain before the next catheterization. The patient also stated that he / she had a problem with nurses not coming as scheduled and would not call to let her know that they would be late. The patient stated the times should be 9:00 to 10:00 AM, 1:00 to 2:00 PM, and 5:00 to 6:00 PM. The patient stated that he / she had things to do and can't wait all day for the nurses to come. c. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 p.m. The Director of Nursing stated the home health aide new his / her			

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	schedule and a written plan of care was put in the patient's home a few weeks prior. The Director of Nursing also stated the patient had the tendency to not be home when nurses arrived even when the visits were prescheduled. 4. The clinical record for patient number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. Review of the skilled nursing visit notes dated 03/01/16 and 03/07/16, the skilled nurses failed to assess the cardiovascular system, respiratory system, and / or failed to obtain vital signs. 5. The clinical record for patient number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. The patient also had respite nursing 1 - 30 hours for 12 months. a. Review of the skilled nursing visit notes, the skilled nurse provided 1 hour on 2/22; 3 consecutive hours on			

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	03/08, 03/09, 03/16 (PM), 03/30 (PM); 4 consecutive hours on 03/10, 03/23, 03/30 (AM); 5 consecutive hours on 2/25, 03/03, 03/04, 03/28; 9 consecutive hours on 2/29, 03/22; 6 consecutive hours on 03/17 (PM); 7 consecutive hours on 2/23, 2/24, 03/02; 8 consecutive hours on 2/15, 2/18, 2/19, 2/25, 03/01, 02/21, 03/31, 04/01; 10 consecutive hours on 02/29; and 12 consecutive hours on 04/08/16. During week 6 (03/20 to 03/26/16), the skilled nurse only provided services for 3 days. The skilled nurse failed to follow the plan of care. 6. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month for 12 months. a. Review of the skilled nursing visit notes, the skilled nurse provided 3 of 5 visits each week between the dates of 02/14 to 03/12/16. b. During a home visit with the patient and Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H stated the patient attended an adult day			

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	care 3 days a week and would sometimes go with a parent to work. Employee H also stated he / she provides services to the patient on Tuesday from 3:45 to 9:00 PM and 10:00 AM to 9:00 PM on Thursday, Friday, and Saturday. The skilled nurse failed to follow the plan of care. 7. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all patient visit notes had been provided. 8. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 9. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... " 10. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Registered Nurse ... b. Regularly reevaluates the patient needs, and			

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	coordinates the necessary services .... " 11.. A policy titled Scope of Services and Core Skilled Service Provided dated 07/10/15, indicated " ... Services will be coordinated by the Registered Nurse managing the care .... " 12. 4. A policy titled Tardiness and Unplanned Absence dated 07/10/15, indicated " ... f an employee is unable to report for work, he / she must notify his or her supervisor at least four (4) hours prior to the beginning of the work shift. The team member must personally contact the supervisor .... "			
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, the Registered Nurse failed to ensure the comprehensive reassessments were accurate and / or completed to support the services provided as written in the plan of care for 7 of 9 records reviewed of patients recertified for another 60 days in a sample of 11. (#1, 4, 5, 6, 7, 9, an 10) Findings include: 1. The clinical record for number 1, SOC	G 0172	G172– Duties of the Registered Nurse Allskilled nurses will be in-serviced on Tag G172 (Duties of the Registered Nurse)by 6/10/16. Individual trainingsessions with Registered Nurses to train on comprehensive reassessments and furnishingservices in accordance with the POC which covers all pertinent diagnoses,including mental status, types of services and equipment required, frequency ofvisits, prognosis, rehabilitation potential, functional	06/10/2016

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	(start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension. a. Review of the comprehensive reassessment dated 03/22/16, the assessment failed to include that the patient needed to be placed on a ventilator at bedtime, failed to include settings of the ventilator, indicated the patient was short of breath in the respiratory section but indicated the patient tolerated suctioning with dyspnea, failed to include a size and type of a foley catheter used for in and out		limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulseoximetry– measurements and sizes) any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician started on 5/24/16 and ongoing with the Director ofNursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on comprehensive reassessments andfurnishing services in accordance with the POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functional limitations,activities permitted, nutritional requirements, medications and treatmentsw/specific instructions, (including but not limited to: trach, vents, cathes, g and j	

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	catheterizations, failed to include assessment / need for bladder irrigation, failed to include the patient was a paraplegic in the neurological assessment, indicated the patient was able to dress his / her upper and lower body, including socks and shoes, indicated the patient has a need for home health aide services and an order had been obtained, indicated a home health health aide supervisory visit was made instead of a LPN supervisory visit, failed to include specific detail in the teaching / training (indicated "see ASV"), and failed to include documentation in the summary section. b. A skilled nursing visit note dated 03/23/16 and 03/24/16 from 12:00 AM to 10:00 AM, indicated the skilled nurse changed out filters and tubing to the patient's vent, trach collar and canula changed out, used a 14 Fr catheter to catheterize the patient, irrigated the patient's catheter with 60 cc of unknown solution, applied Nystatin powder to the folds of the peri area and 40% zinc oxide applied to the patients buttocks. b. A skilled nursing visit note dated 03/24/16 from 4:00 PM to 7:00 PM, indicated the skilled nurse used a 16 Fr catheter to catheterize the patient and irrigated the patient's catheter with 60 cc		tubes, oxygen, suctioning,wounds, pulse oximetry– measurements and sizes) any safety measures to protectagainst injury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. On 5/28/16 andongoing The "Welcome Letter" was updated to include a statement "Willyou accept a Float Staff to start your services and fill in when your permanentstaff calls off." The "Welcome Letter" will require client/family signature andwill be filed in client chart and a copy in yellow folder. On 5/25/16 and ongoing an In Home Quality AssuranceCommittee was developed to make home visits on 10% of clients monthly (untilall clients have been seen) (the committee will continue to make home visits10% quarterly). During the home visitthe committee member will ensure that the comprehensive reassessments andfurnishing services in accordance with the POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities	

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	of saline. c. A skilled nursing visit note dated 03/25/16, indicated the skilled nurse provided stand by assistance with bathing, shampooed the patient's hair, and assisted with meal prep. d. Employee E, a Registered Nurse / Case Manager, was interviewed on 04/06/16 at 3:10 PM. Employee E confirmed the patient had a ventilator but did not know the settings nor did he / she try to obtain those settings from a physician. The employee stated that he / she had tried to obtain the settings from Employee K, but never did receive them. The employee also was not able to indicate what size or type of trach the patient had. e. Employee F, a Licensed Practical Nurse, was interviewed on 04/06/16 at 4:30 PM. The employee stated the patient had to be catheterized, had to be placed on the vent at night, needed suction, and assisted the patient with AM care and meals. Employee F stated he / she did not know the patient's vent settings for it was programmed on a SD (scan disk card) by the hospital during the patient's last hospitalization. The employee stated he / she had received a call from Employee E prior to		permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen,suctioning, wounds, pulse oximetry–measurements and sizes) any safety measuresto protect against injury, instructions for timely discharges or referral, andany other appropriate items; and promptly report any changes to the physicianthat suggest a need to alter the POC ; and Conformance with Physician Orderswhich include all medications, treatments and services provided to patientsmust be ordered by a physician. The committee member, when educating, will getsigned documents of the training provided. Each document signed will be placed in the staff personnel file andclient chart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved., Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence of comprehensive reassessments and furnishing services in accordancewith the POC which covers all pertinent	

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	surveyor's call asking about the patient's ventilator settings. The comprehensive reassessment failed to be accurate to support the written plan of care. 2. The clinical record for patient number 4, SOC 06/19/15, included a plan of care established by a physician for the certification period of 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis and constipation. a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The plan of care failed to be updated and revised to specifically indicate skilled nursing to perform a digital stimulation / bowel program as well as failed to include measurable goals for the program. b. Review of the comprehensive reassessment for recertification dated 08/17/15, indicated the patient was incontinent of bowel on a daily basis. The comprehensive reassessment failed		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 w/specific instructions,(including but not limited to: trach,vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulse oximetry–measurements and sizes) any safety measures to protect against injury,instructions for timely discharges or referral, and any other appropriateitems; and promptly report any changes to the physician that suggest a need toalter the POC ; and Conformance with Physician Orders which include allmedications, treatments and services provided to patients must be ordered by aphysician. Staff failing to follow procedurewill receive additional training with corrective action up to termination. The QualityAssurance Committee, Compliance Officer, Administrator and Director of Nursingwill be responsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

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	to be accurate to support the written plan of care. 3. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. The patient diagnoses include chronic obstructive pulmonary disease, congestive heart failure, and rheumatoid arthritis. a. During a home visit on 04/12/16 from 9:00 to 9:45 AM, at an Independent Living Apartments, the patient's room was observed to have a large bed in the living quarters with a kitchenette and bathroom. The living space was cluttered with oxygen concentrator (not in use) and other durable medical equipment between the patient bed and entry / door. The patient was observed sitting up in her bed eating a bowel of cereal while the home health aide was sitting in a chair conversing			

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	with the patient. After the patient ate, the home health aide took the bowel into the kitchenette and went into the bathroom and picked up the area. The home health aide indicated that the patient has home health aide services from 9:00 AM to 3:00 PM then personal care services from 3:00 PM to 4:45 PM. The home health aide stated that he / she assists the patient with her bathing, picks up around the apartment, runs errands, and provide companionship. b. Review of the comprehensive reassessment for recertification dated 01/21/16, indicated the patient had some dyspnea with exertion. The Nutritional Status assessment was left blank and did not specify if the patient has physically able to shop, cook, and or feed him / herself. The reassessment indicated the patient was continent of bowel and bladder. The fall risk assessment was left blank. The reassessment indicated the patient was able to participate in bathing self in shower or tub but required presence of another person for assistance or supervision, able to get to and from the toilet and transfer independently with or without device. The reassessment indicated the patient was able to transfer with minimal human assistance or with use of an assistive device, able to ambulate with use of a one - handed			

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	device, able to to independently walk on even and uneven surfaces and negotiate stairs with or without railings. The comprehensive reassessment failed to be accurate and completed to support the plan of care. c. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was unable to provide any further information regarding the findings referenced above when asked on 04/18/16 at 3:45 PM. 4. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterizations and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to assist with bed bath, assist with bath chair, pericare, nail care, foot care, pm care, assist with feeding, ambulation assist / mobility, commode, wheelchair, transfer / positioning, feeding, meal set up, oral care, encourage fluids, urine incontinence, check pressure areas, skin care, medication reminders, blood sugar reminders, make bed, and straighten patient area. The patient primary diagnoses was Rheumatoid Arthritis and			

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	Fibromyalgia. Secondary diagnoses listed in order were Bipolar Disorder, Diabetes, Sleep Apnea, Hypertension, and Urinary Retention. a. During a home visit on 04/12/16 at 10:30 AM, the patient stated that his / her daughter lived in the home but the daughter attended college during the day and provided the in and out catheterization at bedtime. The patient was then observed to transfer herself from the bed to a motorized wheelchair, from the motorized wheelchair to the toilet, from the toilet to the shower chair with stand by assistance from the home health aide. After the shower, the patient transferred herself from the shower chair to the toilet and dried herself off to the upper portion of the body and the home health aide dried the lower extremities. The patient transferred herself to the motorized wheelchair and was observed to dress herself with a sun dress type gown. After getting dressed, the patient operated her motorized wheelchair in the bedroom. An oxygen concentrator was observed in the room. b. Review of the start of care comprehensive assessment dated 03/17/16, the primary diagnosis was rheumatoid arthritis followed by secondary diagnoses of fibromyalgia,			

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	bipolar, diabetes mellitus, sleep apnea, hypertension, asthma, and urinary retention. The assessment did not indicate the patient had respiratory treatments used in the home. The assessment indicated the patient received meals from a community delivery service, able to take oral and injection medications independently, chairfast, unable to ambulate and is unable to wheel self, able to feed self independently, patient depends entirely upon another person to dress the upper body, unable to get to and from the toilet but is able to use a bedside commode with or without assistance, the nutritional assessment was left blank and did not specify if the patient was physically able to shop, cook, and or feed him / herself, and the summary indicated the patient must be catheterized 4 times a day, but 3 of the 4 catheterizations were to be provided by the agency nurses. The comprehensive assessment did not include the size of the pediatric catheter. The plan of care failed to include the size of the pediatric foley catheter to be used for in and out catheterizations and failed to include coordination with Mom's meals. The comprehensive reassessment failed to be accurate and completed to support the written plan of care. 5. The clinical record for number 7, SOC			

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	09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. The goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. b. Review of the comprehensive reassessment for recertification dated 03/02/16, the reassessment failed to provide a complete pain assessment, failed to include measurements to the lower extremity edema due to cellulitis, failed to provide wound bed assessment and measurement of the venous stasis			

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	ulcer to the right lower extremity as well as current treatment, failed to complete the nutritional assessment, failed to document the fall risk assessment, failed to document the psychosocial assessment, failed to answer M1840 Toilet transferring assessment, failed to document patient / caregiver / family education, and failed to document a summary / progress of the past 60 days in the summary section. The comprehensive reassessment for was incomplete and failed to support the services provided as written in the plan of care. 6. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month to assess cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / fall prevention, and Oxygen at 2 liters per trach at night. The patient primary diagnosis was Cerebral Palsy, sleep apnea, cerebral vascular accident, coarotation of aorta, and urinary			

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	incontinence. a. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H was observed cooking dinner for the patient. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The plan of care failed to be updated and revised to include trach care, ventilator settings / management, preparing meals, supra pubic catheter care, and suctioning as needed. b. Review of the comprehensive reassessment for recertification dated 03/18/16, the reassessment failed to provide a complete cardiopulmonary assessment, failed to complete the nutritional status, failed to provide an assessment of the suprapubic catheter / insertion site, failed to complete the assessment to the neurological and musculoskeletal system, failed to complete patient / caregiver / family education, and failed to complete a summary of the past 60 days. The comprehensive assessment failed to be accurate and completed to support the written plan of care.			

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	7. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week, to provide a shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, make bed / straighten patient areas. The primary diagnosis indicated carbon monoxide poisoning, followed by secondary diagnoses of lumbago, esophageal reflux, hypothyroidism, and coronary artery disease. a. A form titled "Intake / Referral" dated 03/27/15, indicated the patient was a self referral and the patient had carbon monoxide poisoning in 2011. b. A physician visit note dated 03/03/15, indicated the physician would not diagnose the patient with carbon monoxide poisoning due to the patient had been moved out of the environment and there was no labs to prove the patient had the poisoning although the patient symptom complex was similar to carbon monoxide poisoning. c. A comprehensive reassessment for recertification dated 09/22/15,			

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	indicated the patient was not short of breath, continent of both bowel and bladder. The musculoskeletal system and functional limitations, the neurological assessment, and the summary of care failed to be completed. The primary diagnosis failed to be supported by the comprehensive assessment and physician visit note. The comprehensive assessment failed to be accurate and completed to support the written plan of care. 8. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 9. A policy titled Plan of Care dated 08/15/15, indicated " ... The Plan of Care is based on a comprehensive assessment and information provided y the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The Plan of Care shall be completed in full to include ... All pertinent diagnosis (es), principle and secondary ... Medications, treatments, and procedures, Medical supplies and equipment required .... "			

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	10. A policy titled Comprehensive Patient Reassessments / Updates, Resumption of Care, SCIC (significant change in condition), and Transfer OASIS for Skilled Patients dated 08/15/15, indicated " ... 1. Patients are reassessed to determine their response to care, when significant changes occurred in their condition, their diagnosis, in their environment or support system that affect the plan of care, and when they released from the hospital ... 3. The Registered Nurse is responsible for reassessing the need for Home Care Aide services. 4. Special attention will be paid to patient - centered goal setting, clarifying the patient's personal goals and his / her expectations of the home care services. 5. The assessment will identify the problems, needs, and strengths of the patient and the care the family can provide. The ... ongoing assessments include consideration ... a. Specific individualized patient needs pertinent to the care or service being provided. b. Description of any applicable strength the patient has including physical, psychosocial, and or spiritual resources that increase their ability to respond effectively to treatment and the ability to learn ... d. Appropriateness of the level of care provided by the family or support system to safely meet the patient needs ... f. Need for continuing home care			

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	services. g. Ability / willingness of the patient / family to assume responsibility for healthcare needs .... "			
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 Registered Nurse failed to ensure that the plan of care was supported by the comprehensive assessment for 5 of 11 records reviewed (#5, 6, 7, 9, and 10), failed to update and revise the plan of care to include specific instructions for a bowel program for 1 of 1 record reviewed of patients with bowel program (#4), failed to include the type, frequency and duration of services to be provided (#2), ventilator settings, size of trach, frequency and instruction of trach care to be provided in 3 of 3 records reviewed of patients with trach's (#1, 2, and 9), failed to include directions for application of braces in 1 of 1 record reviewed of patients with braces (#2), failed to include the type of feeding, rate, and frequency of gastrointestinal tube feedings in 2 of 2 records reviewed of patients with tube feedings (#2 and 8), failed to include the size of foley catheters for in out catheterizations in 2 of 2 records reviewed with patients receiving in and out catheterizations (#1	G 0173	G173– Duties of the Registered Nurse Allskilled nurses will be in-serviced on Tag G173 (Duties of the Registered Nurse)by 6/10/16. Individual trainingsessions with Registered Nurses to ensure that the plan of care is implemented,revised, and updated by Registered Nurse and is supported by the comprehensiveassessment which covers all pertinent diagnoses, including mental status, typesof services and equipment required, frequency of visits, prognosis,rehabilitation potential, functional limitations, activities permitted,nutritional requirements, medications and treatments w/specific instructions,(including but not limited to: trach,vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulse oximetry–measurements and sizes) any safety measures to protect against injury,instructions for timely discharges or referral, and any other appropriateitems; and promptly report any changes to the physician that suggest a	06/10/2016

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	and 6), failed to include the size / frequency of changes for suprapubic catheter in 1 of 1 record reviewed for patients with suprapubic catheters (#9), failed to include instructions for foley catheter flushes in 1 of 1 record reviewed of patients with foley catheter irrigations (#1), failed to include instructions for wound treatments in 1 of 1 records reviewed of patients with wound treatments (#7), failed to include the location for the application of powder and ointments in 1 of 1 records reviewed of patients receiving medicated powder and ointments, and failed to include instruction for bathing and meal preps in 1 of 11 records reviewed of patients receiving assistance with bathing and meal prep. (# 1) Findings include: 1. The clinical record for patient number 1, SOC 01/20/15, included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing " to ... O2 [oxygen] at 0.5 - 6 liters 1 minute [per minute] ... administer tach [sic] care, change trach collar QD [every day], suction trach ... I & O cath [in and out catheter] TID [three times a day] and prn [as needed]. Goals indicated the patient would maintain good hygiene and		need toalter the POC ; and Conformance with Physician Orders which include allmedications, treatments and services provided to patients must be ordered by aphysician started on 5/24/16 and ongoing with the Director of Nursing,Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to ensure that the plan of care isimplemented, revised, and updated by Registered Nurse and is supported by thecomprehensive assessment and furnishing services in accordance with the POCwhich covers all pertinent diagnoses, including mental status, types ofservices and equipment required, frequency of visits, prognosis, rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements, medications and treatments w/specific instructions, (includingbut not limited to: trach, vents,cathes, g and j tubes, oxygen, suctioning, wounds, pulse oximetry–measurementsand sizes) any safety measures to protect against injury, instructions fortimely discharges or referral, and any other appropriate items; and promptlyreport any changes to the physician that suggest a need to alter the POC ; andConformance with Physician	

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	comfort and patient safety would be maintained. a. A skilled nursing visit note dated 03/23/16 and 03/24/16 from 12:00 AM to 10:00 AM, indicated the skilled nurse changed out filters and tubing to the patient's vent, trach collar and canula changed out, used a 14 Fr catheter to catheterize the patient, irrigated the patient's catheter with 60 cc of unknown solution, applied Nystatin powder to the folds of the peri area and 40% zinc oxide applied to the patients buttocks. b. A skilled nursing visit note dated 03/24/16 from 4:00 PM to 7:00 PM, indicated the skilled nurse used a 16 Fr catheter to catheterize the patient and irrigated the patient's catheter with 60 cc of saline. c. A skilled nursing visit note dated 03/25/16, indicated the skilled nurse provided stand by assistance with bathing, shampooed the patient's hair, and assisted with meal prep. d. Employee E, a Registered Nurse / Case Manager, was interviewed on 04/06/16 at 3:10 PM. Employee E confirmed the patient had a ventilator but did not know the settings nor did he / she try to obtain those settings from a		Orders which include all medications, treatments andservices provided to patients must be ordered by a physician. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill ensure that the POC is implemented, revised and updated by a RN and issupported by followed by the comprehensive assessment which covers allpertinent diagnoses, including mental status, types of services and equipmentrequired, frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen,suctioning, wounds, pulse oximetry–measurements and sizes) any safety measuresto protect against injury, instructions for timely discharges or referral, andany other appropriate items; and promptly report any changes to the physicianthat suggest a need to alter the POC ; and Conformance with Physician Orderswhich include all medications, treatments and	

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	physician. The employee stated that he / she had tried to obtain the settings from Employee K, but never did receive them. The employee also was not able to indicate what size or type of trach the patient had. e. Employee F, a Licensed Practical Nurse, was interviewed on 04/06/16 at 4:30 PM. The employee stated the patient had to be catheterized, had to be placed on the vent at night, needed suction, and assisted the patient with AM care and meals. Employee F stated he / she did not know the patient's vent settings for it was programmed on a SD (scan disk card) by the hospital during the patient's last hospitalization. The employee stated he / she had received a call from Employee E prior to surveyor's call asking about the patient's ventilator settings. The plan of care failed to include instructions for trach care, size of foley catheter to use for catheterizations, instructions for foley catheter irrigation, vent settings, specific treatment areas for the application of zinc oxide and Nystatin powder, and instructions for assistance with bathing and meal preps. The goals on the plan of care failed to be reflective of the patient's current status and treatment.		services provided to patientsmust be ordered by a physician. Thecommittee member, when educating, will get signed documents of the trainingprovided. Each document signed will beplaced in the staff personnel file and client chart. The committee members will provide a writtenreport of the visit to the Administrator and Director of Nursing within 24hours. The committee will meet thefirst Wednesday of each month to discuss findings and the outcomes and toensure that each finding was addressed and resolved., Effective 4/17/16 andongoing 10% of all clinical records will be audited quarterly for evidence ofthe plan of care is implemented, revised, and updated by Registered Nurse andis supported by the comprehensive assessment and furnishing services inaccordance with the POC which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulseoximetry– measurements and sizes) any safety measures to protect againstinjury,	

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	2. The clinical record for patient number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders for skilled nursing to" ... administer flushes as ordered, O2 [oxygen] during naps / bedtime, administer trach care ... administer feedings." The patient's diagnoses included Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance. a. A start of care comprehensive assessment dated 02/11/16, indicated Pediasure 1.0, 720 milliliters through out the night, Pediasure 410 [sic] milliliters per hour, and Pediasure 1.5, 4 ounce bolus 4 times a day, the patient had both a gastric and jejunostomy feeding tubes, the patient was receiving bolus and continuous feedings, with 35 milliliter flushes of water to the gastric feeding tube and 10 milliliter flushes of water to the jejunostomy feeding tube after night feedings, NPO (nothing by mouth) a 4 x 4 dressing under the patient's trach with 1 liter of oxygen via concentrator when sleeping, the patient had a trach, humidifier for oxygen, ventilator, pulse oximetry to be done every visit and "AFO in progress."		instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders which includeall medications, treatments and services provided to patients must be orderedby a physician. Staff failing to followprocedure will receive additional training with corrective action up totermination. The Quality AssuranceCommittee, Compliance Officer, Administrator and Director of Nursing will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

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	b. Section 16 of the initial plan of care titled "Nutritional Req [requirements]" indicated Pediasure 1.0, 720 milliliters overnight. c. Section 18 of the initial plan of care titled "Activities Permitted" indicated AFOs [braces] were in progress. 1. The plan of care failed to be updated and revised to include the type, amount, and frequency of "flushes", failed to include the route of oxygen usage, failed to include the type of trach and frequency of trach care [including suctioning protocols], failed to include ventilator settings and management of the ventilator, failed to include the management of the humidifier, failed to include pulse oximetry, failed to include the amount of flushes and frequency to both gastric and jejunostomy feeding tubes, failed to include both types of Pediasure feedings along with the the specific tube used for feedings, the amount and rate of all tube feedings, failed to include that the patient was NPO, and failed to indicate the location and frequency of the AFOs to be placed and worn by the patient. 3. The clinical record for patient number			

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	4, SOC 06/19/15, included a plan of care established by a physician for the certification period of 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis and constipation. a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The plan of care failed to be updated and revised to specifically indicate skilled nursing to perform a digital stimulation / bowel program as well as failed to include measurable goals for the program. b. Review of the comprehensive reassessment for recertification dated 08/17/15, indicated the patient was incontinent of bowel on a daily basis. The plan of care failed to be supported by the comprehensive assessment. 4. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to			

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	03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. The patient diagnoses include chronic obstructive pulmonary disease, congestive heart failure, and rheumatoid arthritis. a. During a home visit on 04/12/16 from 9:00 to 9:45 AM, at an Independent Living Apartments, the patient's room was observed to have a large bed in the living quarters with a kitchenette and bathroom. The living space was cluttered with oxygen concentrator (not in use) and other durable medical equipment between the patient bed and entry / door. The patient was observed sitting up in her bed eating a bowel of cereal while the home health aide was sitting in a chair conversing with the patient. After the patient ate, the home health aide took the bowel into the kitchenette and went into the bathroom and picked up the area. The home health aide indicated that the patient has home health aide services from 9:00 AM to 3:00 PM then personal care services from			

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	3:00 PM to 4:45 PM. The home health aide stated that he / she assists the patient with her bathing, picks up around the apartment, runs errands, and provide companionship. b. Review of the comprehensive reassessment for recertification dated 01/21/16, indicated the patient had some dyspnea with exertion. The Nutritional status assessment was left blank and did not specify if the patient has physically able to shop, cook, and or feed him / herself. The reassessment indicated the patient was continent of bowel and bladder. The fall risk assessment was left blank. The reassessment indicated the patient was able to participate in bathing self in shower or tub but required presence of another person for assistance or supervision, able to get to and from the toilet and transfer independently with or without device. The reassessment indicated the patient was able to transfer with minimal human assistance or with use of an assistive device, able to ambulate with use of a one - handed device, able to to independently walk on even and uneven surfaces and negotiate stairs with or without railings. The plan of care failed to be supported by the comprehensive assessment. c. The Administrator, Director of			

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	Nursing, and Assistant Director of Nursing was unable to provide any further information regarding the findings referenced above when asked on 04/18/16 at 3:45 PM. 6. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterizations and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to assist with bed bath, assist with bath chair, pericare, nail care, foot care, pm care, assist with feeding, ambulation assist / mobility, commode, wheelchair, transfer / positioning, feeding, meal set up, oral care, encourage fluids, urine incontinence, check pressure areas, skin care, medication reminders, blood sugar reminders, make bed, and straighten patient area. The patient primary diagnoses was Rheumatoid Arthritis and Fibromyalgia. Secondary diagnoses listed in order were Bipolar Disorder, Diabetes, Sleep Apnea, Hypertension, and Urinary Retention. a. During a home visit on 04/12/16 at 10:30 AM, the patient stated that his / her daughter lived in the home			

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	but the daughter attended college during the day and provided the in and out catheterization at bedtime. The patient was then observed to transfer herself from the bed to a motorized wheelchair, from the motorized wheelchair to the toilet, from the toilet to the shower chair with stand by assistance from the home health aide. After the shower, the patient transferred herself from the shower chair to the toilet and dried herself off to the upper portion of the body and the home health aide dried the lower extremities. The patient transferred herself to the motorized wheelchair and was observed to dress herself with a sun dress type gown. After getting dressed, the patient operated her motorized wheelchair in the bedroom. An oxygen concentrator was observed in the room. b. Review of the start of care comprehensive assessment dated 03/17/16, the primary diagnosis was rheumatoid arthritis followed by secondary diagnoses of fibromyalgia, bipolar, diabetes mellitus, sleep apnea, hypertension, asthma, and urinary retention. The assessment did not indicate the patient had respiratory treatments used in the home. The assessment indicated the patient received meals from a community delivery service, able to take oral and injection			

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	medications independently, chairfast, unable to ambulate and is unable to wheel self, able to feed self independently, patient depends entirely upon another person to dress the upper body, unable to get to and from the toilet but is able to use a bedside commode with or without assistance, the nutritional assessment was left blank and did not specify if the patient was physically able to shop, cook, and or feed him / herself, and the summary indicated the patient must be catheterized 4 times a day, but 3 of the 4 catheterizations were to be provided by the agency nurses. The comprehensive assessment did not include the size of the pediatric catheter. The plan of care failed to be supported by the comprehensive assessment. The plan of care failed to include the size of the pediatric foley catheter to be used for in and out catheterizations and failed to include coordination with Mom's meals. 7. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze			

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	dressing. The goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. Review of the comprehensive reassessment for recertification dated 03/02/16, the reassessment failed to provide a complete pain assessment, failed to include measurements to the lower extremity edema due to cellulitis, failed to provide wound bed assessment and measurement of the venous stasis ulcer to the right lower extremity, failed to complete the nutritional assessment, failed to document the fall risk assessment, failed to document the psychosocial assessment, failed to answer M1840 Toilet transferring assessment, failed to document patient / caregiver / family education, and failed to document a summary / progress of the past 60 days in the summary section. The comprehensive reassessment for recertification was incomplete and failed to support the services provided as written in the plan of care. The plan of care failed to be supported by the comprehensive assessment. b. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower			

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	extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. c. The plan of care failed to be updated and revised to include type of solution to cleanse the lower extremities and the location of wounds to be treated. The goals on the plan of care failed to be reflective of the patient's current status and treatment. 8. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days to to administer medication as ordered, administer gastric tube feedings / flushes as ordered. a. The plan of care failed to be updated and revised to include the amount of tube feeding to be provided, as well as the amount and frequency of flushes. 9. The clinical record for patient number 9, SOC 11/03/09, included a plan of care			

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	established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month to assess cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / fall prevention, and Oxygen at 2 liters per trach at night. The patient primary diagnosis was Cerebral Palsy, sleep apnea, cerebral vascular accident, coarotation of aorta, and urinary incontinence. a. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H was observed cooking dinner for the patient. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The plan of care failed to be updated and revised to include trach care, ventilator settings / management, preparing meals, supra pubic catheter care, and suctioning as needed.			

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	b. Review of the comprehensive reassessment for recertification dated 03/18/16, the reassessment failed to provide a complete cardiopulmonary assessment, failed to complete the nutritional status, failed to provide an assessment of the suprapubic catheter / insertion site, failed to complete the assessment to the neurological and musculoskeletal system, failed to complete patient / caregiver / family education, and failed to complete a summary of the past 60 days. The plan of care failed to be supported by the comprehensive assessment. 10. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week, to provide a shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, make bed / straighten patient areas. The primary diagnosis indicated carbon monoxide poisoning, followed by secondary diagnoses of lumbago, esophageal reflux, hypothyroidism, and coronary artery disease. a. A form titled "Intake / Referral" dated 03/27/15, indicated the			

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	patient was a self referral and the patient had carbon monoxide poisoning in 2011. b. A physician visit note dated 03/03/15, indicated the physician would not diagnose the patient with carbon monoxide poisoning due to the patient had been moved out of the environment and there was no labs to prove the patient had the poisoning although the patient symptom complex was similar to carbon monoxide poisoning. c. A comprehensive reassessment for recertification dated 09/22/15, indicated the patient was not short of breath, continent of both bowel and bladder, failed to complete the musculoskeletal system and functional limitations, failed to complete the neurological assessment, and failed to complete the summary of care (including progress toward goals to date. The primary diagnosis and plan of care failed to be supported by the comprehensive assessment and physician visit note 11. The Administrator, Alternate Administrator, Director of Nursing, and Assistant Director of Nursing was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM.			

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	12. A policy titled Plan of Care dated 08/15/15, indicated " ... The Plan of Care is based on a comprehensive assessment and information provided y the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The Plan of Care shall be completed in full to include ... All pertinent diagnosis (es), principle and secondary ... Medications, treatments, and procedures, Medical supplies and equipment required .... " 13. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Registered Nurse ... c. Initiates the Plan of Care and necessary revisions and updates to the plan care and the care plan .... " 14. A policy titled Scope of Services and Core Skilled Service Provided dated 07/10/15, indicated " ... Services will be coordinated by the Registered Nurse managing the care. This will include implementing, revising, and updating the Plan of Care .... " 15. A policy titled Comprehensive Patient Reassessments / Updates, Resumption of Care, SCIC (significant change in condition), and Transfer OASIS for Skilled Patients dated			

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	08/15/15, indicated " ... 1. Patients are reassessed to determine their response to care, when significant changes occurred in their condition, their diagnosis, in their environment or support system that affect the plan of care, and when they released from the hospital ... 3. The Registered Nurse is responsible for reassessing the need for Home Care Aide services. 4. Special attention will be paid to patient - centered goal setting, clarifying the patient's personal goals and his / her expectations of the home care services. 5. The assessment will identify the problems, needs, and strengths of the patient and the care the family can provide. The ... ongoing assessments include consideration ... a. Specific individualized patient needs pertinent to the care or service being provided. b. Description of any applicable strength the patient has including physical, psychosocial, and or spiritual resources that increase their ability to respond effectively to treatment and the ability to learn ... d. Appropriateness of the level of care provided by the family or support system to safely meet the patient needs ... f. Need for continuing home care services. g. Ability / willingness of the patient / family to assume responsibility for healthcare needs .... "			

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G 0174 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse furnishes those services requiring substantial and specialized nursing skill. Based on observation, record review and interview, the Registered Nurse failed to document a description / assessment of wounds being treated and failed to document the treatment provided for 2 of 2 records reviewed and 1 of 1 home visit of patients with wounds in a sample of 11. (# 7 and 8) Findings include: 1. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The patient's diagnoses were venous stasis ulcer and cellulitis. a. Review of the comprehensive reassessment for recertification dated 03/02/16, indicated the patient had stasis ulcers and wound #1 indicated left lower extremity had cellulitis, with edema, moderate amount of clear, thick drainage. Wound #2 indicated the right lower	G 0174	G174– Duties of the Registered Nurse Allskilled nurses will be in-serviced on Tag G174 (Duties of the Registered Nurse)by 6/10/16. Individual trainingsessions with Registered Nurses to ensure that the RN is furnishing,documenting and assessing services requiring substantial and specializednursing skill as the plan of care is implemented, revised, and updated byRegistered Nurse and is supported by the comprehensive assessment which covers allpertinent diagnoses, including mental status, types of services and equipmentrequired, frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning,wounds, pulse oximetry– measurements and sizes) any safety measures to protectagainst injury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a	06/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/07/2016
NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356	

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	extremity had venous ulcer cellulitis, with edema, moderate amount of clear, thick drainage. The assessment failed to include measurements of the lower extremities as well as measurements and appearance of the venous ulcer. b. Review of the skilled nursing notes dated 03/01, 03/04, 03/05, 03/07, and 03/08/16, indicated the treatments were done as ordered. The RN failed to include a description / assessment of the wounds being treated and description of the treatment being provided. The RN also failed to provide weekly measurements of the venous stasis ulcer. 2. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. a. A skilled nursing visit note dated 02/18/16, indicated the patient recently had surgery to remove two loose pins and replaced it with a rod from the hip to knee in the right leg. The following skilled nursing visits failed to document a complete assessment to the incisional area - 02/18, 02/20, 02/22, 02/23, 02/24,		need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician started on 5/24/16 and ongoing with the Director ofNursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to ensure that the RN is furnishing,documenting and assessing services requiring substantial and specializednursing skill as the plan of care is implemented, revised, and updated byRegistered Nurse and is supported by the comprehensive assessment which covers allpertinent diagnoses, including mental status, types of services and equipmentrequired, frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning,wounds, pulse oximetry– measurements and sizes) any safety measures to protectagainst injury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a	

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	02/25, 02/26, 02/29, 03/02, 03/03, 03/04, 03/07, 03/08, 03/09, 03/10, and 03/11/16. 3. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing stated that the expectation for the nurse to document treatments provided was "as ordered" in regards to clinical record number 7. The Director of Nursing was not able to provide any further documentation or comments in regards to clinical record number 8. 4. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse: a. Performs the initial assessment visit. b. Regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the Plan of Care an necessary revisions and updates to the plan of care and the care plan. d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. informs the physician and other personnel of changes in the patient condition and needs ... g. Prepares clinical and progress notes .... "		need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. On 5/25/16 and ongoing an In Home Quality AssuranceCommittee was developed to make home visits on 10% of clients monthly (untilall clients have been seen) (the committee will continue to make home visits10% quarterly). During the home visitthe committee member will ensure that the RN is furnishing, documenting andassessing services requiring substantial and specialized nursing skill as theplan of care is implemented, revised, and updated by Registered Nurse and issupported by the comprehensive assessment which covers all pertinent diagnoses,including mental status, types of services and equipment required, frequency ofvisits, prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulseoximetry– measurements and sizes) any safety measures to protect againstinjury, instructions for timely discharges or referral, and any	

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			otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. The committeemember, when educating, will get signed documents of the trainingprovided. Each document signed will beplaced in the staff personnel file and client chart. The committee members will provide a writtenreport of the visit to the Administrator and Director of Nursing within 24hours. The committee will meet thefirst Wednesday of each month to discuss findings and the outcomes and toensure that each finding was addressed and resolved., Effective 4/17/16 andongoing 10% of all clinical records will be audited quarterly for evidence ofthe that the RN is furnishing, documenting and assessing services requiringsubstantial and specialized nursing skill as the plan of care is implemented,revised, and updated by Registered Nurse and is supported by the comprehensiveassessment which covers all pertinent diagnoses, including mental status, typesof services and equipment required, frequency of visits, prognosis,rehabilitation potential,	

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			functional limitations, activities permitted,nutritional requirements, medications and treatments w/specific instructions,(including but not limited to: trach,vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulse oximetry–measurements and sizes) any safety measures to protect against injury,instructions for timely discharges or referral, and any other appropriateitems; and promptly report any changes to the physician that suggest a need toalter the POC ; and Conformance with Physician Orders which include allmedications, treatments and services provided to patients must be ordered by aphysician. Staff failing to followprocedure will receive additional training with corrective action up totermination. The Quality Assurance Committee, Compliance Officer, Administratorand Director of Nursing will be responsible for monitoring these correctiveactions to ensure that this deficiency is corrected and will not recur.	
G 0176 Bldg. 00	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. Based on record review and interview,	G 0176	G176– Duties of the Registered	06/10/2016

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	the agency failed to notify the primary care physician in relation to a patient's discharge for 1 of 5 records reviewed of patients discharged by the agency (# 4) , failed to notify the physician of missed visits in 1 of 6 active / current records reviewed (# 6), failed to notify the primary care physician of a patient's elevated blood pressures for 1 of 6 records reviewed of active / current patients (# 6), and failed to notify the primary care physician for a patient with no urinary output for 1 of 2 patients reviewed with in and out catheterizations (# 6), failed to ensure that all treatments provided had a physician's order for 2 of 2 records reviewed of patients with wounds (#7 and 8) and 1 of 1 records reviewed of patients receiving a bowel program (# 4) in a sample of 11. Findings include: 1. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week.		Nurse Allskilled nurses will be in-serviced on Tag G176 (Duties of the Registered Nurse)by 6/10/16. Individual trainingsessions with Registered Nurses to ensure that the RN is preparing clinical andprogress notes, coordinates services, informs the physician and other personnelof changes in the patient's condition and needs and furnishing, documenting andassessing services requiring substantial and specialized nursing skill as theplan of care is implemented, revised, and updated by Registered Nurse and is supportedby the comprehensive assessment which covers all pertinent diagnoses, includingmental status, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulseoximetry – measurements and sizes) any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician	

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	a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The agency failed to ensure physician orders had been obtained prior to digital stimulation / conducting a bowel program. b. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15. c. Review of skilled nursing visit notes, a discharge comprehensive assessment was made on 08/26/15, but the last skilled nursing visit note was dated 09/15/15. d. Review of the home health aide visit notes, the last home health aide visit note was dated 09/08/15. e. The clinical record failed to evidence a physician's order to discontinue services on 08/31/15 as anticipated in the patient's discharge letter, failed to evidence an order to stopped home health aide services on 09/08/15, and failed to evidence an order		Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician started on 5/24/16 and ongoing with the Director ofNursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to ensure that the RN is preparing clinicaland progress notes, coordinates services, informs the physician and otherpersonnel of changes in the patient's condition and needs and is furnishing,documenting and assessing services requiring substantial and specializednursing skill as the plan of care is implemented, revised, and updated byRegistered Nurse and is supported by the comprehensive assessment which coversall pertinent diagnoses, including mental status, types of services andequipment required, frequency of visits, prognosis, rehabilitation potential,functional limitations, activities permitted, nutritional requirements,medications and treatments w/specific instructions, (including but not limitedto: trach, vents, cathes, g and j tubes,oxygen, suctioning, wounds, pulse oximetry–measurements and sizes) any safetymeasures to protect against injury, instructions for timely discharges orreferral, and any	

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	to discharge skilled nursing services on 09/15/15. 2. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention. a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The agency failed to provide documentation that the physician had been notified of the missed visits. b. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified. c. Review of a skilled nursing visit note on 03/23/16 at 10:00 AM, the		other appropriate items; and promptly report any changes tothe physician that suggest a need to alter the POC ; and Conformance withPhysician Orders which include all medications, treatments and servicesprovided to patients must be ordered by a physician. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill ensure that the RN is preparing clinical and progress notes, coordinatesservices, informs the physician and other personnel of changes in the patient'scondition and needs and is furnishing, documenting and assessing servicesrequiring substantial and specialized nursing skill as the plan of care isimplemented, revised, and updated by Registered Nurse and is supported by thecomprehensive assessment which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: trach, vents,	

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	skilled nurse documented the patient had a blood pressure of 149/101. The clinical record failed to evidence that the physician had been notified. 3. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. The clinical record failed to include a physician's order for the treatment that had been provided. 4. The clinical record for number 8, SOC 05/14/12, included a plan of care		cathes, g and j tubes, oxygen, suctioning, wounds, pulseoximetry– measurements and sizes) any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. The committee member, when educating, will getsigned documents of the training provided. Each document signed will be placed in the staff personnel file andclient chart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved., Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence of the that the RN is preparing clinical and progress notes,coordinates services, informs the physician and other personnel of changes inthe patient's condition and needs and is furnishing, documenting and assessingservices requiring	

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	established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. a. A skilled nursing visit note dated 02/18/16, indicated the patient recently had surgery to remove two loose pins and replaced it with a rod from the hip to knee in the right leg. Skilled nursing visit notes dated 03/09 and 03/10/16, indicated that the patient's surgical incision dressing had been changed. The clinical record failed to include a physician's order for the treatment to be provided. 5. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing did not have any further information or documentation in relation to physician orders for wound treatments. 6. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator did not provided further information or documentation in regards to notifying the physician of an impending discharges. 7. A policy titled Physician Orders dated 07/10/15, indicated "All medications,		substantial and specialized nursing skill as the plan ofcare is implemented, revised, and updated by Registered Nurse and is supportedby the comprehensive assessment which covers all pertinent diagnoses, includingmental status, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen, suctioning, wounds, pulseoximetry– measurements and sizes) any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. Staff failing tofollow procedure will receive additional training with corrective action up totermination. The Quality Assurance Committee, Compliance Officer, Administratorand Director of Nursing will be responsible for monitoring these correctiveactions to ensure that this deficiency is corrected and	

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	treatments and services provided to patients must be ordered by a physician 8. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse informs the physician and other personnel of changes in the patient condition of needs .... "		will not recur.	
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 Licensed Practical Nurse [licensed practical nurse] failed to ensure assessments / visit notes were clear, complete and accurate for 3 of 5 records reviewed with LPN providing services in a sample of 11. (#1, 2, and 7) Findings include: 1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and	G 0180	G180– Duties of the Licensed Practical Nurse AllLicensed Practical Nurses will be in-serviced on Tag G180 (Duties of the LicensedPractical Nurse) preparing clinical and progress notes, reports findings andobservations to the Registered Nurse and other members of the team to assurecoordination and timely response to client changes or needs by 6/10/16. On 4/13/16 all staff (nurses (RN and LPN),administration, HHA's, and ancillary staff, etc.) mandatory in-service was sentvia e-mail (for all staff with email addresses), U.S. Post Office mailing forthose without emails, along with a phone call or text explaining the urgencyand severity of the mandated training on 4/13/16 with a mandatory response dead	06/10/2016

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	symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension. a. The clinical record of patient number 1 was reviewed on 04/06/16 at 12:40 PM and indicated the following: 1. The OASIS discharge assessment dated 03/29/16, the summary indicated the patient was found dead at his / her home at 08:00 AM. The patient was in his wheelchair at the kitchen table. 2. Review of the nursing visit notes on 04/06/16 at 12:40 PM, the clinical record failed to contain visit notes 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16. b. An agency investigation note dated 03/29/16 at 9:57 AM, was reviewed and indicated the Director of		line of4/15/16. Training includes PatientRights (including patient and/or family responsibilities, Care Plans andClinical Documentation, Attendance and Reporting (including specific call offprocedures for all staff) along with Progressive Disciplinary Action forfailure to comply. Effective4/18/16 and ongoing the Director of Nursing, Alternate Director ofNursing/Compliance Officer will review clinical and progress notes everyWednesday to ensure LPN's are following POC and reporting findings andobservations to the Registered Nurse and other members of the team to assurecoordination and timely response to client changes or needs. Effective 4/17/16 and ongoing 10% of all clinicalrecords will be audited quarterly for evidence of the that the LPN's ispreparing clinical and progress notes, reporting findings and observations tothe RN and other members of the team to assure coordination and timelyresponses to client changes or needs. Effective 6/1/16 a Medical Records Specialistis hired to review nursing notes (front and back) and POC has date for verbalorders, and back-up filer to ensure notes are accurate and complete in medicalrecords within 14 days, etc. A weeklyreport will be generated and submitted to DON, ADON, Alt. Adm, Administratorand Compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/07/2016

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INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

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	Clinical Services had taken a phone call from Employee F, LPN (Licensed Practical Nurse) at 9:30 AM. Employee F reported that he / she had developed a fever and did not feel that he / she should come to work. Employee F asked the patient if he / she would like for Employee F to notify the office and the patient replied that he / she did not want any of the nurses from the office because of previous issues. Employee F indicated he / she had spoken to the patient around midnight on the phone and messaged with him / her on facebook around 3:00 AM. Employee F indicated he / she had called the patient to let him / her know that he / she was coming to assist him / her around 7:00 AM but the employee got no answer. When Employee F arrived at the patient's home around 8:00 AM, he / she did not get an answer at the door and someone had to let him / her in and that was when Employee F found the patient sitting in his wheelchair at the kitchen table. Employee F called 911. Employee F indicated he / she was trying to follow the client's wishes. The Director of Clinical Services informed Employee F of the immediate suspension pending the investigation. c. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was interviewed on		Officer on missing paperwork and incomplete/inaccuratepaperwork. Staff will be given five(5) days to correct and be re-trained on incomplete paperwork – ongoing. Failure to meet timeline will result insuspension until complete up to termination. The Compliance Office, Administratorand Director of Nursing will be responsible for monitoring these correctiveactions to ensure that this deficiency is corrected and will not recur.	

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	04/06/16 at 1:40 PM. The Director of Clinical Services stated Employee F had failed to return phone calls and text messages, so a letter of termination had gone out to him / her in the mail. At 3:40 PM, the Administrator, Director of Clinical Services, and Assistant Director of Clinical Services were interviewed again. To prevent this occurrence from happening again, measures that had been put into place included reiterating to patients to contact the office when staff fails to show up and there was a live person to take calls 24/7. Another measure included retraining the staff to notify the office for call offs. The Director of Clinical Services stated there was not a sign-in sheet of the staff training. The Director of Nursing stated Employee F knew he / she needed to call in, for he / she had called off a few weeks ago. d. Employee F was interviewed on 04/06/16 at 4:30 PM. The employee stated he / she did not show up at the patient's home as scheduled and did not notify the office of his / her absence per patient wishes. Employee F stated he / she did notify the office and spoke with the Director of Clinical Services in regards to the absence and death. Employee F did confirmed the typed conversation with the Director of Clinical			

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	Services with the exception that he / she observed the patient's facebook as "active" at 3:00 AM, but did not speak with the patient at this time. The Employee also stated he / she was not placed on suspension, but was allowed time off to grieve due to the close relationship he / she had with the patient. The employee stated he / she had not received any text messages or phone calls from the Director of Clinical Services. Employee F stated he / she was contacted today by Employee R, a Registered Nurse / Case Manager, but also stated he / she had another death in the family and had been out of town where phone reception was poor. The employee stated that a scheduler had reached out to him / her on 03/31/16, about taking another case and was planning to send him / her the plan of care. e. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. The Administrator stated Employee F did notify the office the previous evening. The Administrator stated the employee was still fired. The Administrator provided an employee list of names that the Director of Clinical Services produced, of staff who had been in-serviced on call offs. At 10:30 AM,			

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	the Administrator provided Employee F's missing visit notes of patient number 1 and also provided a business news letter. The Administrator stated the news letter went out with payroll, which was within the same week of the patient's death. The news letter stressed the importance of calling the office for call offs and failure to follow the agency policy would result in termination. The 03/27 and 03/28/16 skilled nursing visit notes were not provided. f. On 04/08/16 at 3:00 PM, Employee F was interviewed in person. Employee F provided a text message between him / herself and the patient on 03/28/16, indicating that Employee F continued to be ill and the patient declined to have a replacement nurse. Employee F stated the patient was able to take him / herself off the vent but felt better if someone was there due to random episodes of desaturation when removed and at times, would become unresponsive for a few minutes then return to normal. Both agreed for Employee F to follow up with the patient in the morning of 03/29/16. Employee F provided a text message between him / herself and the Administrator dated 04/07/16 at 5:15 PM. The message indicated "you are suspended pending investigation. Client died and you did			

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	not cover the shift or call the office as policy states." Employee F provided a text message dated 03/31/16, from an unknown scheduler in regards to taking on a new case and another text message dated 04/02/16, indicating the plan of care was going to be sent out. Employee F was questioning why he / she was asked to take on a new client if he / she was suspended. Employee F provided a text dated 04/04/16, where he / she had made contact with the office requesting information about the new case. Employee F also stated that when he / she met with the Alternate Administrator on 04/07/16, he had provided him / her with a $20 gift card for meeting with him. Employee F stated the missing 03/27 and 03/28/16 skilled nursing visit notes were not provided to the Alternate Administrator because the visit notes were to be turned in with the next payroll. Employee F stated he / she had thought he / she would have them to turn in with the new case. g. During a home visit with Employee P, home health aide, on 04/12/16 at 9:00 AM, Employee P was interviewed and had stated he / she had never seen a company newsletter, but then the agency did not have his / her correct address. Employee P also stated he / she had not been told or reminded			

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	about notifying the office about call offs and the repercussions. h. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 AM, Employee I was interviewed and had stated he / she had never seen a company newsletter, nor had he / she been told or reminded about notifying the office about calls offs and the repercussions. i. During a home visit with Employee J, a LPN, on 04/12/16 at 1:40 PM, Employee J was interviewed and stated he / she had not received a company newsletter, but did receive a text from the office the previous week about calls offs, but was unable to remember the specific details of the text nor the date received. j. During a home visit with Employee K, a Registered Nurse on 04/12/16 at 3:40 PM, Employee K was interviewed and stated that he / she would get a company newsletter in an email sometimes but had not received an email within the past few weeks. Employee K stated he / she did get a text the previous week to contact the Director of Nursing for call offs but unable to provide a specific date.			

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	k. During a home visit with Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H was interviewed. Employee H stated that he / she had not received a company newsletter and could not remember the last time he / she had received one. Employee H recalled hearing about call offs a few weeks prior, but don't recall specifics or repercussions. l. The Administrator was interviewed on 04/13/16 at 4:00 PM. The Administrator was in agreement that the text message to Employee F on 04/07/16 at 5:15 PM, had taken place. The Administrator stated she had did that because she had felt bad for the employee and wanted cooperation to get the visit notes. The Administrator had no explanation of the field staff interviews on 04/12/16 in regards to the newsletter and the lack of knowledge of the call off policy and repercussions. m. The detective involved in the patient's death investigation was interviewed on 04/18/16 at 10:16 AM. The Detective stated the initial findings was asphyxiation due to a mucous plug, but the final coroners report would take anywhere from 2 to 3 weeks. The time of death usually would be upon arrival of the coroner, but was unsure at this time.			

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	The projected time of death was anticipated between 6:00 AM to 7:00 AM. The Detective also stated that there was a video that put Employee F's arrival time to the patient's home at 8:35 AM on 03/29/16. The Detective stated Employee M, a home health aide / administrative assistant, came by the police station the previous week and obtained a copy of the report. 2. The clinical record for number 2, SOC 02/11/16, included two plans of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders to" ... administer flushes as ordered, O2 [oxygen] during naps / bedtime, administer trach care ... administer feedings." The patient's diagnoses included Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance. a. A nursing visit note dated 2/24/16, failed to include a cardiovascular assessment, the type and rate of tube feedings [elaborate the meaning "2 hrs [hours] 6 hrs > slow feed"] if the patient was having feeding intolerance's, flushes, a skin assessment, a pain assessment, if trach care had been provided, and the number of incontinent episodes of urine.			

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	b. A nursing visit note dated 2/26/16, failed to properly identify if the patient had a g/tube (gastric feeding tube) and / or j/tube (jejunostomy feeding tube), if the feedings had been provided and tolerance of feedings, flushes, if trach care had been provided, the number of incontinent episodes / assessment of the genitourinary (number of incontinent of urine episodes) and digestive system (bowel sounds and bowel movements). c. A nursing visit note dated 03/01/16, failed to properly identify if the patient had a g/tube and / or j/tube, the rate, frequency, and duration of the feedings, tolerance of feedings, if trach care had been provided, and assessment of the digestive system (bowel sounds and bowel movements). d. A nursing visit note dated 03/03/16, failed to properly identify if the patient had a g/tube and / or j/tube, the rate and duration of the feedings, tolerance feedings, an assessment of the digestive system (bowel sounds and bowel movements), assessment of the neurosensory system, and if trach care had been provided. e. The Assistant Director of Clinical Services was interviewed on			

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	04/13/16 at 2:15 PM, and stated the patient had a j/tube. f. The Director of Clinical Services was interviewed on 04/13/16 at 2:25 PM, and stated the patient had both g/tube and j/tube. 3. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. a. Review of the skilled nursing notes dated 03/02, 03/06, 03/09 to 03/12/16, the LPN failed to include a description / assessment of the wounds being treated and description of the treatment being provided. 4. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing stated the visit notes should have included an assessment of the wounds. 5. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Licensed Practical Nurse: a. Provides service in accordance with			

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	ISHHA [Individual Services Home Health Agency] policy and nursing standards of practice ... d. Reports findings and observations to the Registered Nurse and other members of the team to assure coordination and timely response to client changes or needs. e. Prepares clinical and progress notes .... "			
G 0181 Bldg. 00	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse assists the physician and registered nurse in performing specialized procedures. Based on record review and interview, the Licensed Practical Nurse (Licensed Practical Nurse) failed to ensure that all treatments provided had a physician's order for 2 of 2 records reviewed of patients with wounds in a sample of 11. (# 6 and 7) Findings include: 1. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients	G 0181	G181– Duties of the Licensed Practical Nurse AllLicensed Practical Nurses will be in-serviced on Tag G181 (Duties of theLicensed Practical Nurse) in assisting the Physician and Registered Nurse inperforming specialized procedures by 6/10/16. On 4/13/16 all staff (nurses (RNand LPN), administration, HHA's, and ancillary staff, etc.) mandatory in-servicewas sent via e-mail (for all staff with email addresses), U.S. Post Officemailing for those without emails, along with a phone call or text explainingthe urgency and severity of the mandated training on 4/13/16 with a mandatory response dead line of4/15/16. Training includes PatientRights (including patient and/or family responsibilities,	06/10/2016

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	cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention. a. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified. b. Review of a skilled nursing visit note on 03/25/16 at 9:00 PM, the skilled nurse documented no urine output. The clinical record failed to evidence that the physician had been notified. 2. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a		Care Plans andClinical Documentation, Attendance and Reporting (including specific call offprocedures for all staff) along with Progressive Disciplinary Action forfailure to comply. Effective 6/1/16 aMedical Records Specialist is hired to review nursing notes (front and back)and POC has date for verbal orders, and back-up filer to ensure notes areaccurate and complete in medical records within 14 days, etc. A weekly report will be generated andsubmitted to DON, ADON, Alt. Adm, Administrator and Compliance Officer onmissing paperwork and incomplete/inaccurate paperwork. Staff will be given five (5) days tocorrect and be re-trained on incomplete paperwork – ongoing. Failure to meet timeline will result insuspension until complete up to termination. Effective4/18/16 and ongoing the Director of Nursing, Alternate Director ofNursing/Compliance Officer will review clinical and progress notes everyWednesday to ensure LPN's are assisting the Physician and Registered Nurse inperforming specialized procedures Effective 4/17/16 and ongoing 10% of all clinical records will beaudited quarterly for evidence of the that the LPN's is assisting the Physicianand Registered Nurse in performing specialized procedures. The	

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	LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. The clinical record failed to include a physician's order for the treatment that had been provided. 3. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing did not have any further information or documentation. 4. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Licensed Practical Nurse: a. Provides service in accordance with ISHHA [Individual Services Home Health Agency] policy and nursing standards of practice ... d. Reports findings and observations to the Registered Nurse and other members of the team to assure coordination and timely response to client changes or needs .... "		Compliance Officer, Administrator andDirector of Nursing will be responsible for monitoring these corrective actionsto ensure that this deficiency is corrected and will not recur.	
G 0210 Bldg. 00	484.36(a)(3) HHA TRAINING - DOCUMENTATION The HHA must maintain sufficient			

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	documentation to demonstrate that the requirements of this standard are met. Based on record review and interview, the agency failed to ensure that the home health aide skills competency check offs provided documentation of tasks, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient for 3 of 3 home health aides hired in 2015. (Employees I, N, S) Findings include: 1. The agency personnel files was reviewed on 04/15/16 at 1:30 PM. The files indicated the following: a. Employee I, Date of Hire (DOH) 05/12/14, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a	G 0210	G210– HHA Training – Documentation AllStaff including Home Health Aides will be in-serviced on Tag G210 (Home HealthAide Training - Documentation) by 6/10/16. All HHA's have and were trained on the skills competency check list usinga patient. Effective 5/27/16 the skillscompetency check offs will include a client ID for proof that all Home HealthAides training has been performed on a patient. Agency policy was updated on 5/27/16 toinclude skills competency check offs will include a client ID. A client ID key will be initiated on 5/27/16by the Administrator. 5/27/16 the ClientID key was shared with the BusinessAssociate Agreement and Registered Nurse The client ID key will be updated asnecessary. On 5/27/16 the review ofClient ID's listed on employee competency check offs was added to the review ofnew hire packets, and quarterly review of personnel files. On 5/27/16 staff were in-serviced on thechange in policy to include Client ID's listed on the employee competency checkoffs. The Administrator and Director ofNursing will be responsible for monitoring these corrective actions to ensurethat this deficiency is corrected and will not recur.	06/10/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/07/2016

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INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

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	patient. b. Employee N, DOH 08/18/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. c. Employee S, DOH 02/24/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. 2. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services did not provide any further information by the end of the exit conference on 04/18/16 at 03:40 PM.			
G 0212	484.36(b)(1)			

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	15K025		04/07/2016

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Bldg. 00	COMPETENCY EVALUATION & IN-SERVICE TRAI The HHA is responsible for ensuring that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements of this section. Based on record review and interview, the agency failed to ensure that the individuals who furnish home health aide services on its behalf meet the competency evaluation requirements, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient for 3 of 3 home health aides hired in 2015. (Employees I, N, S) Findings include: 1. The agency personnel files was reviewed on 04/15/16 at 1:30 PM. The files indicated the following: a. Employee I, Date of Hire (DOH) 05/12/14, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath),	G 0212	G212– Competency Evaluation and In-Service Training AllStaff including Home Health Aides will be in-serviced on Tag G212 (CompetencyEvaluation and In-Service Training) by 6/10/16. All HHA's have and were trainedon the skills competency check list using a patient. Effective 5/25/16 and ongoing the CompetencyEvaluation and In-Service Training will include a client ID for proof that allHome Health Aides training has been performed on a patient. Agency policy was updated on 5/27/16 toinclude Competency Evaluation and In-Service Training will include a clientID. A client ID key was initiated on5/27/16 by the Administrator. 5/27/16the Client ID key was shared with theBusiness Associate Agreement and Registered Training Nurse. The key will be updated as necessary. On 5/27/16 the review of Client ID's listedon employee Competency Evaluation and In-Service Training was added to thereview of new hire packets, and quarterly review of personnel files. On 5/27/16 staff were in-serviced on thechange in policy to include Client ID's listed on the employee CompetencyEvaluation and	06/10/2016

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	shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. b. Employee N, DOH 08/18/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. c. Employee S, DOH 02/24/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. 2. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of		In-Service Training. TheAdministrator and Director of Nursing will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

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	Clinical Services did not provide any further information by the end of the exit conference on 04/18/16 at 03:40 PM.			
G 0218 Bldg. 00	484.36(b)(3)(iii) COMPETENCY EVALUATION & IN-SERVICE TRAI The subject areas listed at paragraphs (a)(1)(iii), (ix), (x), and (xi) of this section must be evaluated after observation of the aides performance of the tasks with a patient. The other subject areas in paragraph (a)(1) of this section may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient. Based on record review and interview, the agency failed to ensure that the home health aide was evaluated after observation of the aides performance of the tasks with a patient, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient for 3 of 3 home health aides hired in 2015. (Employees I, N, S) Findings include:	G 0218	G218– Competency Evaluation and In-Service Training AllStaff including Home Health Aides will be in-serviced on Tag G218 (CompetencyEvaluation and In-Service Training) by 6/10/16. All HHA's have and were trainedon the skills competency check list using a patient. Effective 5/25/16 and ongoing the CompetencyEvaluation and In-Service Training will include a client ID for proof that allHome Health Aides training has been performed on a patient. Agency policy was updated on 5/27/16 toinclude Competency Evaluation and In-Service Training will include a clientID. A client ID key was initiated on5/27/16 by the Administrator. 5/27/16the Client ID key was shared with	06/10/2016

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356	

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	1. The agency personnel files was reviewed on 04/15/16 at 1:30 PM. The files indicated the following: a. Employee I, Date of Hire (DOH) 05/12/14, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. b. Employee N, DOH 08/18/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. c. Employee S, DOH 02/24/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or		theBusiness Associate Agreement and Registered Training Nurse. The key will be updated as necessary. On 5/27/16 the review of Client ID's listedon employee Competency Evaluation and In-Service Training was added to thereview of new hire packets, and quarterly review of personnel files. On 5/27/16 staff were in-serviced on thechange in policy to include Client ID's listed on the employee CompetencyEvaluation and In-Service Training. TheAdministrator and Director of Nursing will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

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	shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. 2. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services did not provide any further information by the end of the exit conference on 04/18/16 at 03:40 PM.			
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 agency failed to ensure the home health aide followed the plan of care for 6 of 6 records reviewed with home health aide services in a sample of 11. (#3, 4, 5, 6, 10, and 11) Findings include: 1. The clinical record for number 3, SOC 06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health	G 0225	G225– Assignment and Duties of Home Health Aide AllStaff including Home Health Aides will be in-serviced on Tag G225 (Assignmentand Duties of Home Health Aide) following the POC and reporting any changesthat suggest a need to alter the POC to the Registered Nurse to report to thePhysician by 6/10/16. Effective 4/17/16 andongoing 10% of all clinical records will be audited quarterly for evidence ofthe HHA's are following POC and reporting any changes to the Registered Nursethat suggest a need to alter	06/10/2016

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	aide services 14 hours per week, 1 - 2 hours per day, 7 days a week for 9 weeks. The patient diagnoses included, but limited to arthritis, coronary artery bypass graft, coronary artery disease, diabetes, and autonomic instability. a. Review of the clinical record on 04/07/16 at 1:54 PM, the clinical record failed to evidence home health aide visits from 06/22/15 to 07/14/15, 07/15/15, 07/16/15, and 07/18/16 to 07/27/15. b. The Administrator on 04/07/16 at 4:00 PM, and provided a typed statement indicating that employee E, a Registered Nurse / Case Manager, that the patient had been complaining about not getting all of his / her hours. The statement indicated the Administrator had spoken to employee L, a Home Health Aide and Manager of a Personal Service Agency owned by the Administrator. The statement indicated Employee L had spoken with the patient and the patient was not satisfied with the staff Employee L was sending, the patient wanted the agency to hire a family member, and was holding the agency off. The statement indicated the Administrator had left a message on the patient's phone on 7/23, 7/24, 7/27, and 7/28/15. On 7/25/15, the statement		the POC to be reported to the Physician . Effective 4/18/16 Management personnel wereinstructed to transfer all complaints from patients or caregivers (includingschedules and staffing) to the Administrator or Director of Nursing or designee. All complaints will be investigated anddocumented with a resolution. Ifresolution of the complaint was not possible, the actions that were attemptedand the outcomes will be documented by ISHHA. On 5/27/16 policy was updated toinclude a letter will be sent to the patient upon resolution (will include theactions that were attempted and the outcomes). A copy of the letter will accompany the ISHHA investigation. On 5/25/and ongoing an In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all clients have been seen) (the committee will continue to make homevisits 10% quarterly). During home visits, thecommittee members will review the POC and HHA documentation to ensure HHA's arefollowing POC and documenting as POC states, Registered Nurse will alert thePhysician if documentation suggest a need to alter the POC. The committee member,when educating, will get signed documents of the training provided. Each document signed will be placed in thestaffs personnel file. Thecommittee will	

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	indicated the patient had emailed Employee M, also a home health aide and coordinator for both the home health agency and personal services agency, and had asked about hiring the patient's sister [name of sister was included]. The statement indicated Employee M had informed the patient that he / she was unaware of the request and would investigate it. The statement indicated the Administrator and Employee M had talked with the patient and the patient indicated "it didn't matter he / she fired us and was going with an agency that would hire his / her sister in one day." The Administrator stated new staff must have orientation for approximately 1 week. c. Patient number 3 was interviewed on 04/07/16 at 7:00 PM. The patient had stated that the named sister in the statement, was a patient of the agency's and had been for many years. The patient stated he / she used to work for the agency and took care of the named sister until he / she had their own surgery in 2009. The patient stated that his / her niece currently works for the agency and was taking care of the mentioned sister. The patient stated he / she would never ask to have his / her niece removed from the sister's care. The patient stated that he / she did not want weekend staff, but wanted to take the weekend hours and		meet the first Wednesday of each month to discuss findings andthe outcomes and to ensure that each finding was addressed and resolved. Effective 6/1/16 and ongoing a HHA DocumentationReview Committee was established to audit 10% of all HHA documentationquarterly for evidence that the HHA's are following POC and reporting anychanges that suggest a need to alter the POC to the Registered Nurse to bedocumented and reported to the Physician. Thecommittee will provide audit results to the staff's "Point of Contact" personfor re-training of HHA's, the Administrator and DON. A training document will be placed in thepersonnel file. The Administrator andDirector of Nursing will be responsible for monitoring these corrective actionsto ensure that this deficiency is corrected and will not recur.	

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	apply it to the week day hours. The patient stated he / she had never canceled or refused a visit, but complained to the agency about not having home health aides to his / her home as ordered. The patient stated on one occaision, a home health aide was in an accident on his / her way to the patient's home, but the home health aide was not replaced. The patient stated the agency told him / her would need to find another agency. d. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 PM. The Director of Clinical Services stated she was not aware of the missing home health aide visits. The Director of Clinical Services stated she mostly manages the nursing and the Administrator, Employee L and Employee M managed the home health aides. e. Employee M and the Administrator were interviewed on 4/18/16 at 2:25 PM. Employee M stated he / she was a home health aide and nothing further. The Administrator stated Employee M did helped with coordination as well. Employee M was not able to recall the event nor conversation with the patient. After the statement was read, Employee M was not able to add any further information and			

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	indicated the statement summed up the situation. The Administrator stated the name mentioned in the statement must have been wrong. 2. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis. a. Review of the home health aide visit notes indicated the following: 1. The home health aide provided (4) 2 hour visits on 07/19, 07/20, 07/22, 07/23, 08/04, and 08/30/15. 2. The home health aide provided a 4 plus hour visits on 07/24, 08/10, and 08/17 (6:30 PM to 10:30 PM), 07/27, 07/31, 08/18 (6:00 PM to 10:15 PM), 07/28, 07/30, 08/11, 08/16, 08/20, 08/25, 08/27 (6:00 PM to 10:00 PM), 08/21/15 (6:20 PM - 10:20 PM), and 08/10 and 08/17/15 (6:00 PM to 10:30 PM). 3. The home health aide provided a 6 plus hour visit on 08/30/15			

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	(9:00 AM to 3:15 PM). 4. The home health aide provided (2) 3 hour visits on 09/01 to 09/08/15 (6:00 PM to 9:00 PM / 8:00 PM to 11:00 PM) and a single 3 hour visit on 07/25/15 (8:00 PM to 11:00 PM). 5. The home health aide provided (2) visits on 07/21, 07/25, 07/31, 08/03, 08/10, 08/11, 08/14, 08/17, 08/25, 08/27, 08/29, and 09/01 to 09/08/15. The home health aides failed to follow the plan of care. b. The plan of care indicated the home health aide was to provide assistance with tub / shower, assist bath - chair, pericare, nail care - file only, foot care, ambulation assist / mobility to commode and with wheelchair, transfer or positioning, encourage fluids, incontinent care of urine, check pressure areas, skin care with lotion, make bed / straighten patient areas, and range of motion to all extremities. 1. Review of the home health aide visits notes dated 07/19 to 07/24/15, 07/27 to 07/29, 08/02, 08/04 to 08/07, 08/10, 08/12, 08/14, 08/16, 08/17, 08/18, 08/19, 08/20, 08/24, 08/27, 08/28, 08/30, 08/31, and 09/01 to 09/08, 2015, failed to evidence that tub / shower, assist			

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	bath - chair, pericare, nail care - file only, foot care, ambulation assist / mobility to commode and with wheelchair, transfer or positioning, encourage fluids, incontinent care of urine, check pressure areas, skin care with lotion, make bed / straighten patient areas, and / or range of motion to all extremities had been provided. The home health aide failed to follow the plan of care. 3. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. a. Review of the home health aide notes dated 02/15, 02/19, 02/20, 02/21, 02/22, 02/26, 02/29, 03/04, 03/05, 03/06, 03/07, 03/11, 03/14, 03/17, 03/18, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, and 03/28/16, the home health aide documented "NN" (Not Needed) for bathing, pericare, nail care,			

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	foot care, pm care, ambulation assist / mobility, assist with feeding, incontinent care, checking pressure areas, skin care, medication assistance, and / or making the bed / straighten patient area. The home health aide failed to follow the plan of care. b. Review of the home health aide visit notes dated 02/14/16 to 02/17/16, 02/19/16 to 03/16/16, 03/18/16 to 03/21/16, 03/23 to 03/25/16, 03/17/16, and 04/02/16, the home health aide indicated he / she had provided services to the patient from the hours of 9:00 AM. to 3:00 PM. On 02/18/16 and 03/26/16, the home health aide indicated he / she had provided services from 10:30 AM to 3:30 PM. On 03/17/16, the home health aide indicated he / she had provided services from 12:00 PM to 4:00 PM. On 03/22/16, the home health aide indicated he / she had provided services from 9:00 AM to 11:50 AM. On 03/28/16, the home health aide indicated he / she provided services from 9:00 AM to 7:25 PM. The home health aide failed to follow the plan of care. c. During a home visit on 04/12/16 at 9:00 AM., the patient's agency binder was reviewed. The binder included a page of a breakdown of home health aide and attendant care hours			

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	through the personal services agency owned by the Administrator. The page indicated 9:00 AM to 11:00 AM, 11:30 AM to 12:30 PM, 1:00 PM to 2:00 PM, and 2:15 PM to 4:15 PM, and weekends 9:00 AM to 3:00 PM services were to be home health aide hours through the home health agency. The other times 11:00 AM to 11:30 AM, 12:30 PM to 1:00 PM, and 2:00 PM to 2:15 PM, services were to be provided with the personal services agency. d. The home health aide, Employee P, was interviewed during this time. The employee stated that he / she was unfamiliar with the breakdown of time sheet and pulled the sheet from the binder. Employee P stated she works from 9:00 AM to 3:00 PM and does the personal care services from 3:00 PM to 4:45 PM. e. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 p.m. The Director of Nursing stated the home health aides should have been following the plan of care. 4. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for home health			

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	aide services (2) 2 hour visits and (1) 1 hour visits per day 7 days a week. a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The skilled nurse failed to follow the plan of care. b. Review of the home health aide visit notes dated 03/17, 03/18, 03/21 to 03/25/16, the home health aide provided services from 9:00 AM to 3:45 PM. Review of the home health aide visit notes dated 03/19, /03/20, and 03/26/16, the home health aide provided services from 9:00 AM to 2:00 PM. The home health aide failed to follow the plan of care. c. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 a.m., the employee stated he / she did not have a written plan of care to follow and did not know his / her hours of care between the home health agency and the personal service agency that was also owned by the Administrator. The patient stated that he / she had to cancel a few nursing visits due to a nurse who caused him / her pain during a catheterization and he / she			

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	wanted to get rid of the pain before the next catheterization. The patient also stated that he / she had a problem with nurses not coming as scheduled and would not call to let her know that they would be late. The patient stated the times should be 9:00 to 10:00 AM, 1:00 to 2:00 PM, and 5:00 to 6:00 PM. The patient stated that he / she had things to do and can't wait all day for the nurses to come. d. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 p.m. The Director of Clinical Services stated the home health aide new his / her schedule and a written plan of care was put in the patient's home a few weeks prior. The Director of Clinical Services also stated the patient had the tendency to not be home when nurses arrived even when the visits were prescheduled. 5. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and make bed / straighten patient			

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	areas. a. Review of the home health aide visit notes, the record failed to evidence a home health aide visit on 10/5/15 and 10/25. The home health aide failed to follow the plan of care. b. Review of the home health aide notes dated 10/01, 10/02, 10/06, 10/07, 10/08, 10/09, 10/12, 10/14, 10/15, 10/17, 10/18, 10/23, and 10/24/16, the home health aide documented "NN" (Not Needed) for shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and / or make bed / straighten patient areas. The home health aide failed to follow the plan of care. 6. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health aide services 3 hours per day 5 days a week to assist with bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care			

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	(lotion), and make bed / straighten client area, range of motion exercises (all extremities). a. Review of the home health aide visit notes during the certification period of 08/19/15 to 10/17/15, the home health aide failed to evidence 5 visits during week 1, 1 visit during week 2, 5, and 7, and 2 visits during week 3, 4, and 6. The home health aide failed to follow the plan of care. The home health aide provided 2 extra visits during week 8 and 9. b. Review of the home health aide visit notes dated 08/27, 08/28, and 08/31/15, the home health aid provided 6 hour visits. The home health aide failed to follow the plan of care. c. Review of the home health aide notes dated 08/25 to 08/27, 09/02, 09/04, 09/09, 09/14 to 09/17, 09/22 to 09/24, 09/28 to 09/30, 10/04 to 10/17/15, the home health aide documented "NN" (Not Needed) for bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care			

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	(lotion), and make bed / straighten client area, range of motion exercises (all extremities). The home health aide failed to follow the plan of care. 7. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all patient visit notes had been provided. 8. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 9. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to e provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... "			
G 0235 Bldg. 00	484.48 CLINICAL RECORDS Based on record review and interview, the agency failed to ensure the missed visit notes and supervisory visits forms were filled out accurately for 2 of 11 records reviewed, failed to ensure nursing	G 0235	G235– Clinical Records AllStaff will be in-serviced on Tag G235 (Clinical Records) by 6/10/16 (includingbut not limited to: accuracy andcompletion of missed visit notes, accuracy and	06/10/2016

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	visit notes that were faxed to the office, were faxed in its entirety for 2 of 11 records reviewed, failed to ensure the plan of care included a date of the verbal order for 1 of 11 records reviewed, and failed to incorporate visit notes into the medical record within 14 days of the visit for 6 of 11 records reviewed. 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.		completion of supervisory visitforms, accuracy and completion of skilled nurse notes front and back (everyMonday), POC include date of verbal orders and all notes are in medical recordswithin 14 days. Nurse visit notes are entered as received intothe tracker and tracked back to the schedule. A comparison report is generated on each Wednesday to determine if thereare missing nurse visit notes. Thestaff, that have missing nursing notes or have not submitted the back copy,will be contacted on each Wednesday , in their method of communication and willhave until each Friday to submit. Stafffailing to submit timely will be suspended until missing nursing notes or thesubmission of the back copy are received. ISHHA will assist staff in receiving nursing notes by means of gascards, gift cards, kind words, picking them up to ensure ISHHA stays in complianceand this deficiency will not recur. Effective 6/1/16 a Medical Records Specialistwas hired to review and track missed visit forms, supervisory visit forms,nursing notes (front and back) and POC has date for verbal orders, and back-upfiler to ensure notes are accurate and complete in medical records within 14days, etc. A weekly report will begenerated and submitted to DON, ADON, Alt. Adm, Administrator and	

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			ComplianceOfficer on missing paperwork and incomplete/inaccurate paperwork. Staff will be given five (5) days tocorrect and be re-trained on incomplete paperwork – ongoing. Failure to meet timeline will result insuspension until complete. Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence of missed visit notes and supervisory visit from are filled out intheir entirety and accurate, nurse visit notes are received front and back and completeand accurate, and the POC have dates included for verbal orders and all notesare in medical record within 14 days. The Administrator and Director of Nursing will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	
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.			

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	Based on record review and interview, the agency failed to ensure the missed visit notes (#3 and 11) and supervisory visits forms (#3) were filled out accurately for 2 of 11 records reviewed, failed to ensure nursing visit notes that were faxed to the office, were faxed in its entirety (#1 and 8) for 2 of 11 records reviewed, failed to ensure the plan of care included a date of the verbal order (#8) for 1 of 11 records reviewed, and failed to incorporate visit notes into the medical record within 14 days of the visit for 6 of 11 records reviewed. (#1, 5, 6, 7, 9, and 11) Findings include: 1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week. a. Review of the skilled nursing visit notes between March 1, 2016 to March 26, 2016, the clinical record failed to evidence the back pages of the skilled nursing visit notes on 03/02/16 from 12:00 AM to 10:00 AM and 04:00 PM to 07:00 PM, 03/03/16 from 04:00 PM to 07:00 PM, 03/05/16 from 09:00 PM to	G 0236	G236– Clinical Records AllStaff will be in-serviced on Tag G236 (Clinical Records) by 6/10/16 (includedbut not limited to: documentation willbe completed and accurate for each service rendered on the day the service, willbe filed in medical record within 14 days, documentation will show interchange,reporting and coordination of patient care that occurred, documentation will belegible, documentation errors will be have one line through the entry in such away that the written information underneath may still be read, initial and dateentry, write corrected information near entry or where the correct entry can befound and Physician Orders will include date, specific order, signed with fullname and title of the person receiving the order. On5/27/16 staff processing documentation sheets were trained on proper, legibledocumentation and error correction. A weekly report will be generated andsubmitted to DON, ADON, Alt. Adm, Administrator and Compliance Officer onmissing paperwork and incomplete/inaccurate paperwork. Staff will be given five (5) days tocorrect and be re-trained on incomplete paperwork – ongoing. Failure to meet timeline will result insuspension up to termination until complete. ISHHAwill assist staff in receiving notes/paperwork	06/10/2016

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	12:00 AM, 03/06/16 from 12:00 AM to 10:00 AM and 09:00 PM to 12:00 AM, 03/07/16 from 12:00 AM to 10:00 AM, 06:00 PM to 09:00 PM, and 09:00 PM to 12:00 AM, and 03/08/16 from 12:00 AM to 10:00 AM. b. The clinical record was reviewed on 04/06/16 at 12:40 PM. The clinical record failed to evidence visit notes from Employee F on 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16. c. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. At 10:30 AM, the Administrator provided Employee F's missing visit notes of patient number 1. Skilled nursing visit notes dated 03/27 and 03/28/16 continued to be missing. 2. The clinical record for number 3, SOC 06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health aide services 14 hours per week, 1 - 2 hours per day, 7 days a week for 9 weeks. a. A form titled "Aide Supervision Note" dated 07/22/15, the note indicated the home health aide was		by means of gas cards, giftcards, kind words, picking them up to ensure ISHHA stays in compliance and thisdeficiency will not recur. Effective 6/1/16 a Medical Records Specialist washired to track missing and inaccurate/incomplete documentation forms, verbalPhysician Orders and file in medical records within 14 days, etc. A weekly report will be generated andsubmitted to DON, ADON, Alt. Adm, Administrator and Compliance Officer onmissing paperwork and incomplete paperwork. Staff will be given five (5) days to correct and be re-trained onincomplete paperwork – ongoing. Failureto meet timeline will result in staff suspensionupt to termination untilcomplete. Effective 4/17/16 and ongoing 10%of all clinical records will be audited quarterly for evidence of missing,inaccurate, incomplete documentation forms filed in medical record within 14days and verbal orders and written orders to follow within 21 days. The Administrator and Director of Nursingwill be responsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

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	present and the assessment of care given to the patient was good. The supervisory note failed to include the name of the home health aide present during the supervisory visit. A form titled "Missed Visit Report" indicated the patient had missed visits per patient request between 07/18/15 to 07/24/15. Review of the home health aide visit notes, the record failed to include a home health aide visit note for the date of 07/22/15. b. The patient was interviewed on 04/07/16 at 7:00 PM. The patient stated he / she did not cancel or refused services from the agency. c. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services did not have any further information or documentation when asked. 3. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week.			

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	a. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15. b. Review of skilled nursing visit notes, a discharge comprehensive assessment was made on 08/26/15, but the last skilled nursing visit note was dated 09/15/15. c. Review of the home health aide visit notes, the last home health aide visit note was dated 09/08/15. d. The clinical record failed to evidence a physician's order to discontinue services on 08/31/15 as anticipated in the patient's discharge letter, failed to evidence an order to stopped home health aide services on 09/08/15, and failed to evidence an order to discharge skilled nursing services on 09/15/15. The record also failed to include a discharge OASIS assessment on or after 09/15/15. e. An interview with patient number 4 on 04/12/16 at 7:30 PM, the patient indicated he / she had received two letters of discharge. The patient stated he / she did not refuse nursing nor			

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	did he / she refused home health aides. The patient stated he / she did not like the team leaders that came into his / her home and his / her last complaint was over a home health aide that spit over his / her food when he / she spoke. The patient stated he / she had to be fed and he / she would lose his / her appetite and couldn't eat. f. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing stated the discharge comprehensive assessment was for the discontinuation of nursing only and home health aide to continue beyond the assessment date. g. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator stated the patient constantly wanted team leaders and refused the home health aides. The Administrator did not provided further information or documentation in regards to continuing services and providing the patient with a new discharge date. 4. The clinical record for patient number 5, SOC 03/01/10, included a plan of care established by a physician for the certification period of 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour			

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	visits daily 7 days a week . The clinical record failed to include visit notes after 03/28/16. 5. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterization and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week. The clinical record failed to include visit notes after 03/26/16. 6. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week. The clinical record failed to include visit notes after 03/12/16. 7. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days.			

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	a. Review of the skilled nursing visit notes from 02/13 to 03/11/16, the progress notes on the back side of the assessment page contained information of care that the skilled nurse provided through out his / her visit. Skilled nursing visit notes after 03/14 to 03/23/16 failed to include progress notes on the back side of the assessment notes. 8. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month . a. Review of the comprehensive reassessment for recertification dated 03/18/16 and review of the plan of care, the Registered Nurse failed to document date of the verbal accepted by the physician for the patient's recertification. b. The clinical record failed to include visit notes after 03/12/16. 9. The clinical record for patient number 11, SOC 02/20/15, included two plans of care established by a physician for the certification periods of 08/19/15 to 10/17/15 and 10/18/15 to 12/16/15, with			

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	orders for home health aide services. a. A form titled "Missed Visit Report" dated 10/06/15, indicated there would be missed visits from 10/07/15 to 11/22/15, per family request due to a fall break. Review of the home health aide visit notes, the home health aide made visits from 10/07/15 to 10/17/15. The agency failed to ensure the clinical record contained accurate information. b. A form titled "Missed Visit Report" dated 10/24/15, indicated there would be missed visits from 10/25/15 to 10/27/15, per family request due to the holidays. Another form titled "Missed Visit Report" dated 10/26/15, indicated there would be missed visits from "10-18/26/15" and visits were rescheduled for 10/27/15, per family request. The agency failed to ensure missed visits missed visits were written in a timely manner and written in a clear understanding. c. A form titled "Missed Visit Report" dated 11/06/15, indicated there would be a missed visit on 11/06/15, per family request. Review of the home health aide visit notes, a home health aide visit was made on 11/06/15. The agency failed to ensure the clinical record contained accurate information.			

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	d. A form titled "Missed Visit Report" dated 11/10/15, indicated there would be a missed visit on 11/10/15. The form failed to include if the cancellation was per family request or for other reasons. e. A form titled "Missed Visit Report" dated 11/13/15, indicated there would be a missed visit on 11/13/15. The form failed to include if the cancellation was per family request or for other reason. 13. A form titled "Missed Visit Report" dated 11/06/15, indicated there would be a missed visit on 11/06/15, per family request. Review of the home health aide visit notes, a home health aide visit was made on 11/06/15. The agency failed to ensure the clinical record contained accurate information. 10. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all clinical visit notes to date had been provided to the surveyor and nothing was waiting to be filed. By 4:00 PM, no further notes had been provided by the Administrator. 11. The Administrator was interviewed on 04/18/15 at 2:25 PM. The Administrator had indicated that the			

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	patient / caregiver could have changed his / her mind about the missed visit after calling to cancel the visit. 12. On 04/18/16 at 3:10 PM, the Assistant Director of Nursing had indicated the expectation of notes faxed from outlying areas, would be mailed to the office and the faxed note would be replaced with the original note. 13. 12. A policy titled "Medical Record Management, Documentation of Changes, Confidentiality and Retention of Clinical Records" dated 07/10/15, indicated " ... Clinical Record ... Required documentation for each service or care provided must be completed on the day the services is rendered and filed in the clinical record within fourteen (14) days ... Documentation shall show effective interchange, reporting, and coordination of patient care that occurred. All documentation must be legible ... There shall be no obliteration of entries by erasures, whiting - out, and pasting over, et., in the patient's medical record. To correct an error in the clinical record, the following method should be used: a. Draw a single line though the entry in such a way that the written information underneath may still be read. Initial and date the entry. b. Write corrected information near the entry or where the			

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	correct information is found .... " 14. A policy titled "Physician Orders" dated 07/10/15, indicated " ... When the nurse receives a verbal order from the physician, he / she shall write the order as given ... The order must include the date, specific order, be signed with the full name and title of the person receiving the order .... "			
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 review a sample of both active and closed clinical records, develop, implement, maintain, and evaluate a Quality Assessment and Performance Improvement (QAPI) program quarterly. The agency also failed to delineate the home health agency and the personal service agency notes and information. Findings include: 1. On 04/15/16 at 10:10 AM, the Quality	G 0250	G250– Clinical Record Review Allstaff will be in-serviced on Tag 250 (Clinical Record Review) by 6/10/16. On 5/27/16 QAPI committee werere-trained on developing, implementing, maintaining and evaluating a performance improvement quality assessment plan to measure, assess,and improve the performance of clinical and other processes with a cleardelineation of agencies quarterly. The plan willreflect the complexity of the home health organization (only) and its services, including those services(included but not limited to: clinicalrecords review,	06/10/2016

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	Assessment Performance Improvement (QAPI) book / or equivalent was requested. At 10:50 AM, the binder was provided. At 11:14 AM, the QAPI binder was reviewed. The binder failed to include any information in the Performance Improvement Plan (PIP), clinical record reviews, corporate compliance plan, and customer satisfaction surveys sections. At 11:56 AM, the Administrator was requested to provide the minutes and any other information in regards to their QAPI program. At 12:10 PM, the Admnistrator and the Assisting Director of Clinical Services provided their notes as well as other member notes to review. At 1:15 PM, the information provided was reviewed. The agency failed to produce identification of any current issues and progress of issues that had been previously identified. 2. The Quality Assessment Performance Improvement was reviewed on 04/15/16 at 1:15 PM. The notes reviewed indicated the last two meetings dated 09/23/15 and 12/2015, combined both Individual Support Home Health Agency and Individual Support Services upon discussion of hired employees in the Middletown, Martinsville, and Noblesville offices. The notes also included a notation about how to track		corporate compliance plan, customer satisfaction survey, etc.) provideddirectly or under arrangement, to identify current issues andthe progress of previously identified issues. The plan will be designed to use objective measures to improve clientoutcomes and the perceptions of clients/families about the quality andvalue of services. Effective 6/1/16 a MedicalRecords Specialist was hired to take minutes and combine notes, specifically toISHHA, and type the PIP quarterly report. The Quarterly PIP report and meeting minutes will be submitted to theQAPI committee within 48 hours of meeting. Report and minutes will be in the same binder with a signed reviewedsheet by the Administrator. TheAdministrator and Director of Nursing will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

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	the attendant care and homemakers. 3. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services did not have any further information in regards to their QAPI program by exit on 04/18/16 at 3:10 PM.			
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 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 patient medications had been reviewed to	G 0330	G330 – ComprehensiveAssessment of Patients Allstaff will be in-serviced on Tag 330 (ComprehensiveAssessment	06/10/2016

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	identify any potential adverse effect and drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy for 2 of 11 records reviewed in a sample of 11 (See G 337); failed to ensure the comprehensive reassessments were accurate and / or completed to support the services provided as written in the plan of care for 7 of 9 records reviewed of patients recertified for another 60 days in a sample of 11 (See G 339), and failed to ensure that the discharge assessments / OASIS elements were completed at the time of discharge for 2 of 2 patients discharged with skilled services in a sample of 11 (See G341). 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.		of Patients) by 6/10/16. Individual trainingsessions with Case Managers to train on ComprehensiveAssessment of Patients (including but not limited to: the accuracy and detail completion of theassessment to support the POC, patient specific, current health status,information that may be used to demonstrate the patient's progress towardachievement of desired outcomes and measurable goals, coordination of care, thecontinuing need for home care, meet the patient's medical, nursing,rehabilitative, social, and discharge planning, type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, catheters (size andtype), wounds, size, measurements, instructions for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge assessments/OASIS at the time of patient discharge startedon 5/24/16 and ongoing with the Director of Nursing, Alternate Director ofNursing/Compliance Officer. An all CaseManager	

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			training session has been scheduled for Friday, June 17, 2016 to trainon Comprehensive Assessment of Patients (includingbut not limited to: the accuracy and detailcompletion of the assessment to support the POC, patient specific, currenthealth status, information that may be used to demonstrate the patient'sprogress toward achievement of desired outcomes and measurable goals, coordinationof care, the continuing need for home care, meet the patient's medical, nursing,rehabilitative, social, and discharge planning, type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, catheters (size andtype), wounds, size, measurements, instructions for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge assessments/OASIS at the time of patient discharge. Effective 6/1/16 a MedicalRecords Specialist was hired to track the date the initial assessment isdue. The Medical Records staff	

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			willnotify the DON and Administrator if timeframe not met. 6/1/16 a form was be added as achecklist and/or auditing tool for assessments for RN, Medical RecordsSpecialist, for chart audits, etc. Theform will serve as a check and balance system by asking questions and/or givingreminders for an accurate and detailed assessment. The DON and/or theAdministrator will contact nurse with a 24 hour turn around – suspension up totermination will follow if timelines not met. Effective 4/17/16 and ongoing 10% of all clinical records will beaudited quarterly for evidence Comprehensive Assessment ofPatients (including but not limited to: the accuracy and detail completion of theassessment to support the POC, patient specific, current health status,information that may be used to demonstrate the patient's progress towardachievement of desired outcomes and measurable goals, coordination of care, thecontinuing need for home care, meet the patient's medical, nursing,rehabilitative, social, and discharge planning, type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning,	

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			catheters (size andtype), wounds, size, measurements, instructions for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge assessments/OASIS at the time of patient discharge. TheCompliance Officer, Administrator and Director of Nursing will be responsiblefor monitoring these corrective actions to ensure that this deficiency iscorrected and will not recur.	
G 0337 Bldg. 00	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must 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 review and interview, the agency failed to ensure patient medications had been reviewed to identify any potential adverse effect and drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy for 2 of 11 records reviewed in a sample of 11.	G 0337	G337– Drug Regimen Review Allstaff will be in-serviced on Tag 337 (Drug Regimen Review) by 6/10/16. Individual trainingsessions with Case Managers to train on complete and accurate Drug RegimenReview of patient review of patient medications to identify anypotential adverse effect and drug reactions, ineffective drug	06/10/2016

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	(#2 and 5) Findings include: 1. The clinical record for number 2, SOC 02/11/16, included plan of care established by a physician for the certification period of 02/11/16 to 04/10/16. The clinical record contained two forms, both undated, indicating adverse effects / reaction, significant side effects, significant drug interaction, duplicative drug therapy, potential actual ineffective therapy, understands instructions, needs further instructions, potential noncompliance issues with drugs, effectiveness of drug therapy, and immediate desired effects. One form was incomplete and failed to answer yes or no to the questions and the other form did answer yes and no but failed to provide a date of review. 2. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 03/27/16 to 05/25/16. The medication form failed to indicate adverse effects / reaction, significant side effects, significant drug interaction, duplicative drug therapy, potential actual ineffective therapy, understands instructions, needs further instructions, potential noncompliance		therapy,significant side effects, significant drug interactions, duplicate drug therapyand noncompliance with drug therapy reviewed every 60 days and updated wheneverthere is a change or discontinuation inmedication. The RN will sign and datethe profile started on 5/24/16 and ongoing with the Director of Nursing,Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on complete and accurate DrugRegimen Review of patient review of patient medications to identify anypotential adverse effect and drug reactions, ineffective drug therapy,significant side effects, significant drug interactions, duplicate drug therapyand noncompliance with drug therapy every 60 days and updated whenever there isa change or discontinuation inmedication. The RN will sign and date theprofile. Effective6/1/16 a Medical Records Specialist was hired to track the date medicationreview due, updates, revisions, changes. A ten and five day reminder will be forwarded to nurse forcompletion. The staff will notify theDON and Administrator if timeframe not met. The DON and/or the Administrator will contact nurse with a 24 hour turnaround – suspension up to termination will	

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	issues with drugs, effectiveness of drug therapy, and immediate desired effects. The last medication review was dated 09/30/15. 3. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services did not provide any further information or documentation when asked. 4. A policy titled Medication Profile dated 07/10/16, indicated " ... 3. The Medication Profile shall document ... f. Contraindications or special precautions. g. Medication actions and side effects. h. Discontinuation date. i. Appropriate storage directions. j. Drug or food - drug interactions ... 8. The Nurse shall review all medications with the patient and / or caregiver to ensure he / she understands how the drugs are to be stored, administered,and is aware of side effects that could be experienced following administration ... 9. The Nurse shall review all medication effectiveness to ensure appropriateness and identify potential complications. 10. 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. The Registered Nurse shall sign and date the Medication Profile upon initiation and, at		follow if timelines not met. Effective 4/17/16 and ongoing 10% of allclinical records will be audited quarterly for evidence complete and accurateDrug Regimen Review of patient review of patient medications to identifyany potential adverse effect and drug reactions, ineffective drug therapy,significant side effects, significant drug interactions, duplicate drug therapyand noncompliance with drug therapy every 60 days and updated whenever there isa change or discontinuation in medication. The RN will sign and date the profile. The ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur.	

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	minimum, every sixty (60) days thereafter .... "			
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 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 the comprehensive reassessments were accurate and / or completed to support the services provided as written in the plan of care in 7 of 9 records reviewed of patients recertified for another 60 days in a sample of 11. (#1, 4, 5, 6, 7, 9, an 10) Findings include: 1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and	G 0339	G339– Update of the Comprehensive Assessment Allstaff will be in-serviced on Tag 339 (Update of the Comprehensive Assessment) by 6/10/16. Individual trainingsessions with Case Managers to train on accuracy and completeness of detailsand Update and revise of the Comprehensive Assessment –including the administration of the OASIS – the last 5 days of every 60 daysbeginning with the start of care date (including but not limited to: the accuracy and completeness of details ofthe assessment to support the POC (will include specific services with a writtenout detailed step by step instruction on “how to” and includes needed suppliieswith specific size, type, settings, management, etc.) patient specific, current health	06/10/2016

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	symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension. a. Review of the comprehensive reassessment dated 03/22/16, the assessment failed to include that the patient needed to be placed on a ventilator at bedtime, failed to include settings of the ventilator, indicated the patient was short of breath in the respiratory section but indicated the patient tolerated suctioning with dyspnea, failed to include a size and type of a foley catheter used for in and out catheterizations, failed to include assessment / need for bladder irrigation, failed to include the patient was a paraplegic in the neurological assessment, indicated the patient was able to dress his / her upper and lower body, including socks and shoes, indicated the patient has a need for home health aide		status,information that may be used to demonstrate the patient's progress towardachievement of desired outcomes and measurable goals, coordination of care, thecontinuing need for home care, meet the patient's medical, nursing,rehabilitative, social, and discharge planning, type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, catheters (size andtype), wounds, size, measurements, instructions for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge assessments/OASIS at the time of patient discharge. 6/1/16a form was be added as a checklist and/or auditing tool for assessments for RN,Medical Records Specialist, for chart audits, etc. The form will serve as a check and balancesystem by asking questions and/or giving reminders for an accurate and detailedassessment.. A monthly required specific detail in thetraining and teaching will be established for supervisory visits (withspecifics to nursing or aide	

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	services and an order had been obtained, indicated a home health health aide supervisory visit was made instead of a LPN supervisory visit, failed to include specific detail in the teaching / training (indicated "see ASV"), and failed to include documenation in the summary section. b. A skilled nursing visit note dated 03/23/16 and 03/24/16 from 12:00 AM to 10:00 AM, indicated the skilled nurse changed out filters and tubing to the patient's vent, trach collar and canula changed out, used a 14 Fr catheter to catheterize the patient, irrigated the patient's catheter with 60 cc of unknown solution, applied Nystatin powder to the folds of the peri area and 40% zinc oxide applied to the patients buttocks. b. A skilled nursing visit note dated 03/24/16 from 4:00 PM to 7:00 PM, indicated the skilled nurse used a 16 Fr catheter to catheterize the patient and irrigated the patient's catheter with 60 cc of saline. c. A skilled nursing visit note dated 03/25/16, indicated the skilled nurse provided stand by assistance with bathing, shampooed the patient's hair, and assisted with meal prep.		supervisory visit) started on5/24/16 and ongoing with the Director of Nursing, Alternate Director ofNursing/Compliance Officer. An all CaseManager training session has been scheduled for Friday, June 17, 2016 to train onaccuracy and completeness of details and Update and revise of the Comprehensive Assessment – including the administration of the OASIS –the last 5 days of every 60 days beginning with the start of care date (includingbut not limited to: the accuracy andcompletion of the assessment to support the POC (will include specific serviceswith a written out detailed step by step instruction on “how to” and includesneeded supplies with specific size, type, settings, management, etc.) , patientspecific, current health status, information that may be used to demonstratethe patient’s progress toward achievement of desired outcomes and measurablegoals, coordination of care, the continuing need for home care, meet thepatient’s medical, nursing, rehabilitative, social, and discharge planning,type, frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, catheters (size andtype), wounds, size, measurements, instructions	

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	d. Employee E, a Registered Nurse / Case Manager, was interviewed on 04/06/16 at 3:10 PM. Employee E confirmed the patient had a ventilator but did not know the settings nor did he / she try to obtain those settings from a physician. The employee stated that he / she had tried to obtain the settings from Employee K, but never did receive them. The employee also was not able to indicate what size or type of trach the patient had. e. Employee F, a Licensed Practical Nurse, was interviewed on 04/06/16 at 4:30 PM. The employee stated the patient had to be catheterized, had to be placed on the vent at night, needed suction, and assisted the patient with AM care and meals. Employee F stated he / she did not know the patient's vent settings for it was programmed on a SD (scan disk card) by the hospital during the patient's last hospitalization. The employee stated he / she had received a call from Employee E prior to surveyor's call asking about the patient's ventilator settings. The comprehensive reassessment failed to be accurate to support the written plan of care. 2. The clinical record for patient number 4, SOC 06/19/15, included a plan of care established by a physician for the		for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge assessments/OASIS at the time of patient discharge. Amonthly required specific detail in the training and teaching will beestablished for supervisory visits (with specifics to nursing or aidesupervisory visit) Effective6/1/16 a Medical Records Specialist was hired to track the follow-upcomprehensive assessment when due. Reviewthe Comprehensive Assessment for completeness and supporting the POC. A comprehensive tracker of patientsneeds/services will be completed by 6/30/16 to include but not limited to:patient on ventilator (setting / management), catheters (size and type), wounds(size, measurement, details of care), etc. A review of nursing notes will compare back to tracker for eachpatient. Medical Records Specialist willreview for accuracy. The tracker willnote when staff is not following POC, missing information on assessment, andwill be reported to DON and Administrator. A ten and five day reminder will be forwarded to nurse for completion	

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	certification period of 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis and constipation. a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The plan of care failed to be updated and revised to specifically indicate skilled nursing to perform a digital stimulation / bowel program as well as failed to include measurable goals for the program. b. Review of the comprehensive reassessment for recertification dated 08/17/15, indicated the patient was incontinent of bowel on a daily basis. The comprehensive reassessment failed to be accurate to support the written plan of care. 3. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with		ofassessment. The staff will be notifiedof their failure to follow the POC. TheDON and/or the Administrator will contact nurse with a 24 hour turn around –suspension up to termination will follow if timelines and accuracy (notfollowing the Plan of Care) and not reporting needs of supplies to providepatient service. Effective 4/17/16 andongoing 10% of all clinical records will be audited quarterly for evidence accuracyand completeness of details and Update and revise of the Comprehensive Assessment – including the administration of the OASIS –the last 5 days of every 60 days beginning with the start of care date (includingbut not limited to: the accuracy andcompletion of the assessment to support the POC (will include specific serviceswith a written out detailed step by step instruction on “how to” and includesneeded supplies with specific size, type, settings, management, etc.) , patientspecific, current health status, information that may be used to demonstratethe patient’s progress toward achievement of desired outcomes and measurablegoals, coordination of care, the continuing need for home care, meet thepatient’s medical, nursing, rehabilitative, social, and discharge planning,type, frequency and duration, irrigations, ventilator (including settings /management),	

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	orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. The patient diagnoses include chronic obstructive pulmonary disease, congestive heart failure, and rheumatoid arthritis. a. During a home visit on 04/12/16 from 9:00 to 9:45 AM, at an Independent Living Apartments, the patient's room was observed to have a large bed in the living quarters with a kitchenette and bathroom. The living space was cluttered with oxygen concentrator (not in use) and other durable medical equipment between the patient bed and entry / door. The patient was observed sitting up in her bed eating a bowel of cereal while the home health aide was sitting in a chair conversing with the patient. After the patient ate, the home health aide took the bowel into the kitchenette and went into the bathroom and picked up the area. The home health aide indicated that the patient has home health aide services from 9:00 AM to 3:00 PM then personal care services from 3:00 PM to 4:45 PM. The home health		trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, catheters (size andtype), wounds, size, measurements, instructions for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge assessments/OASIS at the time of patient discharge. TheCompliance Officer, Administrator and Director of Nursing will be responsiblefor monitoring these corrective actions to ensure that this deficiency iscorrected and will not recur.	

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	aide stated that he / she assists the patient with her bathing, picks up around the apartment, runs errands, and provide companionship. b. Review of the comprehensive reassessment for recertification dated 01/21/16, indicated the patient had some dyspnea with exertion. The Nutritional status assessment was left blank and did not specify if the patient has physically able to shop, cook, and or feed him / herself. The reassessment indicated the patient was continent of bowel and bladder. The fall risk assessment was left blank. The reassessment indicated the patient was able to participate in bathing self in shower or tub but required presence of another person for assistance or supervision, able to get to and from the toilet and transfer independently with or without device. The reassessment indicated the patient was able to transfer with minimal human assistance or with use of an assistive device, able to ambulate with use of a one - handed device, able to to independently walk on even and uneven surfaces and negotiate stairs with or without railings. The comprehensive reassessment failed to be accurate and completed to support the plan of care. c. The Administrator, Director of			

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	Clinical Services, and Assistant Director of Clinical Services was unable to provide any further information regarding the findings referenced above when asked on 04/18/16 at 3:45 PM. 4. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterizations and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to assist with bed bath, assist with bath chair, pericare, nail care, foot care, pm care, assist with feeding, ambulation assist / mobility, commode, wheelchair, transfer / positioning, feeding, meal set up, oral care, encourage fluids, urine incontinence, check pressure areas, skin care, medication reminders, blood sugar reminders, make bed, and straighten patient area. The patient primary diagnoses was Rheumatoid Arthritis and Fibromyalgia. Secondary diagnoses listed in order were Bipolar Disorder, Diabetes, Sleep Apnea, Hypertension, and Urinary Retention. a. During a home visit on 04/12/16 at 10:30 AM, the patient stated that his / her daughter lived in the home			

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	but the daughter attended college during the day and provided the in and out catheterization at bedtime. The patient was then observed to transfer herself from the bed to a motorized wheelchair, from the motorized wheelchair to the toilet, from the toilet to the shower chair with stand by assistance from the home health aide. After the shower, the patient transferred herself from the shower chair to the toilet and dried herself off to the upper portion of the body and the home health aide dried the lower extremities. The patient transferred herself to the motorized wheelchair and was observed to dress herself with a sun dress type gown. After getting dressed, the patient operated her motorized wheelchair in the bedroom. An oxygen concentrator was observed in the room. b. Review of the start of care comprehensive assessment dated 03/17/16, the primary diagnosis was rheumatoid arthritis followed by secondary diagnoses of fibromyalgia, bipolar, diabetes mellitus, sleep apnea, hypertension, asthma, and urinary retention. The assessment did not indicate the patient had respiratory treatments used in the home. The assessment indicated the patient received meals from a community delivery service, able to take oral and injection			

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	medications independently, chairfast, unable to ambulate and is unable to wheel self, able to feed self independently, patient depends entirely upon another person to dress the upper body, unable to get to and from the toilet but is able to use a bedside commode with or without assistance, the nutritional assessment was left blank and did not specify if the patient was physically able to shop, cook, and or feed him / herself, and the summary indicated the patient must be catheterized 4 times a day, but 3 of the 4 catheterizations were to be provided by the agency nurses. The comprehensive assessment did not include the size of the pediatric catheter. The plan of care failed to include the size of the pediatric foley catheter to be used for in and out catheterizations and failed to include coordination with Mom's meals. The comprehensive reassessment failed to be accurate and completed to support the written plan of care. 5. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine			

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	cream to wounds, wrap with gauze dressing. The goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. b. Review of the comprehensive reassessment for recertification dated 03/02/16, the reassessment failed to provide a complete pain assessment, failed to include measurements to the lower extremity edema due to cellulitis, failed to provide wound bed assessment and measurement of the venous stasis ulcer to the right lower extremity as well as current treatment, failed to complete the nutritional assessment, failed to document the fall risk assessment, failed to document the psychosocial assessment, failed to answer M1840 Toilet transferring assessment, failed to document patient / caregiver / family			

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	education, and failed to document a summary / progress of the past 60 days in the summary section. The comprehensive reassessment for was incomplete and failed to support the services provided as written in the plan of care. 6. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month to assess cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / fall prevention, and Oxygen at 2 liters per trach at night. The patient primary diagnosis was Cerebral Palsy, sleep apnea, cerebral vascular accident, coarotation of aorta, and urinary incontinence. a. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H was observed cooking dinner for the patient. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times,			

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	provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The plan of care failed to be updated and revised to include trach care, ventilator settings / management, preparing meals, supra pubic catheter care, and suctioning as needed. b. Review of the comprehensive reassessment for recertification dated 03/18/16, the reassessment failed to provide a complete cardiopulmonary assessment, failed to complete the nutritional status, failed to provide an assessment of the suprapubic catheter / insertion site, failed to complete the assessment to the neurological and musculoskeletal system, failed to complete patient / caregiver / family education, and failed to complete a summary of the past 60 days. The comprehensive assessment failed to be accurate and completed to support the written plan of care. 7. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week, to provide a shower, pericare, nail care,			

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	foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, make bed / straighten patient areas. The primary diagnosis indicated carbon monoxide poisoning, followed by secondary diagnoses of lumbago, esophageal reflux, hypothyroidism, and coronary artery disease. a. A form titled "Intake / Referral" dated 03/27/15, indicated the patient was a self referral and the patient had carbon monoxide poisoning in 2011. b. A physician visit note dated 03/03/15, indicated the physician would not diagnose the patient with carbon monoxide poisoning due to the patient had been moved out of the environment and there was no labs to prove the patient had the poisoning although the patient symptom complex was similar to carbon monoxide poisoning. c. A comprehensive reassessment for recertification dated 09/22/15, indicated the patient was not short of breath, continent of both bowel and bladder. The musculoskeletal system and functional limitations, the neurological assessment, and the summary of care failed to be completed. The primary diagnosis failed to be supported by the comprehensive assessment and physician			

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	visit note. The comprehensive assessment failed to be accurate and completed to support the written plan of care. 8. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 9. A policy titled Plan of Care dated 08/15/15, indicated " ... The Plan of Care is based on a comprehensive assessment and information provided y the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The Plan of Care shall be completed in full to include ... All pertinent diagnosis (es), principle and secondary ... Medications, treatments, and procedures, Medical supplies and equipment required .... " 10. A policy titled Comprehensive Patient Reassessments / Updates, Resumption of Care, SCIC (significant change in condition), and Transfer OASIS for Skilled Patients dated 08/15/15, indicated " ... 1. Patients are reassessed to determine their response to care, when significant changes occure in			

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	their condition, their diagnosis, in their environment or support system that affect the plan of care, and when they released from the hospital ... 3. The Registered Nurse is responsible for reassessing the need for Home Care Aide services. 4. Special attention will be paid to patient - centered goal setting, clarifying the patient's personal goals and his / her expectations of the home care services. 5. The assessment will identify the problems, needs, and strengths of the patient and the care the family can provide. The ... ongoing assessments include consideration ... a. Specific individualized patient needs pertinent to the care or service being provided. b. Description of any applicable strength the patient has including physical, spychosocial, and or spiritual resources that increase their ability to respond effectively to treatment and the ability to learn ... d. Appropriateness of the level of care provided by the family or support system to safely meet the patient needs ... f. Need for continuing home care services. g. Ability / willingness of the patient / family to assume responsibility for healthcare needs .... "			
G 0341	484.55(d)(3)			

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Bldg. 00	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 that the discharge assessments / OASIS elements were completed at the time of discharge for 2 of 2 patients discharged with skilled services in a sample of 11. (# 1 and 4) Findings include: 1. The clinical record for patient number 1, SOC 01/28/15, included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing. a. Review of the skilled nursing visit notes, the discharge comprehensive assessment dated 03/29/16, the pain, integumentary, vital signs with cardiopulmonary, neuro / emotional behavior, psychosocial fall risk, activities of daily living / instrumental activities of daily living, care management assessments and summary, failed to be completed by the last qualifying discipline assessment. 2. The clinical record for patient number 4, SOC 06/19/15, included a plan of care established by a physician for the	G 0341	G341- Update of the Comprehensive Assessment Allstaff will be in-serviced on Tag 341 (Update of the Comprehensive Assessment)by 6/10/16. Individualtraining sessions with Case Managers to train on Update and revise theComprehensive Assessment (including butnot limited to: the accuracy andcompletion of the assessment to support the POC, patient specific, currenthealth status, information that may be used to demonstrate the patient'sprogress toward achievement of desired outcomes, the continuing need for homecare, meet the patient's medical, nursing, rehabilitative, social, anddischarge planning, review of patient medications to identify any potentialadverse effect and drug reactions, ineffective drug therapy, significant sideeffects, significant drug interactions, duplicate drug therapy andnoncompliance with drug therapy, and completing discharge/transfer assessments/administrationof OASIS at the time of patient discharge/transfer within 48 hours of(knowledge) started on 5/24/16 and ongoing with the Director of Nursing,Alternate Director of Nursing/Compliance Officer. An	06/10/2016

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	certification period of 08/18/15 to 10/16/15, with orders for skilled nursing and home health aide services. a. Review of the home health aide visit notes, the last home health aide visit note was dated 09/08/15 b. Review of skilled nursing visit notes, the last skilled nursing visit note was dated 09/15/15. The clinical record failed to include a discharge OASIS assessment. 3. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services was not able to provided any further documentation when asked. 4. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator was not able to provide any further information or documentation when asked. 6. A policy titled Comprehensive Patient Reassessments / Updates, Resumption of Care, SCIC (significant change in condition), and Transfer OASIS for Skilled Patients dated 08/15/15, indicated " ... Transfer / Discharge OASIS Assessments must be done within 48 hours of (or knowledge of) discharge or		all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on Update and review theComprehensive Assessment (including but not limited to: the accuracy and completion of the assessmentto support the POC, patient specific, current health status, information thatmay be used to demonstrate the patient's progress toward achievement of desiredoutcomes, the continuing need for home care, meet the patient's medical,nursing, rehabilitative, social, and discharge planning, review of patientmedications to identify any potential adverse effect and drug reactions,ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge/transfer assessments/administration of the OASIS at thetime of patient discharge/transfer within 48 hours of (knowledge). Effective6/1/16 a Medical Records Specialist is hired to track update and revisions(including the administration of OASIS) at discharges/transfers to be completedwithin 48 hours. The staff will notifythe DON and Administrator if 48 hours is not met. The DON and/or the Administrator will contactnurse with a 24 hour turn around – suspension up to termination will follow iftimelines not met.	

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	transfer.		Effective 4/17/16 andongoing 10% of all clinical records will be audited quarterly for evidenceUpdate and review of the Comprehensive Assessment (including but not limitedto: the accuracy and completion of theassessment to support the POC, (including but not limited to: the accuracy and completion of the assessmentto support the POC, patient specific, current health status, information thatmay be used to demonstrate the patient's progress toward achievement of desiredoutcomes, the continuing need for home care, meet the patient's medical,nursing, rehabilitative, social, and discharge planning, review of patientmedications to identify any potential adverse effect and drug reactions,ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge/transfer assessments/administration of the OASIS at thetime of patient discharge/transfer within 48 hours of (knowledge). The ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur.	
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Bldg. 00	This was a State Complaint Survey that was extended on 4/8/16. Survey Dates: April 6, 7, 8, 12, 13, 14, 15, and 18, 2016. Complaint number: IN00197325 Substantiated; State deficiencies were cited. Complaint number: IN00185401 Substantiated; State deficiencies were cited. Complaint number: IN00181930 Substantiated; State deficiencies were cited Complaint number: IN00181526 Substantiated; State deficiencies were cited Complaint number: IN00178606 Substantiated; State deficiencies were cited Facility Number: 011160 Medicaid Number: 200836920A Census: 659 Sample: 11	N 0000	CORRECTED CITED DEFICIENCIES ARE COMPLETE WITH ADDITIONAL TRAINING, UPDATES, IMPROVEMENT, PREVENTION OF DEFICIENCY FROM OCCURRING IN THE FUTURE. ADMINISTRATOR AND DIRECTOR OF NURSING RESPONSIBLE.	

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N 0440 Bldg. 00	410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the Administrator failed to ensure there was delineation of agencies between Individual Support Home Health Agency and with the personal care service agency, and failed to ensure that lines of authority were clearly defined for delegation of responsibility down to the patient care level. Findings include: 1. During the entrance conference on 04/06/16 at 10:30 AM, the Alternate Administrator, Director of Clinical Services, and Assisting Director of Clinical Services, indicated there were drop sites in Martinsville and Noblesville. The drop sites were located within the personal service agency that was also owned by the Administrator.	N 0440	All staffwill be in-serviced on clear lines of delineation, orientation process toinclude Organization's structure/Agency Leadership of all employees by 6/10/16and ongoing. Effective4/18/16 and ongoing Management personnel were instructed to transfer allcomplaints from patients or caregivers (including, but not limited to lack ofrespect for the patient's property) to the Administrator or Director of Nursingor designee. All complaints will beinvestigated and documented with a resolution. If resolution of the complaint was not possible, the actions that wereattempted and the outcomes will be documented. On 5/27/16 policy was updated to include a letter will be sent to thepatient/caregiver upon resolution (will include the actions that were attemptedand the outcomes). A copy of the letterwill accompany the ISHHA	06/10/2016

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	2. On 04/06/16 at 11:15 AM, an employee list was provided by the Administrator. The employee list indicated Employee L was an ADM [administrator] and Employee M was AADM [assisting administrator]. The Administrator had stated Employee L managed the personal service branch in Martinsville. 3. On 04/11/16 at 10:30 AM, the personal service branch was visited. The doors were locked and a sign on the back door provided Employee L and the Administrator's name and phone number as well as the Middletown office phone number. There were 7 company vehicles in the parking lot. Six (6) of the 7 vehicles had Individual Support Home Health Agency advertisement on the vehicles. 4. During a home visit with patient number 5 on 04/12/16 at 9:00 AM, Employee P, a home health aide, stated he / she works from the "Martinsville office" and he / she provided both attendant care and home health aide services from both [name of personal service agency] and Individual Support Home Health Agency. Employee P stated Employee L was the supervisor for both companies. Patient number 5 stated when he / she needs to contact the office,		investigation and attached to the complaintinvestigation and maintained in the Complaint Book. On 5/25/16 and ongoing In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all clients have been seen) (the committee will continue to make homevisits 10% quarterly). During home visits, thecommittee members will ask patients how they would express a grievance orproblem should one occur. If one had already occurred, they are to ask how itwas handled and what were the results or outcomes. If they have not reported one, but discusseda complaint, a report from the member will be given to the Administrator orDirector of Nursing or designee within 24 hours to investigate. The committee member will re-educate thepatient on the complaint/grievance process and organization chart.The committee member, when educating, will get signed documents of the trainingprovided. Each document signed will beplaced in the staff personnel file and client chart. The committee willmeet the first Wednesday of each month to discuss findings and the outcomes andto ensure that each finding was addressed and resolved and located in theComplaint Book. The 5/27/16 newsletterincluded pictures, names and titles to ensure the	

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	he / she starts with Employee L and would go down the list of phone numbers. The patient also stated he / she would text Employee L as well. The patient stated he / she received services from both the home health agency and personal service agency. a. Review of the patient's agency folder during the home visit, a form titled "Emergency Back Up Plans" listed Middletown / Noblesville with the phone numbers of the Administrator, Employee M, and the office number. The next paragraph listed Martinsville area and the name of Employee L and Employee U with their phone numbers, then provided an on-call line. b. Another form in the patient's agency folder titled "Welcome to ISHHA ... If you have any questions or concerns please call us. Martinsville Workstation," Name of Employee L, Program Director, office number and cell number, on call line for after hours, home office number, the Administrator's name and cell number, Employee M as the VP [vice president] with cell number, followed by a title of "Supervisor" and Employee L signature. c. There was another form in the patient's agency folder that indicated		delineation of agencies. The 5/27/16 newsletter included clear linesof authority/supervision along with the organization chart. Staff are assigned the closest drop sitebased on their location for their convenience for paperwork needs andsupplies. Staff are assigned a “Point ofContact” person based on their location for scheduling and otherneeds/information. Phones areestablished at the drop sites for the convenience of the staff andclients. Phone calls received at dropsites are transferred to the Middletown Office in relationship to theneed. The drop site phones also ringsdirectly to the Middletown Office as needed. The drop sites are not staffed by ISHHA staff and signs are left (forthe convenience of staff) to make contact with the “Point of Contact” person orthe Administrator when no staff is available to assist them. Phone numbers of “Point of Contact” andadditional numbers or cell numbers are for the convenience of our staff toensure they can get their needs met without making unnecessary trips and cannotaccess the drop site or making a trip to the Middletown Office. ISHHA provides transportation to staff whenstaff are in need (car problems, financial problems or simply helping) it’s only logical to advertise on the cars,as they move about and parking them at	

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	[name of personal service agency] with the Administrator and Employee M listed with phone numbers to contact first followed by "Martinsville area" with the name of Employee L and Employee U with phone numbers, followed by an on call number. The form was signed with Employee L signature. 5. During a home visit with patient number 6 on 04/12/16 at 10:30 AM, Employee I, a home health aide, stated he / she reported to Employee Q, the Administrator with the Noblesville office. The employee stated he / she had orientation in Middletown but had paperwork orientation in Noblesville. According to Employee I and patient number 6, they don't know who the Administrator, Alternate Administrator, Assistant Director of Clinical Services, or Employee M were. Both stated they had just recently met the Director of Clinical Services a few weeks ago. The patient stated he / she received services from both the home health agency and personal service agency. 6. During a home visit with patient number 7 on 04/12/16 at 12:20 PM, the patient's spouse stated he / she contacted the "Martinsville" office when there was a need. The patient stated he / she only received services from the home health		drop sites so they are safe and keys arelocked at the drop site for insurance purposes and safety. The cars are another assurance for ourclients to be served when their regular staff call off – we can very quicklysend a staff in a company car, much easier than asking them to drive their owncar. Paperwork training/correction orcompletion for staff at drop sites is for staff convenience. ISHHA provides a “yellow” folder in clienthomes for distinct delineation. Employeesare instructed not to take cell phones in to client homes when they areproviding services. Notes on drop sitesdoors indicated to call the Administrator when “Point of Contact” staff notavailable. Both employees that were contactedby surveyor were staffing clients. Oneemployee was staffing from 8a to 6pm, the other staff was staffing 9:30a to5:30p. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to review and train on the clear lines ofauthority/supervision for a distinct delineation of agencies. On 4/20/16 training was provided to the HumanResources Director on employee titles for the employees. The HR Director was instructed not to titlestaff as Administration and abbreviate as ADM and the AdministrationsAssistants as AADM. On 4/20/16 policywas	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

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	agency. 7. During a home visit to patient number 8 with Employee K on 04/12/16 at 3:40 PM, the patient's parent stated he / she contacted Employee L at the Martinsville office when he / she needed anything. a. The patient's agency folder was reviewed. A business card with Employee R's name and discipline was observed in the folder with an address of 1920 Old State Rd 44, Martinsville, IN [address on the card was that of a branch to the sister agency / name of personal service agency]. Employee K, a Registered Nurse for patient number 7, stated Employee R had recently been transferred to the Noblesville office, which was also a branch of the sister agency. b. Employee K stated he / she did not go to the Middletown office for anything, that he / she did everything from the Martinsville office. The employee stated the last time he / she was in the Middletown office, was upon hire and he / she had been with the company for a few years. 8. The Quality Assessment Performance Improvement was reviewed on 04/15/16 at 1:15 PM. The notes reviewed		updated with title abbreviations per position and the employee list wascorrected. On 5/27/16 The HR Directorreviewed completed personnel files for accurate job descriptions. Staff that were the Alternate Administratoror other positions (job description remains in the personnel file) also have aHome Health Aide Job Description and appropriate job description for theirposition. On 5/27/16 the tracker for theemployee list was corrected with the employee titles to match the policy. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill update, review and ensure that an organizational chart is explained and intheir yellow folder in their home and their understanding of the delineation ofthe agencies and the lines of authority/supervision with a signed form for theclient chart. The committee member, wheneducating, will get signed documents of the training provided. Each document signed will be placed in thestaff personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and	

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	indicated the last two meetings dated 09/23/15 and 12/2015, combined both Individual Support Home Health Agency and [name of personal service agency] discussion of hired employees in the Middletown, Martinsville, and Noblesville offices. The notes also included a notation about how to track the attendant care and homemakers. 9. Review of the personnel files on 04/15/16 at 1:30 PM, Employee L job title / job description indicated he / she was a Program Coodinator for the personal service agency. Employee M job title / job description indicated he / she was the Alternate Administrator. 10. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated she would meet with staff operating from the drop site / personal service agency branch during annual meetings and that staff were asked to come to Middletown for those meetings. The Director of Clinical services also stated other forms of communication with the staff was through text messaging or phone calls. The Director of Clinical Services stated she investigated the nursing complaints and the Administrator or local coordinators would investigate the home health aide complaints. The Director of		Director of Nursing within 24 hours. The committee will meet the first Wednesdayof each month to discuss findings and the outcomes and to ensure that eachfinding was addressed and resolved. All staff will be in-serviced on (ClinicalRecord Review) by 6/10/16. On 5/27/16QAPI committee were re-trained on developing, implementing, maintaining and evaluating a performance improvement quality assessment plan to measure, assess,and improve the performance of clinical and other processes with a cleardelineation of agencies quarterly. The plan willreflect the complexity of the home health organization (only) and its services, including those services(included but not limited to: clinical recordsreview, corporate compliance plan, customer satisfaction survey, etc.) provideddirectly or under arrangement, to identify current issues andthe progress of previously identified issues. The plan will be designed to use objective measures to improve clientoutcomes and the perceptions of clients/families about the quality andvalue of services. Effective 6/1/16 aMedical Records Specialist was hired to take minutes and combine notes,specifically to ISHHA, and type the PIP quarterly report. The Quarterly PIP report and meeting	

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	Clinical Services stated if it was a staffing issue such as scheduling, the local coordinators were closer to the source. 11. The Administrator and Employee M was interviewed on 04/18/16 at 2:25 PM. Employee M stated he /she was a home health aide and did not hold an administrative title. The Administrator stated Employee M was an administrative assistant and helped out in the office occasionally. The Administrator stated the vehicles in Martinsville were for the employees to drive. 12. Employee L and Q was contacted and messages left for return call on 04/18/16 between 10:30 AM and 10:38 AM. Neither employees returned the calls by exit conference on 04/18/16 at 3:10 PM.		minuteswill be submitted to the QAPI committee within 48 hours of meeting. Report and minutes will be in the same binderwith a signed reviewed sheet by the Administrator. TheQuality Assurance Committee, Compliance Officer, HR Director, Administrator andDirector of Nursing will be responsible for monitoring these corrective actionsto ensure that this deficiency is corrected and will not recur.	
N 0441 Bldg. 00	410 IAC 17-12-1(a) Home health agency administration/management Rule 12 Sec. 1(a) Administrative and supervisory responsibilities shall not be delegated to another agency or organization, and all services not furnished directly, including services provided through a branch office, shall be monitored and controlled by the parent agency. Based on record review and interview, the Administrator failed to ensure	N 0441	All staff will be in-serviced on clear lines of delineation, orientation process to include	06/10/2016

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	supervisory functions were not delegated to another agency or organization. Findings include: 1. During the entrance conference on 04/06/16 at 10:30 AM, the Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services, indicated there was a drop site in Martinsville and Noblesville. The drop sites were located within the personal service agency that was also owned by the Administrator. 2. On 04/06/16 at 11:15 AM, an employee list was provided by the Administrator. The employee list indicated Employee L was an ADM [administrator] and Employee M was AADM [assistant administrator]. The Administrator had stated Employee L managed the personal service branch in Martinsville. 3. On 04/11/16 at 10:30 AM, the personal service branch was visited. The doors were locked and a sign on the back door provided Employee L and the Administrator's name and phone number as well as the Middletown office phone number. There were 7 company vehicles in the parking lot. Six (6) of the 7 vehicles had Individual Support Home		Organization's structure/Agency Leadership of all employees by 6/10/16 and ongoing. Effective 4/18/16 and ongoing Management personnel were instructed to transfer all complaints from patients or caregivers (including, but not limited to lack of respect for the patient's property) to the Administrator or Director of Nursing or designee. All complaints will be investigated and documented with a resolution. If resolution of the complaint was not possible, the actions that were attempted and the outcomes will be documented. On 5/27/16 policy was updated to include a letter will be sent to the patient/caregiver upon resolution (will include the actions that were attempted and the outcomes). A copy of the letter will accompany the ISHHA investigation and attached to the complaint investigation and maintained in the Complaint Book. On 5/25/16 and ongoing In Home Quality Assurance Committee was developed to make home visits on 10% of clients monthly (until all clients have been seen) (the committee will continue to make home visits 10% quarterly). During home visits, the committee members will ask patients how they would express a grievance or problem should one occur. If one had already occurred, they are to ask how it	

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	Health Agency advertisement on the vehicles. 4. During a home visit with patient number 5 on 04/12/16 at 9:00 AM, Employee P, a home health aide, stated he / she worked from the "Martinsville office" and he / she provided both attendant care and home health aide services from both [name of personal service agency]and Individual Support Home Health Agency. Employee P stated Employee L was the supervisor for both companies. Patient number 5 stated when he / she needed to contact the office, he / she would start with Employee L and would go down the list of phone numbers until he / she reached someone. The patient also stated he / she would text Employee L as well. The patient stated he / she received services from both the home health agency and personal service agency. a. Review of the patient's agency folder during the home visit, a form titled "Emergency Back Up Plans" listed Middletown / Noblesville with the phone numbers of the Administrator, Employee M, and the office number. The next paragraph listed Martinsville area and the name of Employee L and Employee U with their phone numbers, then provided an on-call line.		was handled and what were the results or outcomes. If they have not reported one, but discussed a complaint, a report from the member will be given to the Administrator or Director of Nursing or designee within 24 hours to investigate. The committee member will re-educate the patient on the complaint/grievance process and organization chart. The committee member, when educating, will get signed documents of the training provided. Each document signed will be placed in the staff personnel file and client chart. The committee will meet the first Wednesday of each month to discuss findings and the outcomes and to ensure that each finding was addressed and resolved and located in the Complaint Book. The 5/27/16 newsletter included pictures, names and titles to ensure the delineation of agencies. The 5/27/16 newsletter included clear lines of authority/supervision along with the organization chart. Staff are assigned the closest drop site based on their location for their convenience for paperwork needs and supplies. Staff are assigned a “Point of Contact” person based on their location for scheduling and other needs/information. Phones are established at the drop sites for the convenience of the staff and clients. Phone calls received at	

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	b. Another form in the patient's agency folder titled "Welcome to ISHHA ... If you have any questions or concerns please call us. Martinsville Workstation," Name of Employee L, Program Director, office number and cell number, on call line for after hours, home office number, Administrator name and cell number, Employee M as the VP [vice president] with cell number, followed by a title of "Supervisor" and Employee L signature. c. There was another form in the patient's agency folder that indicated Individual Support Services with the Administrator and Employee M listed with phone numbers to contact first followed by "Martinsville area" with the name of Employee L and Employee U with phone numbers, followed by on call number. The form was signed with Employee L signature. 5. During a home visit with patient number 6 on 04/12/16 at 10:30 AM, Employee I, a home health aide, stated he / she reported to Employee Q, the Administrator with the Noblesville office. The employee stated he / she had orientation in Middletown but had paperwork orientation in Noblesville. According to Employee I and patient		drop sites are transferred to the Middletown Office in relationship to the need. The drop site phones also rings directly to the Middletown Office as needed. The drop sites are not staffed by ISHHA staff and signs are left (for the convenience of staff) to make contact with the “Point of Contact” person or the Administrator when no staff is available to assist them. Phone numbers of “Point of Contact” and additional numbers or cell numbers are for the convenience of our staff to ensure they can get their needs met without making unnecessary trips and cannot access the drop site or making a trip to the Middletown Office. ISHHA provides transportation to staff when staff are in need (car problems, financial problems or simply helping) it’s only logical to advertise on the cars, as they move about and parking them at drop sites so they are safe and keys are locked at the drop site for insurance purposes and safety. The cars are another assurance for our clients to be served when their regular staff call off – we can very quickly send a staff in a company car, much easier than asking them to drive their own car. Paperwork training/correction or completion for staff at drop sites is for staff convenience. ISHHA provides a “yellow” folder in client homes for distinct delineation. Employees are instructed not to take cell	

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	number 6, they don't know who the Administrator, Alternate Administrator, Assistant Director of Clinical Services, or Employee M were. Both stated they had just recently met the Director of Clinical Services a few weeks ago. The patient stated he / she received services from both the home health agency and personal service agency. 6. During a home visit with patient number 7 on 04/12/16 at 12:20 PM, the patient's spouse stated he / she contacted the "Martinsville" office when there was a need. The patient stated he / she only received services from the home health agency. 7. During a home visit with patient number 8 on 04/12/16 at 3:40 PM, the patient's parent stated he / she contacts Employee L at the Martinsville office when he / she needed anything. a. The patient's agency folder was reviewed. A business card with Employee R's name and discipline was observed in the folder with an address of 1920 Old State Rd 44, Martinsville, IN [address on the card was that of a branch to the sister agency Individual Support Services). Employee K, a Registered Nurse for patient number 7, stated Employee R had recently been transferred		phones in to client homes when they are providing services. Notes on drop sites doors indicated to call the Administrator when "Point of Contact" staff not available. Both employees that were contacted by surveyor were staffing clients. One employee was staffing from 8a to 6pm, the other staff was staffing 9:30a to 5:30p. An all Case Manager training session has been scheduled for Friday, June 17, 2016 to review and train on the clear lines of authority/supervision for a distinct delineation of agencies. On 4/20/16 training was provided to the Human Resources Director on employee titles for the employees. The HR Director was instructed not to title staff as Administration and abbreviate as ADM and the Administrations Assistants as AADM. On 4/20/16 policy was updated with title abbreviations per position and the employee list was corrected. On 5/27/16 The HR Director reviewed completed personnel files for accurate job descriptions. Staff that were the Alternate Administrator or other positions (job description remains in the personnel file) also have a Home Health Aide Job Description and appropriate job description for their position. On 5/27/16 the tracker for the employee list was corrected with the employee titles to match the policy. On 5/25/16 and ongoing an In Home Quality Assurance	

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	to the Noblesville office, which was also a branch of the sister agency. b. During the home visit, Employee K stated he / she did not go to the Middletown office for anything, that he / she did everything from the Martinsville office. The employee stated the last time he / she was in the Middletown office, was upon hire and he / she had been with the company for a few years. 8. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated she would meet with staff operating from the personal service agency branch during annual meetings and that staff were asked to come to Middletown for annual meetings. The Director of Clinical Services also stated other forms of communication with the staff was through text messaging or phone calls. The Director of Clinical Services stated she investigated the nursing complaints and the Administrator or local coordinators would investigate the home health aide complaints. The Director of Clinical Services stated if it was a staffing issue such as scheduling, the local coordinators were closer to the source.		Committee was developed to make home visits on 10% of clients monthly (until all clients have been seen) (the committee will continue to make home visits 10% quarterly). During the home visit the committee member will update, review and ensure that an organizational chart is explained and in their yellow folder in their home and their understanding of the delineation of the agencies and the lines of authority/supervision with a signed form for the client chart. The committee member, when educating, will get signed documents of the training provided. Each document signed will be placed in the staff personnel file and client chart. The committee members will provide a written report of the visit to the Administrator and Director of Nursing within 24 hours. The committee will meet the first Wednesday of each month to discuss findings and the outcomes and to ensure that each finding was addressed and resolved. All staff will be in-serviced on (Clinical Record Review) by 6/10/16. On 5/27/16 QAPI committee were re-trained on developing, implementing, maintaining and evaluating a performance improvement quality assessment plan to measure, assess, and improve the performance of clinical and other processes with a clear delineation of agencies quarterly. The plan	

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	9. The Administrator and Employee M was interviewed on 04/18/16 at 2:25 PM. Employee M stated he /she was a home health aide and did not hold an administrative title. The Administrator stated Employee M was an administrative assistant and helped out in the office occasionally. The Administrator stated the vehicles in Martinsville were for the employees to drive. 10. Employee L and Q was contacted and messages left for return call on 04/18/16 between 10:30 AM and 10:38 AM. Neither employees returned the calls by exit conference on 04/18/16 at 3:10 PM.		will reflect the complexity of the home health organization (only) and its services, including those services (included but not limited to: clinical records review, corporate compliance plan, customer satisfaction survey, etc.) provided directly or under arrangement, to identify current issues and the progress of previously identified issues. The plan will be designed to use objective measures to improve client outcomes and the perceptions of clients/families about the quality and value of services. Effective 6/1/16 a Medical Records Specialist was hired to take minutes and combine notes, specifically to ISHHA, and type the PIP quarterly report. The Quarterly PIP report and meeting minutes will be submitted to the QAPI committee within 48 hours of meeting. Report and minutes will be in the same binder with a signed reviewed sheet by the Administrator. The Administrator and Director of Nursing will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. The Quality Assurance Committee, Compliance Officer, HR Director, Administrator and 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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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 agency failed to ensure performance evaluations had been conducted and signed at the time of the evaluation for 10 of 18 employee files reviewed. (#F, G, H, I, J, K, L, O, Q, and V) Findings: 1. The agency personnel files was reviewed on 04/15/16 at 1:30 PM. The files indicated the following: a. Employee F, Date of Hire (DOH) 01/28/15, performance evaluation indicated it was conducted in 12/2015. The employee failed to sign the evaluation.	N 0458	Employeeperformance evaluations are written in December of each year based on theperformance from January to December (12 month period). Policy states employee evaluations will begiven to the employee from 9 to 15 months from date of hire and annuallythereafter. Prevention of deficiencyfrom occurring in the future, effective 6/1/16, employee evaluations will begiven to the employee within the time frame of 9 to 15 months from date of hireand annually thereafter from their last evaluation with employee and supervisorsigning and dating during the evaluation process. 6/1/16 ISHHA policy was been updated. On 6/10/16 the next Newsletter, a	06/10/2016

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	b. Employee G, DOH 10/21/14, performance evaluation indicated it was conducted in 12/2015. The employee signed the evaluation on 03/19/16. The evaluation failed to be signed by the employee at the time of the evaluation. c. Employee H, DOH 09/24/13, performance evaluation indicated it was conducted in 12/2015. The employee failed to sign the evaluation. d. Employee I, DOH 05/12/15, performance evaluation indicated it was conducted in 12/2015. The employee signed the evaluation on 03/17/16. The evaluation failed to be signed by the employee at the time of evaluation. e. Employee J, DOH 12/07/12, performance evaluation indicated it was conducted in 12/2015. The employee failed to sign the evaluation. f. Employee K, DOH 01/09/14, performance evaluation indicated it was conducted in 12/2015. The employee failed to sign the evaluation. g. Employee L, DOH 02/01/06, performance evaluation indicated it was conducted in 12/2015. The employee signed the evaluation on 04/01/16. The		messagewill be sent to the employees regarding the new evaluation policy. The Administrator and Director of Nursingwill be responsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

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	evaluation failed to be signed by the employee at the time of the evaluation. h. Employee O, DOH 01/28/15, performance evaluation indicated it was conducted in 12/2015. The employee failed to sign the evaluation. i. Employee Q, DOH 11/18/14, performance evaluation indicated it was conducted in 12/2015. The employee signed the evaluation on 02/16/16. The evaluation failed to be signed by the employee at the time of the evaluation. j. Employee V, DOH, 11/29/11, performance evaluation indicated it was conducted in 12/2015. The employee signed the evaluation on 02/19/16. The evaluation failed to be signed by the employee at the time of the evaluation. 2. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services did not provide any further information by the end of the exit conference on 04/18/16 at 03:40 PM.			
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			

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	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: (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 ensure that a patient had received the care and services that were to be provided and ordered by a physician. (#1) Findings include: 1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions,	N 0494	To preventthe deficiency from recurring, on 3/29/16 the DON had a sign off sheet forre-training on call off procedures, and started contacting staff on 3/29/16 andwriting their name on the sheet as she made contact. The staff that she made face to face contactwith she had them sign the sheet. There-training on call off procedures was completed prior to the surveyorsentrance to ensure the health and safety of our clients and was presented tothe surveyor. In the future the DON will put the procedure in writing andensure that each staff make notation of their understanding and put inpersonnel file rather than doing verbal. 1. On4/13/16 a full all staff (nurses, administration, HHA's, and ancillary staff,etc.) mandatory inservice was sent via e-mail (for all staff with emailaddresses), U.S. Post Office mailing for those without emails, along with aphone	06/10/2016

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	administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension. a. On 04/06/16 at 11:00 AM, the Administrator stated that the complaint visit must have been in regards to patient number 1. b. Review of patient number 1 clinical record on 04/06/16 at 12:40 PM, a discharge summary dated 03/29/16, indicated the patient had died at home. c. Review of the OASIS discharge assessment dated 03/29/16, the summary indicated the patient was found dead at his home at 08:00 AM. The patient was in his wheelchair at the kitchen table. d. Review of the nursing visit notes on 04/06/16 at 12:40 PM, the clinical record failed to contain visit notes 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16. e. Review of the agency's investigative note dated 03/29/16 at 9:57 AM, indicated the Director of Clinical		call or text explaining the urgency and severity of the mandated trainingon 4/13/16 with a mandatory response deadline of 4/15/16. Training includes PatientRights (including patient and/or family responsibilities, Care Plans andClinical Documentation, Attendance and Reporting (including specific call offprocedures for all staff) along with Progressive Disciplinary Action forfailure to comply. All staff mustrespond to the e-mail (with signed receipt indicator) or personally sign,acknowledging they received, state they have read and understand the ISHHApolicy and procedures regarding the Mandated Training. All staff must be trained by 4/15/16 or willbe removed from the scheduled (a suspended employee) until the MandatedTraining is completed. Any staff onvacation, sick or unaware of the Mandated Training will be suspended and notallowed to return to work until the Mandated Training is completed. A notification by email, text, mail or phonecall has been given to all employees. Effective immediately 4/13/16 all staff will receive during orientationand annually every April specific training and understanding of Patient Rights(including patient and/or family responsibilities, Care Plans and ClinicalDocumentation, Attendance and Reporting	

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	Services had taken a phone call from Employee F, LPN (Licensed Practical Nurse) at 9:30 AM. Employee F reported that he / she had developed a fever and did not feel that he / she should come to work. Employee F asked the patient if he / she would like for Employee F to notify the office and the patient replied that he / she did not want any of the nurses from the office because of previous issues. Employee F indicated he / she had spoken to the patient around midnight on the phone and messaged with him / her on facebook around 3:00 AM. Employee F indicated he / she had called the patient to let him / her know that he / she was coming to assist him / her around 7:00 AM but the employee got no answer. When Employee F arrived at the patient's home around 8:00 AM, he / she did not get an answer at the door and someone had to let him / her in and that was when Employee F found the patient sitting in his wheelchair at the kitchen table. Employee F called 911. Employee F indicated he / she was trying to follow the client's wishes. The Director of Clinical Services informed Employee F of the immediate suspension pending the investigation. f. The Administrator, Director of Clinical Services, and Assisting Director of Clinical Services was interviewed on		(including specific call off proceduresfor all staff) along with Progressive Disciplinary Action for failure tocomply, with a signed training sheet. Copies of the Mandated Training Sheets and Sign off sheetsattached. Bi-weekly newsletters aresubmitted via QuickBooks for all staff with an email address. We are currently investigating Quickbooksaddition of sending the agency a receipt when the email is opened. The newsletters will be send via email with areturn receipt effective 4/15/16 until the agency investigates Quickbooksversion of acknowledgement of staff receiving agency information via email. A staff list is generated during payrollwith a column added to indicate receipt of agency information submitted viaemail. Staff without emails will be sentcertified registered letters or will be required to come to office and pick upagency information and sign acknowledging receipt. This will be ongoing. Kimberly J Moore, Administrator & CathyYoung, DON & Payroll Coordinator 2. Effective4/13/16 and ongoing ISHHA will verbally notify each staff of their suspensionand follow up with a signed return receipt via email or a registered, certifiedsigned receipt letter via the U.S. Post Office and ongoing. On 4/14/16 an email was sent to the LPNregarding her	

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	04/06/16 at 1:40 PM. The Director of Clinical Services stated Employee F had failed to return phone calls and text messages, so a letter of termination had gone out to him / her in the mail. At 3:40 PM, the Administrator, Director of Clinical Services, and Assisting Director of Clinical Services were interviewed again. To prevent this occurrence from happening again, measures that had been put into place included reiterating to patients to contact the office when staff fails to show up and there was a live person to take calls 24/7. Another measures included retraining the staff to notify the office for call offs. The Director of Clinical Services stated there was not a sign in sheet of the staff training. The Director of Nursing stated Employee F knew he / she needed to call in, for he / she had called off a few weeks ago. g. Employee F was interviewed on 04/06/16 at 4:30 PM. The employee stated he / she did not show up at the patient's home as scheduled and did not notify the office of his / her absence per patient wishes. Employee F stated he / she did notify the office and spoke with the Director of Clinical Services in regards to the absence and death. Employee F did confirmed the typed conversation with the Director of Clinical		termination and a return receipt was requested and a registered,certified signed receipt letter via the U.S. Post Office. A copy of the receipt from the post officewill be attached to the letter and filed in personnel file. Effective 4/13/16 this process will beenforced and be ongoing. Kimberly J Moore, Administrator Responsible & Cathy Young, DON &HR Director 3. Effective4/13/16 and ongoing. The Administratoror designee will make spontaneous checks on clients with staff present. This process will be done with a phone callby calling the clients phone and talking directly to the staff and drop invisits to the clients home. A clientlist has been generated with dates of visits. Special attention will be given to those clients and staff with ahistory of long term care together. Kimberly J Moore, Administrator & Justin Moore, AlternateAdministrator Responsible & Designee 4. Effective4/13/16 and ongoing ISHHA Admission Nurse will have the client and or familymembers sign the welcome letter and also the Patient Information Packet forreceipt and acknowledgement of the Call off Process. The forms are included in the AdmissionPacket to be taken to the admission. Kimberly J Moore, Administrator, Cathy Young, DON and Admission	

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	Services with the exception that he / she observed the patient's facebook as "active" at 3:00 AM, but did not speak with the patient at this time. The Employee also stated he / she was not placed on suspension, but was allowed time off to grieve due to the close relationship he / she had with the patient. The employee stated he / she had not received any text messages or phone calls from the Director of Clinical Services. Employee F stated he / she was contacted today by Employee R, a Registered Nurse / Case Manager, but also stated he / she had another death in the family and had been out of town where phone reception was poor. The employee stated that a scheduler had reached out to him / her on 03/31/16, about taking another case and was planning to send him / her the plan of care. h. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. The Administrator stated Employee F did notify the office the previous evening. The Administrator stated the employee was still fired. The Administrator provided an employee list of names that the Director of Clinical Services produced, of staff who had been in-serviced on call offs. At 10:30 AM,		NursesResponsible. 5. ISHHAhas full systems in place to ensure all clients are staffed at all times whennotified of the need for staff, either by the employee or by the client. ISHHA maintains a full staff of Float Nurses both RN's and LPN's and FloatHHA's at all times available to ensure clients are staffed and nurses arereplaced when they call off for any reason 24 hours a day 7 days a week. ISHHAprovides company cars for the Float staff to ensure quick response to clientcoverage. ISHHA reviews, as needed theneed to increase or decrease the float staffing pool to accommodate the clientbase. The process for the review toincrease: 1) If an Administrative Stafffrom the scheduling department is routinely sent to cover as an HHA for a twoweek period, an additional HHA float will be added. If a CM is routinely sent to cover for askilled nursing case for a two week period, an additional nurse float will beadded. This process has been effective and will continue ongoing. Kimberly J Moore, Administrator and CathyYoung, DON Responsible 4/13/16 and ongoing 6. Effective4/13/16 and ongoing the Attendance and Reporting Policy was updated to includespecific instructions for call offs. TheAttendance and	

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	the Administrator provided Employee F's missing visit notes of patient number 1 and also provided a business news letter. The Administrator stated the news letter went out with payroll, which was within the same week of the patient's death. The news letter stressed the importance of calling the office for call offs and failure to follow the agency policy would result in termination. The 03/27 and 03/28/16 skilled nursing visit notes were not provided. i. On 04/08/16 at 3:00 PM, Employee F was interviewed in person. Employee F provided a text message between him / herself and the patient on 03/28/16, indicating that Employee F continued to be ill and the patient declined to have a replacement nurse. Employee F stated the patient was able to take him / herself off the vent but felt better if someone was there due to random episodes of desaturate when removed and at times, would become unresponsive for a few minutes then return to normal. Both agreed for Employee F to follow up with the patient in the morning of 03/29/16. Employee F provided a text message between him / herself and the Administrator dated 04/07/16 at 5:15 PM. The message indicated "you are suspended pending investigation. Client died and you did		Reporting Policy is part of the Mandated Training required. The updated Attendance and Reporting Policywill be replaced for orientation class and the April Annual Training andongoing. Kimberly J Moore, Administratorand Cathy Young, DON Responsible 7. Effective4/13/16 and ongoing the Nurse Scheduler and all staff on a “need to know basis”will receive a confidential email (blind copy) when the email is sent for thesuspension and/or termination. KimberlyJ Moore, Administrator and Cathy Young, DON Responsible 8. Effective4/14/16 and ongoing ISHHA will verballynotify each staff of their suspension and follow up with a signed returnreceipt via email or a registered, certified signed receipt letter via the U.S.Post Office and ongoing. A copy of thecertified receipt will be attached to the letter and placed in the personnelfile. On 4/14/16 an email was sent tothe LPN regarding her termination and a return receipt was requested and aregistered, certified signed receipt letter via the U.S. Post Office. The certified receipt was attached to theletter and placed in the personnel file. Effective 4/14/16 this process will be enforced and be ongoing. Kimberly J Moore, Administrator & CathyYoung, DON & HR Director Responsible	

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	not cover the shift or call the office as policy states." Employee F provided a text message dated 03/31/16, from an unknown scheduler in regards to taking on a new case and another text message dated 04/02/16, indicating the plan of care was going to be sent out. Employee F was questioning why he / she was asked to take on a new client if he / she was suspended. Employee F provided a text dated 04/04/16, where he / she had made contact with the office requesting information about the new case. Employee F also stated that when he / she met with the Alternate Administrator on 04/07/16, he had provided him / her with a $20 gift card for meeting with him. Employee F stated the missing 03/27 and 03/28/16 skilled nursing visit notes were not provided to the Alternate Administrator because the visit notes were to be turned in with the next payroll. Employee F stated he / she had thought he / she would have them to turn in with the new case. j. During a home visit with Employee P, home health aide, on 04/12/16 at 9:00 AM, Employee P was interviewed and had stated he / she had never seen a company newsletter, but then the agency did not have his / her correct address. Employee P also stated he / she had not been told or reminded		9. Effective4/14/16 and ongoing the scheduling staff will communicate with all staff thecall off procedures and consequences weekly when review of their weeklyschedule. Effective 4/15/16 and ongoing the client monthly calendar hasbeen edited to add the staff call off procedure and client responsibility whenstaff does not show up. All clients arestaffed with permanent staff at all times when staff are hired and trained fora specific client. If the client doesnot have permanent staff float nurses or HHA's are assigned to staff theclient. ISHHA maintains a full staff of float nurses and float HHA's. ISHHA maintains a schedule of all clientswho require staffing. The open list ofclients are reviewed by the Management Team each Monday at 8:30 am andongoing. The schedule is completed inadvance, staff are notified of their staffing schedule in sufficient advancednotice that they are given full opportunity to notify ISHHA of their inabilityto complete a shift, be at the client's home timely, or any other reason theymay be unable to fulfill their staffing obligations. When a call in occurs replacement staff arescheduled and sent to the clients home immediately. This system ensure whenstaff do call-off scheduling has ample time to replace them. Kimberly Moore, Administrator, Cathy	

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	about notifying the office about call offs and the repercussions. k. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 AM, Employee I was interviewed and had stated he / she had never seen a company newsletter, nor had he / she been told or reminded about notifying the office about calls offs and the repercussions. l. During a home visit with Employee J, a LPN, on 04/12/16 at 1:40 PM, Employee J was interviewed and stated he / she had not received a company newsletter, but did receive a text from the office the previous week about calls offs, but was unable to remember the specific details of the text nor the date received. m. During a home visit with Employee K, a Registered Nurse on 04/12/16 at 3:40 PM, Employee K was interviewed and stated that he / she would get a company newsletter in an email sometimes but had not received an email within the past few weeks. Employee K stated he / she did get a text the previous week to contact the Director of Nursing for call offs but unable to provide a specific date.		Young,DON, Scheduling Staff Responsible. 10. Effective 4/14/16 and ongoing The WelcomeLetter was updated to include the clients acceptance of Float Staff by stating“yes” or “no” with the agencies ability to staff adequately. This form is signed by the client ordesignated individual and is be placed in the client chart. The Welcome Letter also includes instructionsfor staff not showing up or trying to make a deal about scheduled hours withthe client and/or designated individual. On 4/15/16 a copy of the new Welcome letter will be mailed to allclients with a self-addressed letter for return to the office. The CM’s will follow-up on the letter forreturn. All letters will be completed in30 days and placed in client charts. Aclient list tracker will be in place to assure every client has a signedWelcome Letter in their chart within 30 by 5/15/16 for completion. Kimberly J Moore, Administrator, Cathy Young,DON and Admission Nurse and Case Managers Responsible Effective4/29/16 and ongoing the call off procedure with repercussions will be in eachnewsletter. All staff will bein-serviced again on (Patient Rights) by 6/10/16. Education on Patient Rights and Call OffProcedures will be the June 2016 in home training with clients and staff duringSupervised Visits	

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	n. During a home visit with Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H was interviewed. Employee H stated that he / she had not received a company newsletter and could not remember the last time he / she had received one. Employee H recalled hearing about call offs a few weeks prior, but don't recall specifics or repercussions. o. The Administrator was interviewed on 04/13/16 at 4:00 PM. The Administrator was in agreement that the text message to Employee F on 04/07/16 at 5:15 PM, had taken place. The Administrator stated she had did that because she had felt bad for the employee and wanted cooperation to get the visit notes. The Administrator had no explanation of the field staff interviews on 04/12/16 in regards to the newsletter and the lack of knowledge of the call off policy and repercussions. p. The detective involved in the patient's death investigation was interviewed on 04/18/16 at 10:16 AM. The Detective stated the initial findings was asphyxiation due to a mucous plug, but the final coroners report would take anywhere from 2 to 3 weeks. The time of death usually would be upon arrival of the coroner, but was unsure at this time.		and will be documented on the ASV by 6/30/16. A current Patient Rights form dated 5/27/16will be signed by the patient and staff and placed in client chart and personnelfile. On 5/25/16 and ongoing an In Home Quality AssuranceCommittee was developed to make home visits on 10% of clients monthly (untilall clients have been seen) (the committee will continue to make home visits10% quarterly) to spontaneously check on staff, to follow-up on each monthlyinservice, call off process, organization chart, updates on client and staffpaperwork, patient rights, etc. Thecommittee member, when educating, will get signed documents of the trainingprovided. Each document signed will beplaced in the staff personnel file and client chart. The committee members will provide a writtenreport of the visit to the Administrator and Director of Nursing within 24hours. The committee will meet thefirst Wednesday of each month to discuss findings and the outcomes and toensure that each finding was addressed and resolved and documented. The Quality Assurance Committee, Chart AuditCommittee, RN Case Managers, Nurse Scheduler, Office Manager, Compliance Officer, Administrator andDirector of Nursing will be responsible for monitoring these corrective actionsto ensure that this	

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	The projected time of death was anticipated between 6:00 AM to 7:00 AM. The Detective also stated that there was a video that put Employee F's arrival time to the patient's home at 8:35 AM on 03/29/16. The Detective stated Employee M, a home health aide / administrative assistant, came by the policy station the previous week and obtained a copy of the report. 2. A policy titled Scope of Services and Core Skilled Service Provided dated 07/10/15, indicated " ... The qualifications and competence of the individual(s) providing services are appropriate to patient needs and the required services and comply with applicable laws and regulations .... " 3. A policy titled Standard of Practice dated 07/10/15, indicated ISHHA staff will deliver services based on each patent's unique and individual needs and clinical decisions will not be altered ... Patient care will be provided in a coordinated, effective, appropriate ... and safe manner in accordance with ISHHA goals, objectives, and philosophy." 4. A policy titled Tardiness and Unplanned Absence dated 07/10/15, indicated " ... f an employee is unable to report for work, he / she must notify his		deficiency is corrected and will not recur.	

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	15K025		04/07/2016

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	or her supervisor at least four (4) hours prior to the beginning of the work shift. The team member must personally contact the supervisor .... "			
N 0514 Bldg. 00	410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.			
	Based on record review and interview, the agency failed to ensure complaints made by patients / or caregivers were reported, documented and / or investigated with a resolution for 4 of 9 interviews. (#1, 4, 8, and 11) Findings include: 1. Employee F, LPN (Licensed Practical Nurse), was interviewed on 04/08/16 at 3:00 PM. A text message was observed on Employee F phone dating 10/05/15. The text message was a conversation between the employee and the Director of	N 0514	Allstaff will be in-serviced on (Exercise of Rights and Respect for Property) by6/10/16. Effective 4/18/16 and ongoingManagement personnel were instructed to transfer all complaints from patientsor caregivers (including, but not limited to lack of respect for the patient'sproperty) to the Administrator or Director of Nursing or designee. All complaints will be investigated anddocumented with a resolution. Ifresolution of the complaint was not possible, the actions that were attemptedand the outcomes will be documented. On5/27/16 policy was updated to include a letter	06/10/2016

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	Nursing. The text message indicated a confirmation of the Director of Clinical Services visiting patient number 1 on 10/05/15. The employee indicated the patient was having problems with Employee O, a LPN, and the Director of Clinical Services was meeting with the patient to discuss the problems. a. Review of the complaint book failed to include an investigation of the patient's problems with Employee O. b. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated the patient was complaining about Employee O being bossy, telling him what to do, and speaking for him. The Director of Clinical Services stated Employee O had taken care of the patient for many years and she had spoken with Employee O about professional boundaries. The Director of Clinical Services stated the patient reported he / she felt safe with Employee O. The Director of Clinical Services did not provide any documentation in regards to the investigation. 2. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the		will be sent to thepatient/caregiver upon resolution (will include the actions that were attemptedand the outcomes). A copy of the letterwill accompany the ISHHA investigation and attached to the complaint investigationand maintained in the Complaint Book. On 5/25/16 and ongoing In Home Quality Assurance Committee was developedto make home visits on 10% of clients monthly (until all clients have beenseen) (the committee will continue to make home visits 10% quarterly). During home visits, the committee members will askpatients how they would express a grievance or problem should one occur. If onehad already occurred, they are to ask how it was handled and what were theresults or outcomes. If they have notreported one, but discussed a complaint, a report from the member will be givento the Administrator or Director of Nursing or designee within 24 hours toinvestigate. Duringthe home visit the committee member will review, update and ensure that the “WelcomeLetter” is explained, understood and signed (a copy will be filed in clientchart and a copy in yellow folder). The committee member willre-educate the patient on the complaint/grievance process, accepting staff andorganization chart. The committee member, when educating,will get signed documents of the training	

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	certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week. a. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15. b. Patient number 4 was interviewed on 04/12/16 at 7:30 PM. The patient indicated he / she had received two letters of discharge. The patient stated he / she did not refuse nursing nor did he / she refused home health aides. The patient stated he / she did not like the team leaders that came into his / her home and his / her last complaint was over a home health aide that spit over his / her food when he / she spoke. The patient stated he / she had to be fed and he / she would lose his / her appetite and couldn't eat. The patient stated he / she was falsely being accused of refusing visits. c. Review of the complaint book, the complaint book failed to include an investigation of the patient's complaint.		provided. Each document signed will be placed in thestaff personnel file and client chart. Thecommittee will meet the first Wednesday of each month to discuss findings andthe outcomes and to ensure that each finding was addressed and resolved andlocated in the Complaint Book. On 5/28/16 The "Welcome Letter" was updated to include a statement "Willyou accept a Float Staff to start your services and fill in when your permanentstaff calls off." The "Welcome Letter" will require client/family signature andwill be filed in client chart and a copy in yellow folder. The Quality Assurance Committee, Compliance Officer, Administrator andDirector of Nursing will be responsible for monitoring these corrective actionsto ensure that this deficiency is corrected and will not recur.	

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	d. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services stated she investigated the nursing complaints and the Administrator or local coordinators would investigate the home health aide complaints. The Director of Clinical Services stated if it was a staffing issue such as scheduling, the local coordinators were closer to the source. e. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator stated the patient constantly wanted team leaders and refused the home health aides. The Administrator. The Administrator was not able to provide any further of documentation of the patient's history of complaints. 3. During a home visit with Employee K, a Registered Nurse, on 04/12/16 at 3:40 PM, a parent for patient number 8 was interviewed. The parent had stated he / she had contacted the office several times to ask for a back up nurse. The parent stated that he / she was very particular in who was allowed in the home and wanted the nurse to meet the patient prior to providing care. Employee K stated there had been no back up nurse since May,			

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	2015. a. The Administrator was interviewed on 04/14/16 at 12:15 PM. The Administrator stated every patient has a back up person and also stated it was difficult to train a back up person due to no reimbursement. By 5:00 PM, the Administrator did not provide any further documentation in relation to the parent's concern / complaint. b. Review of the complaint book, the complaint book failed to include an investigation of the parent's complaint. 3. The clinical record for patient number 11 was reviewed on 04/15/16 at 11:56 AM. The clinical record evidenced multiple missed visit reports. A parent for patient number 11 was interviewed on 04/15/16 at 12:05 PM. The parent had stated he / she was having problems with Employee V, a home health aide. The parent stated Employee V was "more of a hassle and did cancel visits" with Employee V. The parent stated the employee refused to use equipment such as the hoyer lift and felt the employee was not adequately trained to be a home health aide. The parent stated he / she had informed Employee W of his / her concern. The parent also stated he / she would call the Middletown branch and			

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	would get told he / she needed to call the Noblesville office and the other office would tell him / her to contact Middletown. The parent stated he / she kept getting the "run around." a. Review of the complaint book, the complaint book failed to include an investigation of the parent's complaint. b. The Administrator was interviewed on 04/18/16 at 2:55 PM. The Administrator stated she was not made aware of the parent's concern and the parent's call should have stayed within the Middletown office and not referred to the other office. 4. A policy titled Bill of Rights / Grievance Procedure dated 07/10/15, indicated " ... ISHHA will investigate complaints made by a patient / family member or guardian regarding care or treatment furnished or that was not furnished. ISHHA will investigate complaints made identifying a lack of respect for patient property by anyone providing services on behalf of ISHHA. ISHHA will document the existence of a complaint and the resolution. The documentation will be placed in a confidential 'Patient Complaint' filed. If the patient verbalizes a complaint to ISHHA staff in the home the complaint			

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	will be communicated to the Supervising Nurse or designee who will ensure that the complaint will be handled, investigated and documented in a manner consistent with the nature of the complaint. The Patient or Responsible party will be informed of the progress of the investigation and proposed action plan .... "			
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 the skilled nurse and the home health aide followed the plan of care for 11 of 11 records reviewed in a sample of 11. (# 1 to 11) Findings include: 1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and	N 0522	To preventthe deficiency from recurring, on 3/29/16 the DON had a sign off sheet forre-training on call off procedures, and started contacting staff on 3/29/16 andwriting their name on the sheet as she made contact. The staff that she made face to face contactwith she had them sign the sheet. There-training on call off procedures was completed prior to the surveyorsentrance to ensure the health and safety of our clients and was presented tothe surveyor. In the future the DON will put the procedure in writing andensure that each staff make notation of their understanding and put inpersonnel file rather than doing verbal. On 4/13/16 a	06/10/2016

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	symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension. a. The clinical record of patient number 1 was reviewed on 04/06/16 at 12:40 PM and indicated the following: 1. The OASIS discharge assessment dated 03/29/16, the summary indicated the patient was found dead at his / her home at 08:00 AM. The patient was in his wheelchair at the kitchen table. 2. Review of the nursing visit notes on 04/06/16 at 12:40 PM, the clinical record failed to contain visit notes 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16. b. An agency investigation note dated 03/29/16 at 9:57 AM, was reviewed and indicated the Director of		full allstaff (nurses, administration, HHA's, and ancillary staff, etc.) mandatory in-servicewas sent via e-mail (for all staff with email addresses), U.S. Post Officemailing for those without emails, along with a phone call or text explainingthe urgency and severity of the mandated training on 4/13/16 with a mandatory response dead line of4/15/16. Training includes PatientRights (including patient and/or family responsibilities, Care Plans andClinical Documentation, Attendance and Reporting (including specific call offprocedures for all staff) along with Progressive Disciplinary Action forfailure to comply. All staff mustrespond to the e-mail (with signed receipt indicator) or personally sign,acknowledging they received, state they have read and understand the ISHHApolicy and procedures regarding the Mandated Training. All staff completed the training prior tobeing put back on the schedule. Suspension letters were mailed certified/receipt on 4/15/16 to all staffthat had not completed the mandatory training. Any staff on vacation, sick or didnot respond to the Mandated Training weresuspended and not allowed to return to work until the Mandated Training wascompleted. Effective 4/13/16 all staff will receive duringorientation and annually	

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	Clinical Services had taken a phone call from Employee F, LPN (Licensed Practical Nurse) at 9:30 AM. Employee F reported that he / she had developed a fever and did not feel that he / she should come to work. Employee F asked the patient if he / she would like for Employee F to notify the office and the patient replied that he / she did not want any of the nurses from the office because of previous issues. Employee F indicated he / she had spoken to the patient around midnight on the phone and messaged with him / her on facebook around 3:00 AM. Employee F indicated he / she had called the patient to let him / her know that he / she was coming to assist him / her around 7:00 AM but the employee got no answer. When Employee F arrived at the patient's home around 8:00 AM, he / she did not get an answer at the door and someone had to let him / her in and that was when Employee F found the patient sitting in his wheelchair at the kitchen table. Employee F called 911. Employee F indicated he / she was trying to follow the client's wishes. The Director of Clinical Services informed Employee F of the immediate suspension pending the investigation. c. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was interviewed on		every April specific training and understanding ofPatient Rights (including patient and/or family responsibilities, Care Plansand Clinical Documentation, Attendance and Reporting (including specific calloff procedures for all staff) along with Progressive Disciplinary Action forfailure to comply, with a signed training sheet. Bi-weekly newsletters are submitted viaQuickBooks for all staff with an email address. A cell phone was purchased to send a text to all staff, as a reminder, to review their emailwhen newsletters and agency information is released via email. The cell phone will also provide staff, thatdon't have an email, a copy of the newsletter and all agency information. Those staff that can't receive through emailor cell phone will be mailed via US Post Office all newsletters and agencyinformation. Staff that pick upnewsletters and agency information bi-weekly will do so at the office or atdrop sites. Emails will request anacknowledging receipt. Text messageswill require a text back of receipt. USMail will be sent receipt return. Pickup will require a signed receipt. A bi-weeklystaff list is generated during payroll with a column added to indicate receiptof agency information. Newsletter andagency information will also be visually available to all staff at the	

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	04/06/16 at 1:40 PM. The Director of Clinical Services stated Employee F had failed to return phone calls and text messages, so a letter of termination had gone out to him / her in the mail. At 3:40 PM, the Administrator, Director of Clinical Services, and Assistant Director of Clinical Services were interviewed again. To prevent this occurrence from happening again, measures that had been put into place included reiterating to patients to contact the office when staff fails to show up and there was a live person to take calls 24/7. Another measure included retraining the staff to notify the office for call offs. The Director of Clinical Services stated there was not a sign-in sheet of the staff training. The Director of Nursing stated Employee F knew he / she needed to call in, for he / she had called off a few weeks ago. d. Employee F was interviewed on 04/06/16 at 4:30 PM. The employee stated he / she did not show up at the patient's home as scheduled and did not notify the office of his / her absence per patient wishes. Employee F stated he / she did notify the office and spoke with the Director of Clinical Services in regards to the absence and death. Employee F did confirmed the typed conversation with the Director of Clinical		officeand each drop site. On 4/18/16 and ongoing all nurses were notified, intheir method of communication, to submit nurse visit notes every Monday. Nurse visit notes are entered as receivedinto the tracker and tracked back to the schedule. A comparison report is generated on eachWednesday to determine if there are missing nurse visit notes. The staff, that have missing nursing notes,will be contacted on each Wednesday , in their method of communication and willhave until each Friday to submit. Stafffailing to submit timely will be suspended until nursing notes are received. Staff will be terminated after three untimelyweeks. ISHHA will assist staff inreceiving nursing notes timely by means of gas cards, gift cards, kind words,picking them up to ensure ISHHA stays in compliance and this deficiency willnot recur. Effective 4/13/16 policy wasupdated to add that any staff being suspended will be notified in their methodof communication and also a letter will be mailed via US Post Officecertified/receipt. After theinvestigation the staff will be notifiedin their method of communication and also a letter will be mailed via US PostOffice certified/receipt of the outcome (termination or return to work). All signed receipts will be put in staffpersonnel files. Effective 4/29/16 andongoing the call off	

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	Services with the exception that he / she observed the patient's facebook as "active" at 3:00 AM, but did not speak with the patient at this time. The Employee also stated he / she was not placed on suspension, but was allowed time off to grieve due to the close relationship he / she had with the patient. The employee stated he / she had not received any text messages or phone calls from the Director of Clinical Services. Employee F stated he / she was contacted today by Employee R, a Registered Nurse / Case Manager, but also stated he / she had another death in the family and had been out of town where phone reception was poor. The employee stated that a scheduler had reached out to him / her on 03/31/16, about taking another case and was planning to send him / her the plan of care. e. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. The Administrator stated Employee F did notify the office the previous evening. The Administrator stated the employee was still fired. The Administrator provided an employee list of names that the Director of Clinical Services produced, of staff who had been in-serviced on call offs. At 10:30 AM,		procedure with repercussions will be in eachnewsletter. All staff will bein-serviced on (Patient Rights) by 6/10/16. Education on Patient Rights and Call Off Procedures will be the June2016 in home training with clients and staff during Supervised Visits and willbe documented on the ASV by 6/30/16. Acurrent Patient Rights form dated 5/27/16 will be signed by the patient andstaff and placed in client chart and personnel file. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly) to spontaneouslycheck on staff, to follow-up on each monthly inservice, call off process,organization chart, updates on client and staff paperwork, patient rights, etc. The committee member, when educating, willget signed documents of the training provided. Each document signed will be placed in the staff personnel file andclient chart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and	

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	the Administrator provided Employee F's missing visit notes of patient number 1 and also provided a business news letter. The Administrator stated the news letter went out with payroll, which was within the same week of the patient's death. The news letter stressed the importance of calling the office for call offs and failure to follow the agency policy would result in termination. The 03/27 and 03/28/16 skilled nursing visit notes were not provided. f. On 04/08/16 at 3:00 PM, Employee F was interviewed in person. Employee F provided a text message between him / herself and the patient on 03/28/16, indicating that Employee F continued to be ill and the patient declined to have a replacement nurse. Employee F stated the patient was able to take him / herself off the vent but felt better if someone was there due to random episodes of desaturation when removed and at times, would become unresponsive for a few minutes then return to normal. Both agreed for Employee F to follow up with the patient in the morning of 03/29/16. Employee F provided a text message between him / herself and the Administrator dated 04/07/16 at 5:15 PM. The message indicated "you are suspended pending investigation. Client died and you did		resolved anddocumented Allstaff will be in-serviced on Tag G107 (Exercise of Rights and Respect forProperty) by 6/10/16. Effective 4/18/16and ongoing Management personnel were instructed to transfer all complaintsfrom patients or caregivers (including, but not limited to lack of respect forthe patient's property) to the Administrator or Director of Nursing ordesignee. All complaints will beinvestigated and documented with a resolution. If resolution of the complaint was not possible, the actions that wereattempted and the outcomes will be documented. On 5/27/16 policy was updated to include a letter will be sent to thepatient/caregiver upon resolution (will include the actions that were attemptedand the outcomes). A copy of the letterwill accompany the ISHHA investigation and attached to the complaint investigationand maintained in the Complaint Book. On 5/25/16 and ongoing In Home Quality Assurance Committee was developedto make home visits on 10% of clients monthly (until all clients have beenseen) (the committee will continue to make home visits 10% quarterly). During home visits, the committee members will askpatients how they would express a grievance or problem should one occur. If onehad already occurred, they are to ask	

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	not cover the shift or call the office as policy states." Employee F provided a text message dated 03/31/16, from an unknown scheduler in regards to taking on a new case and another text message dated 04/02/16, indicating the plan of care was going to be sent out. Employee F was questioning why he / she was asked to take on a new client if he / she was suspended. Employee F provided a text dated 04/04/16, where he / she had made contact with the office requesting information about the new case. Employee F also stated that when he / she met with the Alternate Administrator on 04/07/16, he had provided him / her with a $20 gift card for meeting with him. Employee F stated the missing 03/27 and 03/28/16 skilled nursing visit notes were not provided to the Alternate Administrator because the visit notes were to be turned in with the next payroll. Employee F stated he / she had thought he / she would have them to turn in with the new case. g. During a home visit with Employee P, home health aide, on 04/12/16 at 9:00 AM, Employee P was interviewed and had stated he / she had never seen a company newsletter, but then the agency did not have his / her correct address. Employee P also stated he / she had not been told or reminded		how it was handled and what were theresults or outcomes. If they have not reportedone, but discussed a complaint, a report from the member will be given to theAdministrator or Director of Nursing or designee within 24 hours toinvestigate. The committee member willre-educate the patient on the complaint/grievance process and organizationchart. The committee member, when educating, will get signeddocuments of the training provided. Eachdocument signed will be placed in the staff personnel file and client chart. The committee willmeet the first Wednesday of each month to discuss findings and the outcomes andto ensure that each finding was addressed and resolved and located in theComplaint Book. Allstaff will be in-serviced on (Acceptance of Patients, POC, Med Super) by6/10/16. On 4/13/16 a full all staff (nurses, administration, HHA's, andancillary staff, etc.) mandatory in-service was sent via e-mail (for all staffwith email addresses), U.S. Post Office mailing for those without emails, alongwith a phone call or text explaining the urgency and severity of the mandatedtraining on 4/13/16 with a mandatoryresponse dead line of 4/15/16. Trainingincludes Patient Rights (including patient and/or family responsibilities, CarePlans and Clinical	

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	about notifying the office about call offs and the repercussions. h. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 AM, Employee I was interviewed and had stated he / she had never seen a company newsletter, nor had he / she been told or reminded about notifying the office about calls offs and the repercussions. i. During a home visit with Employee J, a LPN, on 04/12/16 at 1:40 PM, Employee J was interviewed and stated he / she had not received a company newsletter, but did receive a text from the office the previous week about calls offs, but was unable to remember the specific details of the text nor the date received. j. During a home visit with Employee K, a Registered Nurse on 04/12/16 at 3:40 PM, Employee K was interviewed and stated that he / she would get a company newsletter in an email sometimes but had not received an email within the past few weeks. Employee K stated he / she did get a text the previous week to contact the Director of Nursing for call offs but unable to provide a specific date.		Documentation, Attendance and Reporting (including specificcall off procedures for all staff) along with Progressive Disciplinary Actionfor failure to comply. All staff mustrespond to the e-mail (with signed receipt indicator) or personally sign,acknowledging they received, state they have read and understand the ISHHA policyand procedures regarding the Mandated Training. All staff completed the training prior to being put back on theschedule. Suspension letters weremailed certified/receipt on 4/15/16 to all staff that had not completed themandatory training. Any staff on vacation, sick or did notrespond to the Mandated Training weresuspended and not allowed to return to work until the Mandated Training wascompleted. Effective 4/13/16 all staff will receive duringorientation and annually every April specific training and understanding ofPatient Rights (including patient and/or family responsibilities, Care Plansand Clinical Documentation, Attendance and Reporting (including specific calloff procedures for all staff) along with Progressive Disciplinary Action forfailure to comply, with a signed training sheet. Bi-weekly newsletters are submitted viaQuickBooks for all staff with an email address. A cell phone was purchased to send a text to all staff, as a reminder, to review	

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	k. During a home visit with Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H was interviewed. Employee H stated that he / she had not received a company newsletter and could not remember the last time he / she had received one. Employee H recalled hearing about call offs a few weeks prior, but don't recall specifics or repercussions. l. The Administrator was interviewed on 04/13/16 at 4:00 PM. The Administrator was in agreement that the text message to Employee F on 04/07/16 at 5:15 PM, had taken place. The Administrator stated she had did that because she had felt bad for the employee and wanted cooperation to get the visit notes. The Administrator had no explanation of the field staff interviews on 04/12/16 in regards to the newsletter and the lack of knowledge of the call off policy and repercussions. m. The detective involved in the patient's death investigation was interviewed on 04/18/16 at 10:16 AM. The Detective stated the initial findings was asphyxiation due to a mucous plug, but the final coroners report would take anywhere from 2 to 3 weeks. The time of death usually would be upon arrival of the coroner, but was unsure at this time.		their emailwhen newsletters and agency information is released via email. The cell phone will also provide staff, thatdon't have an email, a copy of the newsletter and all agency information. Those staff that can't receive through emailor cell phone will be mailed via US Post Office all newsletters and agencyinformation. Staff that pick upnewsletters and agency information bi-weekly will do so at the office or atdrop sites. Emails will request anacknowledging receipt. Text messageswill require a text back of receipt. USMail will be sent receipt return. Pickup will require a signed receipt. A bi-weeklystaff list is generated during payroll with a column added to indicate receiptof agency information. Newsletter andagency information will also be visually available to all staff at the officeand each drop site. On 4/18/16 allnurses were notified, in their method of communication, to submit nurse visitnotes every Monday. Nurse visit notesare entered as received into the tracker and tracked back to the schedule. A comparison report is generated on each Wednesday to determine if there aremissing nurse visit notes. The staff,that have missing nursing notes, will be contacted on each Wednesday , in theirmethod of communication and will have until each Friday to submit. Staff	

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	The projected time of death was anticipated between 6:00 AM to 7:00 AM. The Detective also stated that there was a video that put Employee F's arrival time to the patient's home at 8:35 AM on 03/29/16. The Detective stated Employee M, a home health aide / administrative assistant, came by the police station the previous week and obtained a copy of the report. 2. The clinical record for number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders for skilled nursing. The patient's diagnoses included RSV (Respiratory Syncytial Virus), Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance. a. A "Notification of Client Status" dated 02/11/16, indicated the patient had been admitted for respite nursing and "PA" (meaning prior authorization from Medicaid to provide ongoing nursing services on a routine basis). The note also indicated the parents wanted a routine nurse for overnights and no float nurses. b. The initial plan of care		failing to submit timely will besuspended until nursing notes are received. Staff will be terminated after three untimely weeks. ISHHA will assist staff in receiving nursingnotes by means of gas cards, gift cards, kind words, picking them up to ensureISHHA stays in compliance and this deficiency will not recur. Effective 4/13/16 policy was updated to addthat any staff being suspended will be notified in their method ofcommunication and also a letter will be mailed via US Post Officecertified/receipt. After theinvestigation the staff will be notifiedin their method of communication and also a letter will be mailed via US PostOffice certified/receipt of the outcome (termination or return to work). All signed receipts will be put in staffpersonnel files. Effective 4/29/16 andongoing the call off procedure with repercussions will be in eachnewsletter. Individual trainingsessions with Case Managers to train on POC, comprehensive assessment, type,frequency and duration, ventilator, trach, tube feedings, assistive devises,catheters, suctioning, wounds, size, measurements, instructions for specificservices, charting, documentation and notification of physician for alltreatments and discharges started on 5/24/16 and ongoing with the Director ofNursing, Alternate Director of	

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	(undated) had orders for skilled nursing to evaluate but failed to include a nursing frequency / duration. The agency provided respite nursing visits on 02/24, 02/26, 03/01, and 03/03/16. The plan of care also indicated the patient was to receive 1 liter of oxygen during naps / bedtime. A respite nursing notes dated 03/01/16 and 03/03/16, indicated the patient had received 3 liters of oxygen per the trach tube. The nurse failed to follow the plan of care. c. The second plan of care dated 03/22/16, had orders for skilled nursing 8 hours per day, 5 days a week for 9 weeks and respite nursing up to 60 hours per month for 12 months. Review of the clinical record, the agency failed to provide skilled nursing visits 8 hours a day, 5 days a week. d. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was interviewed on 04/07/16 at 12:30 PM. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services stated that the initial plan of care was developed upon admission and the agency were to provide respite nursing services. The patient was transferred into the hospital and returned home on 3/22/16. The		Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC, comprehensive assessment,type, frequency and duration, ventilator, trach, tube feedings, assistivedevises, catheters, suctioning wounds, size, measurements, instructions for specific services,documentation and notification of physician for all treatments and discharges,Updates to the Case Manager training manual on POC, comprehensive assessment,type, frequency and duration, ventilator, trach, tube feedings, assistivedevises, catheters, suctioning, wounds, size, measurements, instructions forspecific services, charting, documentation and notification of physician forall treatments and discharges will be completed by 6/2/16. All Home Health Aides will be in-serviced onfollowing the POC, visit notes, documentation, tardiness and unplanned absencesby 6/10/16. On 5/28/16 The "Welcome Letter" was updated to include astatement "Will you accept a Float Staff to start your servicesand fill in when your permanent staff calls off." The "Welcome Letter" willrequire client/family signature and will be filed in client chart and a copy inyellow folder. On5/25/16 and ongoing an In Home Quality Assurance Committee was developed tomake home visits on 10% of clients monthly (until all clients	

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	Administrator and Assistant Director of Clinical Services stated that Medicaid had instructed the agency to develop a new plan of care versus writing orders and updating the current plan of care. The Assistant Director of Clinical Services stated there was a delay in routine nursing services due to the father's lack of ability to provide job information. The Director of Clinical Services stated the PA (Prior Authorization) came on 3/25/16, but the mother did not want floating nurses in the home and requested that the patient be staffed with a permanent nurse. The Assistant Director of Clinical Services stated the requested visit notes may have been in the patient's home. At 1:00 PM, missed visit notes were provided and the Director of Clinical Services stated she had been interviewing for a permanent nurse and a nurse had been hired and was due to start "today." e. The parent of patient number 2 was interviewed on 04/07/16 at 3:50 PM. The parent had stated that he / she did not recall telling the agency that he / she wanted to hold services or refused services until a permanent nurse was available. The parent stated he / she preferred a permanent nurse but would have taken anyone due to the exhaustion between him / her and their spouse, need		have been seen)(the committee will continue to make home visits 10% quarterly). During the home visit the committee memberwill review, update and ensure that the “Welcome Letter” is explained,understood and signed (a copy will be filed in client chart and a copy inyellow folder), POC is followed, follow-up on each monthly inservice, call offprocess, organization chart, updates on client and staff paperwork, patientrights, etc. The committee member, wheneducating, will get signed documents of the training provided. Each document signed will be placed in the staffpersonnel file and client chart. Thecommittee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesdayof each month to discuss findings and the outcomes and to ensure that eachfinding was addressed and resolved. On5/27/16 policy was updated to include a letter will be sent to the patient uponresolution (will include the actions that were attempted and theoutcomes.) A copy of the letter willaccompany the ISHHA investigation. Effective 4/17/16 and ongoing 10% of all clinical records will beaudited quarterly for evidence that POC, comprehensive assessment, type,frequency and duration, ventilator, trach, tube feedings, assistive devises,catheters,	

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	for rest during the night due to pregnancy / work, and how the patient needed constant supervision during the night due to getting the trach tubing around his / her neck. The parent indicated the patient had respite nursing a few times prior to his / her hospitalization, but when the patient came out of the hospital, his / her respite nurse was in the hospital his / herself and that a replacement respite nurse had not been provided. 3. The clinical record for number 3, SOC 06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health aide services 14 hours per week, 1 - 2 hours per day, 7 days a week for 9 weeks. The patient diagnoses included, but limited to arthritis, coronary artery bypass graft, coronary artery disease, diabetes, and autonomic instability. a. The clinical record was reviewed on 04/07/16 at 1:54 PM, and failed to evidence home health aide visits from 06/22/15 to 07/14/15, 07/15/15, 07/16/15, and 07/18/16 to 07/27/15. b. The Administrator provided a typed statement on 04/07/16 at 4:00 PM, indicating Employee E, a Registered Nurse / Case Manager, had reported that		suctioning, wounds, size, measurements, specific instructions forservices, charting, documentation and notification of physician for alltreatments and discharges are evident, updated "Welcome Letter", along with theSkilled Nurse (notes) and Home Health Aide (documentation) following thePOC. Staff failing to follow POC will receiveadditional training with corrective action up to termination. The Quality Assurance Committee, ComplianceOffice, Administrator and Director ofNursing will be responsible for monitoring these corrective actions to ensurethat this deficiency is corrected and will not recur.	

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	the patient was complaining about not getting all of his / her hours. The statement indicated the Administrator had spoken to employee L, a Home Health Aide and Manager of a Personal Service Agency owned by the Administrator. The statement indicated Employee L had spoken with the patient and the patient was not satisfied with the staff Employee L was sending, the patient wanted the agency to hire a family member, and was holding the agency off. The statement indicated the Administrator had left a message on the patient's phone on 7/23, 7/24, 7/27, and 7/28/15. On 7/25/15, the statement indicated the patient had emailed Employee M, also a home health aide and coordinator for both the home health agency and personal services agency, and had asked about hiring the patient's sister [name of sister was included]. The statement indicated Employee M had informed the patient that he / she was unaware of the request and would investigate it. The statement indicated the Administrator and Employee M had talked with the patient and the patient indicated "it didn't matter he / she fired us and was going with an agency that would hire his / her sister in one day." During this time, the Administrator stated new staff must have orientation for approximately 1 week.			

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	c. Patient number 3 was interviewed on 04/07/16 at 7:00 PM. The patient had stated that the named sister in the statement, was a patient of the agency's and had been for many years. The patient stated he / she used to work for the agency and took care of the named sister until he / she had their own surgery in 2009. The patient stated that his / her niece currently works for the agency and was taking care of the mentioned sister. The patient stated he / she would never ask to have his / her niece removed from the sister's care. The patient stated that he / she did not want weekend staff, but wanted to take the weekend hours and apply it to the week day hours. The patient stated he / she had never canceled or refused a visit, but complained to the agency about not having home health aides to his / her home as ordered. The patient stated on one occasion, a home health aide was in an accident on his / her way to the patient's home, but the home health aide was not replaced. The patient stated the agency told him / her would need to find another agency. d. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 PM. The Director of Clinical Services stated she was not aware of the missing home health aide visits. The			

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	Director of Clinical Services stated she mostly manages the nursing and the Administrator, Employee L and Employee M managed the home health aides. e. Employee M and the Administrator were interviewed on 4/18/16 at 2:25 PM. Employee M stated he / she was a home health aide and nothing further. The Administrator stated Employee M did helped with coordination as well. Employee M was not able to recall the event nor conversation with the patient. After the statement was read, Employee M was not able to add any further information and indicated the statement summed up the situation. The Administrator stated the name mentioned in the statement must have been wrong. 4. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis. a. Review of the skilled nursing			

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	visit notes, the skilled nurse failed to provide 2 visits during the week of 07/19 to 07/25/15 and during the week of 07/26 to 08/01/15. The skilled nurse failed to provide a 2nd visit during the week of 08/09 to 08/15/15. The skilled nurse failed to follow the plan of care. b. Review of the home health aide visit notes indicated the following: 1. The home health aide provided (4) 2 hour visits on 07/19, 07/20, 07/22, 07/23, 08/04, and 08/30/15. 2. The home health aide provided a 4 plus hour visits on 07/24, 08/10, and 08/17 (6:30 PM to 10:30 PM), 07/27, 07/31, 08/18 (6:00 PM to 10:15 PM), 07/28, 07/30, 08/11, 08/16, 08/20, 08/25, 08/27 (6:00 PM to 10:00 PM), 08/21/15 (6:20 PM - 10:20 PM), and 08/10 and 08/17/15 (6:00 PM to 10:30 PM). 3. The home health aide provided a 6 plus hour visit on 08/30/15 (9:00 AM to 3:15 PM). 4. The home health aide provided (2) 3 hour visits on 09/01 to 09/08/15 (6:00 PM to 9:00 PM / 8:00 PM to 11:00 PM) and a single 3 hour visit on 07/25/15 (8:00 PM to 11:00 PM).			

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	5. The home health aide provided (2) visits on 07/21, 07/25, 07/31, 08/03, 08/10, 08/11, 08/14, 08/17, 08/25, 08/27, 08/29, and 09/01 to 09/08/15. The home health aides failed to follow the plan of care. c. The plan of care indicated the home health aide was to provide assistance with tub / shower, assist bath - chair, pericare, nail care - file only, foot care, ambulation assist / mobility to commode and with wheelchair, transfer or positioning, encourage fluids, incontinent care of urine, check pressure areas, skin care with lotion, make bed / straighten patient areas, and range of motion to all extremities. 1. Review of the home health aide visits notes dated 07/19 to 07/24/15, 07/27 to 07/29, 08/02, 08/04 to 08/07, 08/10, 08/12, 08/14, 08/16, 08/17, 08/18, 08/19, 08/20, 08/24, 08/27, 08/28, 08/30, 08/31, and 09/01 to 09/08, 2015, failed to evidence that tub / shower, assist bath - chair, pericare, nail care - file only, foot care, ambulation assist / mobility to commode and with wheelchair, transfer or positioning, encourage fluids, incontinent care of urine, check pressure areas, skin care with lotion, make bed / straighten patient areas, and / or range of			

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	motion to all extremities had been provided. The home health aide failed to follow the plan of care. 5. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. a. Review of the home health aide notes dated 02/15, 02/19, 02/20, 02/21, 02/22, 02/26, 02/29, 03/04, 03/05, 03/06, 03/07, 03/11, 03/14, 03/17, 03/18, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, and 03/28/16, the home health aide documented "NN" (Not Needed) for bathing, pericare, nail care, foot care, pm care, ambulation assist / mobility, assist with feeding, incontinent care, checking pressure areas, skin care, medication assistance, and / or making the bed / straighten patient area. The home health aide failed to follow the plan of care.			

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	b. Review of the home health aide visit notes dated 02/14/16 to 02/17/16, 02/19/16 to 03/16/16, 03/18/16 to 03/21/16, 03/23 to 03/25/16, 03/17/16, and 04/02/16, the home health aide indicated he / she had provided services to the patient from the hours of 9:00 AM. to 3:00 PM. On 02/18/16 and 03/26/16, the home health aide indicated he / she had provided services from 10:30 AM to 3:30 PM. On 03/17/16, the home health aide indicated he / she had provided services from 12:00 PM to 4:00 PM. On 03/22/16, the home health aide indicated he / she had provided services from 9:00 AM to 11:50 AM. On 03/28/16, the home health aide indicated he / she provided services from 9:00 AM to 7:25 PM. The home health aide failed to follow the plan of care. c. During a home visit on 04/12/16 at 9:00 AM., the patient's agency binder was reviewed. The binder included a page of a breakdown of home health aide and attendant care hours through the personal services agency owned by the Administrator. The page indicated 9:00 AM to 11:00 AM, 11:30 AM to 12:30 PM, 1:00 PM to 2:00 PM, and 2:15 PM to 4:15 PM, and weekends 9:00 AM to 3:00 PM services were to be home health aide hours through the home			

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	health agency. The other times 11:00 AM to 11:30 AM, 12:30 PM to 1:00 PM, and 2:00 PM to 2:15 PM, services were to be provided with the personal services agency. d. The home health aide, Employee P, was interviewed during this time. The employee stated that he / she was unfamiliar with the breakdown of time sheet and pulled the sheet from the binder. Employee P stated she works from 9:00 AM to 3:00 PM and does the personal care services from 3:00 PM to 4:45 PM. e. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 p.m. The Director of Nursing stated the home health aides should have been following the plan of care. 6. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and home health aide services (2) 2 hour visits and (1) 1 hour visits per day 7 days a week. a. Review of the skilled nursing visit notes, the skilled nurse failed to			

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	make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The skilled nurse failed to follow the plan of care. b. Review of the home health aide visit notes dated 03/17, 03/18, 03/21 to 03/25/16, the home health aide provided services from 9:00 AM to 3:45 PM. Review of the home health aide visit notes dated 03/19, /03/20, and 03/26/16, the home health aide provided services from 9:00 AM to 2:00 PM. The home health aide failed to follow the plan of care. c. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 a.m., the employee stated he / she did not have a written plan of care to follow and did not know his / her hours of care between the home health agency and the personal service agency that was also owned by the Administrator. The patient stated that he / she had to cancel a few nursing visits due to a nurse who caused him / her pain during a catheterization and he / she wanted to get rid of the pain before the next catheterization. The patient also stated that he / she had a problem with nurses not coming as scheduled and would not call to let her know that they			

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	would be late. The patient stated the times should be 9:00 to 10:00 AM, 1:00 to 2:00 PM, and 5:00 to 6:00 PM. The patient stated that he / she had things to do and can't wait all day for the nurses to come. d. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 p.m. The Director of Clinical Services stated the home health aide new his / her schedule and a written plan of care was put in the patient's home a few weeks prior. The Director of Clinical Services also stated the patient had the tendency to not be home when nurses arrived even when the visits were prescheduled. 7. The clinical record for patient number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a			

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	LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. The LPN failed to follow the plan of care. b. Review of the skilled nursing visit notes dated 03/01, 03/02, 03/07, 03/09, and 03/12/16, the skilled nurses failed to assess the cardiovascular system, respiratory system, and / or failed to obtain vital signs. 8. The clinical record for patient number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. The patient also had respite nursing 1 - 30 hours for 12 months. a. Review of the skilled nursing visit notes, the skilled nurse provided 1 hour on 2/22; 3 consecutive hours on 03/08, 03/09, 03/16 (PM), 03/30 (PM); 4 consecutive hours on 03/10, 03/23, 03/30 (AM); 5 consecutive hours on 2/25,			

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	03/03, 03/04, 03/28; 9 consecutive hours on 2/29, 03/22; 6 consecutive hours on 03/17 (PM); 7 consecutive hours on 2/23, 2/24, 03/02; 8 consecutive hours on 2/15, 2/18, 2/19, 2/25, 03/01, 02/21, 03/31, 04/01; 10 consecutive hours on 02/29; and 12 consecutive hours on 04/08/16. During week 6 (03/20 to 03/26/16), the skilled nurse only provided services for 3 days. The skilled nurse failed to follow the plan of care. 9. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month for 12 months. a. Review of the skilled nursing visit notes, the skilled nurse provided 3 of 5 visits each week between the dates of 02/14 to 03/12/16. b. During a home visit with the patient and Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H stated the patient attended an adult day care 3 days a week and would sometimes go with a parent to work. Employee H also stated he / she provides services to			

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	the patient on Tuesday from 3:45 to 9:00 PM and 10:00 AM to 9:00 PM on Thursday, Friday, and Saturday. The skilled nurse failed to follow the plan of care. 10. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and make bed / straighten patient areas. a. Review of the home health aide visit notes, the record failed to evidence a home health aide visit on 10/5/15 and 10/25. The home health aide failed to follow the plan of care. b. Review of the home health aide notes dated 10/01, 10/02, 10/06, 10/07, 10/08, 10/09, 10/12, 10/14, 10/15, 10/17, 10/18, 10/23, and 10/24/16, the home health aide documented "NN" (Not Needed) for shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and / or make bed / straighten patient areas. The home health aide			

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	failed to follow the plan of care. 11. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health aide services 3 hours per day 5 days a w eek to assist with bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). a. Review of the home health aide visit notes during the certification period of 08/19/15 to 10/17/15, the home health aide failed to evidence 5 visits during week 1, 1 visit during week 2, 5, and 7, and 2 visits during week 3, 4, and 6. The home health aide failed to follow the plan of care. The home health aide provided 2 extra visits during week 8 and 9. b. Review of the home health aide visit notes dated 08/27, 08/28, and 08/31/15, the home health aid provided 6 hour visits. The home health aide failed			

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	to follow the plan of care. c. Review of the home health aide notes dated 08/25 to 08/27, 09/02, 09/04, 09/09, 09/14 to 09/17, 09/22 to 09/24, 09/28 to 09/30, 10/04 to 10/17/15, the home health aide documented "NN" (Not Needed) for bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). The home health aide failed to follow the plan of care. 12. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all patient visit notes had been provided. 13. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 14. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care			

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	is a dynamic process that addresses the care, treatment and services to be provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... " 15. A policy titled Tardiness and Unplanned Absence dated 07/10/15, indicated " ... f an employee is unable to report for work, he / she must notify his or her supervisor at least four (4) hours prior to the beginning of the work shift. The team member must personally contact the supervisor .... "			
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			

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	referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on record review and interview, the agency failed to ensure that the plan of care was supported by the comprehensive assessment for 5 of 11 records reviewed (#5, 6, 7, 9, and 10), failed to update and revise the plan of care to include specific instructions for a bowel program for 1 of 1 record reviewed of patients with bowel program (#4), failed to include the type, frequency and duration of services to be provided (#2), ventilator settings, size of trach, frequency and instruction of trach care to be provided in 3 of 3 records reviewed of patients with trach's (#1, 2, and 9), failed to include directions for application of braces in 1 of 1 record reviewed of patients with braces (#2), failed to include the type of feeding, rate, and frequency of gastrointestinal tube feedings in 2 of 2 records reviewed of patients with tube feedings (#2 and 8), failed to include the size of foley catheters for in out catheterizations in 2 of 2 records reviewed with patients receiving in and out catheterizations (#1 and 6), failed to include the size / frequency of changes for suprapubic catheter in 1 of 1 record reviewed for patients with suprapubic catheters (#9), failed to include instructions for foley	N 0524	Individualtraining sessions with Case Managers to train on POC which covers all pertinentdiagnoses, including mental status, patient specific, current health status,information that may be used to demonstrate the patient's progress towardachievement of desired outcomes and measurable goals, coordination of care, thecontinuing need for home care, meet the patient's medical, nursing,rehabilitative, social, and discharge planning, type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items. review of patient medications to identify any potentialadverse effect and drug reactions, ineffective drug therapy, significant sideeffects, significant drug interactions, duplicate drug therapy andnoncompliance with drug	06/10/2016

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	catheter flushes in 1 of 1 record reviewed of patients with foley catheter irrigations (#1), failed to include instructions for wound treatments in 1 of 1 records reviewed of patients with wound treatments (#7), failed to include the location for the application of powder and ointments in 1 of 1 records reviewed of patients receiving medicated powder and ointments, and failed to include instruction for bathing and meal preps in 1 of 11 records reviewed of patients receiving assistance with bathing and meal prep. (# 1) Findings include: 1. The clinical record for patient number 1, SOC 01/20/15, included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing " to ... O2 [oxygen] at 0.5 - 6 liters 1 minute [per minute] ... administer trach [sic] care, change trach collar QD [every day], suction trach ... I & O cath [in and out catheter] TID [three times a day] and prn [as needed]. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. A skilled nursing visit note dated 03/23/16 and 03/24/16 from 12:00		therapy, and completing discharge assessments/OASIS atthe time of patient discharge 5/24/16 and ongoing with theDirector of Nursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC which covers all pertinentdiagnoses, including mental status, patient specific, current health status,information that may be used to demonstrate the patient's progress towardachievement of desired outcomes and measurable goals, coordination of care, thecontinuing need for home care, meet the patient's medical, nursing, rehabilitative,social, and discharge planning, type, frequency and duration,irrigations, ventilator (including settings / management), trach (size andtype), tube feedings, assistive devises, oxygen (settings), bowel program(detail instructions) suctioning, pulse oximetry, vents (setting/management),catheters (size and type), wounds, size, measurements, instructions forservice, any safety measures to protect against injury, instructions for timelydischarges or referral, and any other appropriate items. review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug	

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INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

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	AM to 10:00 AM, indicated the skilled nurse changed out filters and tubing to the patient's vent, trach collar and canula changed out, used a 14 Fr catheter to catheterize the patient, irrigated the patient's catheter with 60 cc of unknown solution, applied Nystatin powder to the folds of the peri area and 40% zinc oxide applied to the patients buttocks. b. A skilled nursing visit note dated 03/24/16 from 4:00 PM to 7:00 PM, indicated the skilled nurse used a 16 Fr catheter to catheterize the patient and irrigated the patient's catheter with 60 cc of saline. c. A skilled nursing visit note dated 03/25/16, indicated the skilled nurse provided stand by assistance with bathing, shampooed the patient's hair, and assisted with meal prep. d. Employee E, a Registered Nurse / Case Manager, was interviewed on 04/06/16 at 3:10 PM. Employee E confirmed the patient had a ventilator but did not know the settings nor did he / she try to obtain those settings from a physician. The employee stated that he / she had tried to obtain the settings from Employee K, but never did receive them. The employee also was not able to indicate what size or type of trach the		therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge assessments/OASIS at the time of patient discharge On 5/25/16 and ongoing an In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all clients have been seen) (the committee will continue to make homevisits 10% quarterly). During the homevisit the committee member will ensure that POC is being followed anddocumented by reviewing the POC, interview of patient and notes anddocumentation sheets. The committee member, when educating, will get signeddocuments of the training provided. Eachdocument signed will be placed in the staff personnel file and clientchart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved. Effective 4/17/16 and ongoing 10% of allclinical records will be audited quarterly for evidence that POC which covers allpertinent diagnoses, including mental status, patient specific, current health status,information	

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	patient had. e. Employee F, a Licensed Practical Nurse, was interviewed on 04/06/16 at 4:30 PM. The employee stated the patient had to be catheterized, had to be placed on the vent at night, needed suction, and assisted the patient with AM care and meals. Employee F stated he / she did not know the patient's vent settings for it was programmed on a SD (scan disk card) by the hospital during the patient's last hospitalization. The employee stated he / she had received a call from Employee E prior to surveyor's call asking about the patient's ventilator settings. The plan of care failed to include instructions for trach care, size of foley catheter to use for catheterizations, instructions for foley catheter irrigation, vent settings, specific treatment areas for the application of zinc oxide and Nystatin powder, and instructions for assistance with bathing and meal preps. The goals on the plan of care failed to be reflective of the patient's current status and treatment. 2. The clinical record for patient number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to		that may be used to demonstrate the patient's progress towardachievement of desired outcomes and measurable goals, coordination of care, thecontinuing need for home care, meet the patient's medical, nursing,rehabilitative, social, and discharge planning, type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items. review of patient medications to identify any potentialadverse effect and drug reactions, ineffective drug therapy, significant sideeffects, significant drug interactions, duplicate drug therapy andnoncompliance with drug therapy, and completing discharge assessments/OASIS atthe time of patient discharge . Stafffailing to follow POC will receive additional training with corrective actionup to termination. The Quality AssuranceCommittee, Compliance Officer, Administrator and Director of Nursing will	

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	04/10/16, with orders for skilled nursing to" ... administer flushes as ordered, O2 [oxygen] during naps / bedtime, administer trach care ... administer feedings." The patient's diagnoses included Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance. a. A start of care comprehensive assessment dated 02/11/16, indicated Pediasure 1.0, 720 milliliters through out the night, Pediasure 410 [sic] milliliters per hour, and Pediasure 1.5, 4 ounce bolus 4 times a day, the patient had both a gastric and jejunostomy feeding tubes, the patient was receiving bolus and continuous feedings, with 35 milliliter flushes of water to the gastric feeding tube and 10 milliliter flushes of water to the jejunostomy feeding tube after night feedings, NPO (nothing by mouth) a 4 x 4 dressing under the patient's trach with 1 liter of oxygen via concentrator when sleeping, the patient had a trach, humidifier for oxygen, ventilator, pulse oximetry to be done every visit and "AFO in progress." b. Section 16 of the initial plan of care titled "Nutritional Req [requirements]" indicated Pediasure 1.0, 720 milliliters overnight.		beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur. Allstaff will be in-serviced on (Comprehensive Assessment ofPatients) by 6/10/16. Individual training sessions with Case Managers to train on Comprehensive Assessment of Patients (including but not limitedto: the accuracy and detail completionof the assessment to support the POC, patient specific, current health status,information that may be used to demonstrate the patient's progress towardachievement of desired outcomes and measurable goals, coordination of care, thecontinuing need for home care, meet the patient's medical, nursing,rehabilitative, social, and discharge planning, type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, catheters (size andtype), wounds, size, measurements, instructions for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy,	

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	c. Section 18 of the initial plan of care titled "Activities Permitted" indicated AFOs [braces] were in progress. 1. The plan of care failed to be updated and revised to include the type, amount, and frequency of "flushes", failed to include the route of oxygen usage, failed to include the type of trach and frequency of trach care [including suctioning protocols], failed to include ventilator settings and management of the ventilator, failed to include the management of the humidifier, failed to include pulse oximetry, failed to include the amount of flushes and frequency to both gastric and jejunostomy feeding tubes, failed to include both types of Pediasure feedings along with the the specific tube used for feedings, the amount and rate of all tube feedings, failed to include that the patient was NPO, and failed to indicate the location and frequency of the AFOs to be placed and worn by the patient. 3. The clinical record for patient number 4, SOC 06/19/15, included a plan of care established by a physician for the certification period of 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ...		andcompleting discharge assessments/OASIS at the time of patient discharge startedon 5/24/16 and ongoing with the Director of Nursing, Alternate Director ofNursing/Compliance Officer. An all CaseManager training session has been scheduled for Friday, June 17, 2016 to trainon Comprehensive Assessment of Patients (includingbut not limited to: the accuracy anddetail completion of the assessment to support the POC, patient specific,current health status, information that may be used to demonstrate thepatient's progress toward achievement of desired outcomes and measurable goals,coordination of care, the continuing need for home care, meet the patient'smedical, nursing, rehabilitative, social, and discharge planning,type, frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, catheters (size andtype), wounds, size, measurements, instructions for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy,	

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	administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis and constipation. a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The plan of care failed to be updated and revised to specifically indicate skilled nursing to perform a digital stimulation / bowel program as well as failed to include measurable goals for the program. b. Review of the comprehensive reassessment for recertification dated 08/17/15, indicated the patient was incontinent of bowel on a daily basis. The plan of care failed to be supported by the comprehensive assessment. 4. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with		andcompleting discharge assessments/OASIS at the time of patient discharge. Effective 6/1/16 aMedical Records Specialist was hired to track the date the initial assessmentis due. The Medical Records staff willnotify the DON and Administrator if timeframe not met. 6/1/16 a form was be added as achecklist and/or auditing tool for assessments for RN, Medical RecordsSpecialist, for chart audits, etc. Theform will serve as a check and balance system by asking questions and/or givingreminders for an accurate and detailed assessment. The DON and/or theAdministrator will contact nurse with a 24 hour turn around – suspension up totermination will follow if timelines not met. Effective 4/17/16 and ongoing 10% of all clinical records will beaudited quarterly for evidence Comprehensive Assessment ofPatients (including but not limited to: the accuracy and detail completion of theassessment to support the POC, patient specific, current health status,information that may be used to demonstrate the patient's progress towardachievement of desired outcomes and measurable goals, coordination of care, thecontinuing need for home care, meet the patient's medical, nursing,rehabilitative, social, and discharge planning,	

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	feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. The patient diagnoses include chronic obstructive pulmonary disease, congestive heart failure, and rheumatoid arthritis. a. During a home visit on 04/12/16 from 9:00 to 9:45 AM, at an Independent Living Apartments, the patient's room was observed to have a large bed in the living quarters with a kitchenette and bathroom. The living space was cluttered with oxygen concentrator (not in use) and other durable medical equipment between the patient bed and entry / door. The patient was observed sitting up in her bed eating a bowel of cereal while the home health aide was sitting in a chair conversing with the patient. After the patient ate, the home health aide took the bowel into the kitchenette and went into the bathroom and picked up the area. The home health aide indicated that the patient has home health aide services from 9:00 AM to 3:00 PM then personal care services from 3:00 PM to 4:45 PM. The home health aide stated that he / she assists the patient with her bathing, picks up around the apartment, runs errands, and provide companionship.		type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, catheters (size andtype), wounds, size, measurements, instructions for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge assessments/OASIS at the time of patient discharge. The ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur.	

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	b. Review of the comprehensive reassessment for recertification dated 01/21/16, indicated the patient had some dyspnea with exertion. The Nutritional Status assessment was left blank and did not specify if the patient has physically able to shop, cook, and or feed him / herself. The reassessment indicated the patient was continent of bowel and bladder. The fall risk assessment was left blank. The reassessment indicated the patient was able to participate in bathing self in shower or tub but required presence of another person for assistance or supervision, able to get to and from the toilet and transfer independently with or without device. The reassessment indicated the patient was able to transfer with minimal human assistance or with use of an assistive device, able to ambulate with use of a one - handed device, able to to independently walk on even and uneven surfaces and negotiate stairs with or without railings. The plan of care failed to be supported by the comprehensive assessment. c. The Administrator, Director of Nursing, and Assistant Director of Nursing was unable to provide any further information regarding the findings referenced above when asked on 04/18/16 at 3:45 PM.			

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	6. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterizations and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to assist with bed bath, assist with bath chair, pericare, nail care, foot care, pm care, assist with feeding, ambulation assist / mobility, commode, wheelchair, transfer / positioning, feeding, meal set up, oral care, encourage fluids, urine incontinence, check pressure areas, skin care, medication reminders, blood sugar reminders, make bed, and straighten patient area. The patient primary diagnoses was Rheumatoid Arthritis and Fibromyalgia. Secondary diagnoses listed in order were Bipolar Disorder, Diabetes, Sleep Apnea, Hypertension, and Urinary Retention. a. During a home visit on 04/12/16 at 10:30 AM, the patient stated that his / her daughter lived in the home but the daughter attended college during the day and provided the in and out catheterization at bedtime. The patient was then observed to transfer herself from the bed to a motorized wheelchair,			

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	from the motorized wheelchair to the toilet, from the toilet to the shower chair with stand by assistance from the home health aide. After the shower, the patient transferred herself from the shower chair to the toilet and dried herself off to the upper portion of the body and the home health aide dried the lower extremities. The patient transferred herself to the motorized wheelchair and was observed to dress herself with a sun dress type gown. After getting dressed, the patient operated her motorized wheelchair in the bedroom. An oxygen concentrator was observed in the room. b. Review of the start of care comprehensive assessment dated 03/17/16, the primary diagnosis was rheumatoid arthritis followed by secondary diagnoses of fibromyalgia, bipolar, diabetes mellitus, sleep apnea, hypertension, asthma, and urinary retention. The assessment did not indicate the patient had respiratory treatments used in the home. The assessment indicated the patient received meals from a community delivery service, able to take oral and injection medications independently, chairfast, unable to ambulate and is unable to wheel self, able to feed self independently, patient depends entirely upon another person to dress the upper			

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	body, unable to get to and from the toilet but is able to use a bedside commode with or without assistance, the nutritional assessment was left blank and did not specify if the patient was physically able to shop, cook, and or feed him / herself, and the summary indicated the patient must be catheterized 4 times a day, but 3 of the 4 catheterizations were to be provided by the agency nurses. The comprehensive assessment did not include the size of the pediatric catheter. The plan of care failed to be supported by the comprehensive assessment. The plan of care failed to include the size of the pediatric foley catheter to be used for in and out catheterizations and failed to include coordination with Mom's meals. 7. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. The goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained.			

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	a. Review of the comprehensive reassessment for recertification dated 03/02/16, the reassessment failed to provide a complete pain assessment, failed to include measurements to the lower extremity edema due to cellulitis, failed to provide wound bed assessment and measurement of the venous stasis ulcer to the right lower extremity, failed to complete the nutritional assessment, failed to document the fall risk assessment, failed to document the psychosocial assessment, failed to answer M1840 Toilet transferring assessment, failed to document patient / caregiver / family education, and failed to document a summary / progress of the past 60 days in the summary section. The comprehensive reassessment for recertification was incomplete and failed to support the services provided as written in the plan of care. The plan of care failed to be supported by the comprehensive assessment. b. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final			

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	wrap with coban dressing to the bilateral lower extremities. c. The plan of care failed to be updated and revised to include type of solution to cleanse the lower extremities and the location of wounds to be treated. The goals on the plan of care failed to be reflective of the patient's current status and treatment. 8. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days to to administer medication as ordered, administer gastric tube feedings / flushes as ordered. a. The plan of care failed to be updated and revised to include the amount of tube feeding to be provided, as well as the amount and frequency of flushes. 9. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10			

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	hour visits 5 days a week, and respite nursing up to 40 hours a month to assess cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / fall prevention, and Oxygen at 2 liters per trach at night. The patient primary diagnosis was Cerebral Palsy, sleep apnea, cerebral vascular accident, coarotation of aorta, and urinary incontinence. a. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H was observed cooking dinner for the patient. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The plan of care failed to be updated and revised to include trach care, ventilator settings / management, preparing meals, supra pubic catheter care, and suctioning as needed. b. Review of the comprehensive reassessment for recertification dated 03/18/16, the reassessment failed to provide a complete cardiopulmonary			

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	assessment, failed to complete the nutritional status, failed to provide an assessment of the suprapubic catheter / insertion site, failed to complete the assessment to the neurological and musculoskeletal system, failed to complete patient / caregiver / family education, and failed to complete a summary of the past 60 days. The plan of care failed to be supported by the comprehensive assessment. 10. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week, to provide a shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, make bed / straighten patient areas. The primary diagnosis indicated carbon monoxide poisoning, followed by secondary diagnoses of lumbago, esophageal reflux, hypothyroidism, and coronary artery disease. a. A form titled "Intake / Referral" dated 03/27/15, indicated the patient was a self referral and the patient had carbon monoxide poisoning in 2011. b. A physician visit note dated			

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	03/03/15, indicated the physician would not diagnose the patient with carbon monoxide poisoning due to the patient had been moved out of the environment and there was no labs to prove the patient had the poisoning although the patient symptom complex was similar to carbon monoxide poisoning. c. A comprehensive reassessment for recertification dated 09/22/15, indicated the patient was not short of breath, continent of both bowel and bladder, failed to complete the musculoskeletal system and functional limitations, failed to complete the neurological assessment, and failed to complete the summary of care (including progress toward goals to date. The primary diagnosis and plan of care failed to be supported by the comprehensive assessment and physician visit note 11. The Administrator, Alternate Administrator, Director of Nursing, and Assistant Director of Nursing was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 12. A policy titled Plan of Care dated 08/15/15, indicated " ... The Plan of Care is based on a comprehensive assessment and information provided the patient /			

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	family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The Plan of Care shall be completed in full to include ... All pertinent diagnosis (es), principle and secondary ... Medications, treatments, and procedures, Medical supplies and equipment required .... "			
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 skilled nurses notified the physician in relation to discharges for 1 of 5 (# 4) records reviewed of patients discharged by the agency and failed to notify the physician in relation to elevated blood pressures for 1 of 6 records reviewed of active / current patients in a sample of 11. (# 6) Findings include: 1. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with	N 0527	Allskilled nurses will be in-serviced on Tag G168 (Skilled Nursing Services) by6/10/16. Individual training sessionswith Skilled Nurses to train on POC, Periodic Review of POC which covers allpertinent diagnoses, including mental status, types of services and equipmentrequired, frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: type, frequency and duration, irrigations,ventilator (including settings / management), trach (size and type), tubefeedings, assistive	06/10/2016

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	orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide services (3) 2 hour visits per day 7 days a week. a. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15. b. Review of skilled nursing visit notes, a discharge comprehensive assessment was made on 08/26/15, but the last skilled nursing visit note was dated 09/15/15. c. Review of the home health aide visit notes, the last home health aide visit note was dated 09/08/15. d. The clinical record failed to evidence a physician's order to discontinue services on 08/31/15 as anticipated in the patient's discharge letter, failed to evidence an order to stopped home health aide services on 09/08/15, and failed to evidence an order to discharge skilled nursing services on 09/15/15. e. The Administrator was interviewed on 04/18/16 at 2:25 PM.		devises, oxygen (settings), bowel program (detailinstructions) suctioning, pulse oximetry, vents (setting/management), catheters(size and type), wounds, size, measurements, instructions for service, anysafety measures to protect against injury, instructions for timely dischargesor referral, and any other appropriate items. and promptly report any changesto the physician that suggest a need to alter the POC ; and Training onConformance with Physician Orders which include all medications, treatments andservices provided to patients must be ordered by a physician started on 5/24/16and ongoing with the Director of Nursing, Alternate Director ofNursing/Compliance Officer. An all CaseManager training session has been scheduled for Friday, June 17, 2016 to trainon POC, Periodic Review of POC which covers all pertinent diagnoses, includingmental status, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises,	

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	The Administrator did not provided further information or documentation in regards to notifying the physician of an impending discharges. 2. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention. a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The agency failed to provide documentation that the physician had been notified of the missed visits. b. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified.		oxygen (settings), bowel program (detail instructions) suctioning,pulse oximetry, vents (setting/management), catheters (size and type), wounds,size, measurements, instructions for service, any safety measures to protectagainst injury, instructions for timely discharges or referral, and any otherappropriate items.; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Training on Conformance with PhysicianOrders which include all medications, treatments and services provided topatients must be ordered by a physician. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill ensure that POC is being followed and documented by interview withpatient, review of POC, Physician Orders, notes and documentation sheets. The committee member, when educating, willget signed documents of the training provided. Each document signed will be placed in the staff personnel file andclient chart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24	

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	c. Review of a skilled nursing visit note on 03/22/16 at 6:00 PM, the skilled nurse documented no urine output after 2 attempts of catheterizations. The clinical record failed to evidence that the physician had been notified. d. Review of a skilled nursing visit note on 03/23/16 at 10:00 AM, the skilled nurse documented the patient had a blood pressure of 149/101. The clinical record failed to evidence that the physician had been notified. e. Review of a skilled nursing visit note on 03/25/16 at 9:00 PM, the skilled nurse documented no urine output. The clinical record failed to evidence that the physician had been notified. 3. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services did not have any further information or documentation. 4. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse informs the physician and other personnel of changes in the patient condition of needs ... The Licensed Practical Nurse ... Reports findings and observations to the Registered Nurse and other members of		hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved., Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence on POC, Periodic Review of POC which covers all pertinent diagnoses,including mental status, types of services and equipment required, frequency ofvisits, prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specific instructions,(including but not limited to: trach, type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items.; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Training on Conformance with PhysicianOrders which include all medications, treatments and	

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	the team to assure coordination and timely response to client changes or needs .... "		services provided topatients must be ordered by a physician. Staff failing to follow POC will receive additional training withcorrective action up to termination. The Quality Assurance Committee, Compliance Officer, Administrator andDirector of Nursing will be responsible for monitoring these corrective actionsto ensure that this deficiency is corrected and will not recur.	
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 that 60 day summaries were individualized and had a clearly written synopsis of the patient's course of treatment, including all services provided for 9 of 9 records reviewed of patients recertified in a sample of 11. (#1, 2, 4, 5, 7, 8, 9, 10, and 11) Findings include: 1. The clinical record for patient number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to	N 0529	Allstaff will be in-serviced on (Organization, Services and Administration) by6/10/16. Individual training sessionswith Case Managers to train on 60 day summaries to ensure they areindividualized and have clearly written synopsis of the patient's course oftreatment, including all services provided, and the removal of all servicesindicated on "other" (HMK, ATTC, PAC, etc.) and submitted to Physician startedon 5/24/16 and ongoing with the Director of Nursing, Alternate Director ofNursing/Compliance Officer. An all CaseManager training session has been scheduled for	06/10/2016

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	05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. Review of a form titled Clinical Summary / Case Conference dated 03/22/16, the form indicated the services provided were skilled nursing and attendant care services with [name of outside agency]. The form indicated to continue goals / care, response of current treatment / medications, summary of patients conditions / changes in patient condition was left blank, indication to problems / needs / goals were left blank, caregiver support system / home environment indicated the patient "lives with" but was left blank, and no		Friday, June 17, 2016 to trainon 60 day summaries to ensure they are individualized and have clearly writtensynopsis of the patient's course of treatment, including all services provided andthe removal of all services indicated on "other" (HMK, ATTC, PAC, etc.) andsubmitted to Physician. Updates to theCase Manager training manual on 60 day summaries to ensure the clinicalsummaries are individualized and have clearly written synopsis of the patient'scourse of treatment, including all services provided, and the removal of allservices indicated on "other" (HMK, ATTC, PAC, etc.) and submitted to Physicianwill be completed by 6/2/16. Effective4/17/16 10% of all clinical records will be audited quarterly for evidence that60 day summaries are individualized and have clearly written synopsis of thepatient's course of treatment, including all services provided and the removalof all services indicated on "other" (HMK, ATTC, PAC, etc. and submitted toPhysician. The Compliance Officer,Administrator and Director of Nursing will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

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	anticipated discharge plans. The new certification order indicated skilled nursing 1 - 13 hour visit a day for 7 days, 1 to 3 hour visits for 5 days a week for 9 weeks and attendant care services with [name of agency] for the certification period of 03/23/16 to 05/21/16. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment. 2. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to evaluate cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / falls prevention, medication teaching, evaluate med effects / compliance, administer suppository per MD orders, teach bowel regimen, and provide pericare. The patient was also receiving home health aide services (3) 2 hour visits per day 7 days a week to assist with bathing and hygiene, light housekeeping, transfer or positioning, encourage fluids, incontinent care of urine, check pressure areas, skin care, and			

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	range of motion to all extremities. Goals indicated the patient would maintain good hygiene and comfort, safety would be maintained, demonstrates compliance with medications, Stabilization of cardiovascular pulmonary condition, demonstrates competence in following medical regimen, and verbalized pain controlled at acceptable level. a. Review of a form titled Clinical Summary / Case Conference dated 08/18/15, the form indicated the services provided were home health aide and attendant care services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective, summary of patients conditions / changes in patient condition was left blank, no new problems had been identified, lived alone, no indication for anticipated discharge plan, and recertification order indicated skilled nursing 1 to 2 hour visit a day for 2 days a week for 9 weeks, home health aide services (3) 2 hour visits a day 7 days a week for 9 weeks, and attendant care services 58 - 62 hours a month through Medicaid Waiver, for the certification period 08/18/15 to 10/16/15. b. On 08/21/15, the patient was sent a letter for discharge by the agency due to			

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	the patient's frequent refusal of staff. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment, including all services provided, progress toward goals, and the anticipated plan for discharge. The summary included attendant care order / information which was not a part of a service that was provided by the home health agency. 3. The clinical record for patient number 5, SOC 03/01/10, included a plan of care established by a physician for the certification period of 01/27/16 to 03/26/16 with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing and hygiene, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, and light housekeeping. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. Review of the home health aide visit notes during the certification period indicated the home health aides was not breaking up their visits as ordered and was staying with the patient from 9:00 AM to 3:00 PM, then immediately providing attendant care services through			

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	a sister company from 3:00 PM to 4:45 PM. b. Review of the comprehensive recertification assessment dated 03/23/16, indicated the patient's oxygen saturation was 94% percent, patient was incontinent of bladder only, and no assessment of the nutritional status. c. A form titled Clinical Summary / Case Conference dated 03/23/16, the form indicated the services being provided were home health aide services and attendant care services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective, summary of patients conditions / changes in patient condition indicated the patient's oxygen saturations was 93%, nutrition and hydration was adequate, bowel and bladder incontinence, problems / needs / concerns indicated no new problems had been identified, caregiver support / system / home environment indicated the patient lived alone, no planned discharge at the present time, and no change in the plan of treatment / plan of care goals. The recertification order indicated home health aide services (2) 2 hour and (2) 1 hour visits a day 7 days a week for 9 weeks and attendant care services 24 - 28 hours a month for the certification period			

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	from 03/27/16 to 05/25/16. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment. The summary included attendant care order / information which was not a part of a service that was provided by the home health agency. 4. The clinical record for patient number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. During a home visit on 04/12/16 at 12:20 PM, a skilled nurse was observed to clean the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower			

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	extremities. The patient was observed to have a wound to the right outer leg between the knee and ankle. b. Review of a form titled Clinical Summary / Case Conference dated 01/06/16 and 03/04/16, the form indicated the services provided were skilled nursing services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective, summary of patients conditions / changes in patient condition was reflected from the recertification reassessments which indicated the patient was alert and oriented, vital signs within normal limits, breath sounds clear, skin warm / dry with good turgor, abdomen soft with bowel sounds x 4 quads, nutrition and hydration adequate, lower extremity cellulitis continues with skilled nursing and daily dressing changes, no new problems had been identified, lived with a disabled wife, no planned discharge, and no change in plans of treatment / plan of care goals. The new certification indicated to continue skilled nursing 1 hour a day 7 days a week. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care goals for the correct certification period.			

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	5. The clinical record for patient number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. The patient also had respite nursing 1 - 30 hours for 12 months. a. Review of the skilled nursing visit notes, the skilled nurse provided 1 hour on 2/22; 3 consecutive hours on 03/08, 03/09, 03/16 (PM), 03/30 (PM); 4 consecutive hours on 03/10, 03/23, 03/30 (AM); 5 consecutive hours on 2/25, 03/03, 03/04, 03/28; 9 consecutive hours on 2/29, 03/22; 6 consecutive hours on 03/17 (PM); 7 consecutive hours on 2/23, 2/24, 03/02; 8 consecutive hours on 2/15, 2/18, 2/19, 2/25, 03/01, 02/21, 03/31, 04/01; 10 consecutive hours on 02/29; and 12 consecutive hours on 04/08/16. During week 6 (03/20 to 03/26/16), the skilled nurse only provided services for 3 days. b. Review of a form titled Clinical Summary / Case Conference dated 10/14/15 and 12/11/15, indicated the services provided were skilled nursing services and respite nursing, continue goals / care, appeared complementary			

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	with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition was reflected from the recertification reassessments which indicated indicated the patient was alert and oriented, vital signs within normal limits, breath sounds clear, skin warm / dry with good turgor, gastric tube intact and patent, abdomen soft with bowel sounds x4 quads, no signs and symptoms of distress or pain, no new problems had been identified, lived with parents, no planned discharge, and no change in plans of treatment / plan of care goals. The summaries failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care goals for the correct certification period. c. Review of a form titled Clinical Summary / Case Conference dated 02/13/16 and 04/13/16, indicated the services provided were skilled nursing services and respite nursing, continue goals / care, appeared complementary with no duplication, response to current treatment / medications were effective. The summary of patients conditions / changes in patient condition indicated the patient was alert and oriented, vital signs within normal limits, breath sounds clear, skin warm / dry with good turgor, gastric			

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	tube intact and patent, abdomen soft with bowel sounds x4 quads, and both forms also indicated the patient suffered a broken right femur shaft on 02/04/16 and underwent internal fixation device open approach on 02/05/16. Surgical incision was clean, dry, no drainage or odor, edges were approximated without signs and symptoms of infections, no new problems were identified, lived with parents, no planned discharge, and no change in plans of treatment / plan of care goals. The new certification indicated to continue skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days and respite nursing 1 - 30 hours for 12 months. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care goals for the correct certification period. The 04/13/16 summary failed to include the patient's return to surgery for removal of appliances on 02/16/16. 6. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week and respite nursing up to 40 hours a month for 12			

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	months to evaluate cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate and teach for signs and symptoms of infections and standard precautions, teach diet, teach home safety / fall prevention, and oxygen at 2 liters per trach at bedtime. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. Review of a form titled Clinical Summary / Case Conference dated 11/18/15 and two undated clinical summaries for the certification periods 11/22/15 to 01/20/16 and 01/21/16 to 03/20/16, indicated the services provided were skilled nursing services and respite nursing, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition indicated the patent was very stable and seems quite happy surrounded by her family. Problems / Needs / Concerns indicated in all 3 summaries that the patient seemed to have been suffering from a mild stomach flu, no new problems were identified, lived with parent, no planned discharge, and no change in plans of treatment / plan of care goals.			

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	b. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H stated the patient attended an adult day care 3 days a week and would sometimes go with a parent to work. Employee H stated he / she provides services to the patient on Tuesday from 3:45 to 9:00 PM and 10:00 AM to 9:00 PM on Thursday, Friday, and Saturday. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment with adequate plan of care goals for the correct certification period. 7. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and make bed / straighten patient areas. a. Review of a form titled Clinical			

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	Summary / Case Conference dated 09/23/15, indicated the services provided were home health aide services, attendant care services and homemaker services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition was left blank, Problems / Needs / Concerns was left blank, caregiver support system was left blank, no planned discharge, and no indication of changes in plans of treatment / plan of care goals. The new certification indicated home health aide services to continue 1 hour a day 7 days a week and continue 30 hours of attendant care services and 21 - 23 hours of homemaker services for the certification period from 09/23/15 to 11/21/15. The summary failed to be individualized and include a clearly written synopsis of the patient's course of treatment. The summary included attendant care and homemaker orders / information which was not a part of the services that was provided by the home health agency. 8. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health			

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	aide services 3 hours per day 5 days a week to assist with bathing and hygiene, ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and light housekeeping, and range of motion exercises (all extremities). Goals indicated the patient would maintain good hygiene, comfort, and safety will be maintained. a. Review of a form titled Clinical Summary / Case Conference dated 10/18/15, indicated the services provided were home health aide services and PAC services, continue goals / care, appeared complementary with no duplication, response to current treatment / medications was effective. The summary of patients conditions / changes in patient condition was left blank, no new problems identified, caregiver support system indicated the patient lived with parents, no planned discharge, and "NA" (not applicable) to changes in plans of treatment / plan of care goals. The new certification indicated home health aide services to continue (1) 3 hour / day for 5 days a week and PAC 15 hours per week through medicaid waiver for the certification period from 10/18/15 to 12/16/15. The summary failed to be			

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	individualized and include a clearly written synopsis of the patient's course of treatment. The summary included PAC orders / information which was not a part of the services that was provided by the home health agency. 9. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 10. A policy titled Medical Supervision dated 07/10/15, indicated " ... Written reports on the patient's condition are provided to the physician at least every sixth [sic] [60] days. 11. A policy titled Clinical Summary to Physician dated 07/10/15, indicated " ... The summary note will include: a. Clinical summary of the care, treatment and services provided during the previous sixty [60] day episode of care. b. Patient response to the services and progress toward established goals. Summary of current needs and involvement of other community / family caregivers or services .... "			
N 0532 Bldg. 00	410 IAC 17-13-1(d) Patient Care Rule 13 Sec. 1(d) Home health agency			

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	personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact.			
	Based on record review and interview, the agency failed to notify the primary care physician of missed visits in 1 of 6 active / current records reviewed (# 6), failed to notify the primary care physician of a patient's elevated blood pressures for 1 of 6 records reviewed of active / current patients (# 6), and failed to notify the primary care physician for a patient with no urinary output for 1 of 2 patients reviewed with in and out catheterizations (# 6), failed to ensure that all treatments provided had a physician's order for 2 of 2 records reviewed of patients with wounds (#7 and 8) and 1 of 1 records reviewed of patients receiving a bowel program (# 4) in a sample of 11. Findings include: 1. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer	N 0532	Allstaff will be in-serviced on (Conformance with Physician Orders) by 6/10/16. Individual training sessions with CaseManagers to train on Conformance with Physician Orders which include allchanges, notifications, need of supplies, medications, treatments and servicesprovided to patients must be ordered by a physician started on 5/24/16 andongoing with the Director of Nursing, Alternate Director of Nursing/ComplianceOfficer. An all Case Manager trainingsession has been scheduled for Friday, June 17, 2016 to train on Conformancewith Physician Orders which all changes, notifications, need of supplies, medications,treatments and services provided to patients must be ordered by aphysician. On 5/25/16 and ongoing an In Home Quality AssuranceCommittee was developed to make home visits on 10% of clients monthly (untilall clients have been seen) (the committee will continue to make home visits10% quarterly). During the home visitthe	06/10/2016

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	suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The agency failed to ensure physician orders had been obtained prior to digital stimulation / conducting a bowel program. 2. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention. a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The agency failed to provide documentation that the physician had		committee member will ensure that POC is being followed and documented byinterview with patient, review of POC, notes and documentation sheets, missedvisit reports that conform to Physician Orders. The committee member, wheneducating, will get signed documents of the training provided. Each document signed will be placed in thestaff personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesdayof each month to discuss findings and the outcomes and to ensure that eachfinding was addressed and resolved., Effective 4/17/16 and ongoing 10% of allclinical records will be audited quarterly for evidence that Conformance withPhysician Orders which include all changes, notifications, need of supplies, medications,treatments and services provided to patients must be ordered by aphysician. Staff failing to follow POCwill receive additional training with corrective action up to termination. The Quality Assurance Committee, ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will	

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	been notified of the missed visits. b. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified. c. Review of a skilled nursing visit note on 03/23/16 at 10:00 AM, the skilled nurse documented the patient had a blood pressure of 149/101. The clinical record failed to evidence that the physician had been notified. 3. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied		not recur. All skilled nurses will be in-serviced on (Duties of theRegistered Nurse reporting to Physician, Licensed Practical Nurse and otherteam member reporting to RN) by 6/10/16. Individual training sessions with Registered Nurses to ensure that theRN (LPN and other team members are furnishing to the RN) is furnishing, documentingand assessing services requiring substantial and specialized nursing skill asthe plan of care is implemented, revised, and updated by Registered Nurse andis supported by the comprehensive assessment which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures	

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	silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. The clinical record failed to include a physician's order for the treatment that had been provided. 4. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. a. A skilled nursing visit note dated 02/18/16, indicated the patient recently had surgery to remove two loose pins and replaced it with a rod from the hip to knee in the right leg. Skilled nursing visit notes dated 03/09 and 03/10/16, indicated that the patient's surgical incision dressing had been changed. The clinical record failed to include a physician's order for the treatment to be provided. 5. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing did not have any further information or documentation in		to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician started on 5/24/16 and ongoing with the Director of Nursing,Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to ensure that the RN (LPN and other teammembers are furnishing to the RN) isfurnishing, documenting and assessing services requiring substantial andspecialized nursing skill as the plan of care is implemented, revised, andupdated by Registered Nurse and is supported by the comprehensive assessmentwhich covers all pertinent diagnoses, including mental status, types ofservices and equipment required, frequency of visits, prognosis, rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements, medications and treatments w/specific instructions, (includingbut not limited to: type, frequency andduration, irrigations, ventilator (including	

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	relation to physician orders for wound treatments. 6. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator did not provided further information or documentation in regards to notifying the physician of an impending discharges. 7. A policy titled Physician Orders dated 07/10/15, indicated "All medications, treatments and services provided to patients must be ordered by a physician 8. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse informs the physician and other personnel of changes in the patient condition of needs ... The Licensed Practical Nurse ... Reports findings and observations to the Registered Nurse and other members of the team to assure coordination and timely response to client changes or needs .... "		settings / management), trach(size and type), tube feedings, assistive devises, oxygen (settings), bowelprogram (detail instructions) suctioning, pulse oximetry, vents(setting/management), catheters (size and type), wounds, size, measurements,instructions for service, any safety measures to protect against injury,instructions for timely discharges or referral, and any other appropriateitems; and promptly report any changes to the physician that suggest a need toalter the POC ; and Conformance with Physician Orders which include allmedications, treatments and services provided to patients must be ordered by aphysician. On 5/25/16 and ongoing an In Home Quality AssuranceCommittee was developed to make home visits on 10% of clients monthly (untilall clients have been seen) (the committee will continue to make home visits10% quarterly). During the home visitthe committee member will ensure that the RN (LPN and other team members are furnishingto the RN) is furnishing, documenting and assessing services requiringsubstantial and specialized nursing skill as the plan of care is implemented,revised, and updated by Registered Nurse and is supported by the	

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INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

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			comprehensiveassessment which covers all pertinent diagnoses, including mental status, typesof services and equipment required, frequency of visits, prognosis,rehabilitation potential, functional limitations, activities permitted,nutritional requirements, medications and treatments w/specific instructions,(including but not limited to: type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. The committeemember, when educating, will get signed documents of the trainingprovided. Each document signed will beplaced in the staff personnel file and client chart. The committee members will	

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			provide a writtenreport of the visit to the Administrator and Director of Nursing within 24hours. The committee will meet thefirst Wednesday of each month to discuss findings and the outcomes and toensure that each finding was addressed and resolved., Effective 4/17/16 and ongoing10% of all clinical records will be audited quarterly for evidence of the thatthe RN (LPN and other team members are furnishing to the RN) is furnishing, documenting and assessingservices requiring substantial and specialized nursing skill as the plan ofcare is implemented, revised, and updated by Registered Nurse and is supportedby the comprehensive assessment which covers all pertinent diagnoses, includingmental status, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning,pulse oximetry, vents (setting/management), catheters (size and type), wounds,size,	

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			measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. Staff failing tofollow procedure will receive additional training with corrective action up totermination. The Quality Assurance Committee, Compliance Officer, Administratorand Director of Nursing will be responsible for monitoring these correctiveactions to ensure that this deficiency is corrected and will not recur.	
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. (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.			

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	(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 the home health aide followed the plan of care for 4 of 4 records reviewed with home health aide services in a sample of 11. (#3, 5, 10, and 11) Findings include: 1. The clinical record for number 3, SOC 06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health aide services 14 hours per week, 1 - 2 hours per day, 7 days a week for 9 weeks. The patient diagnoses included, but limited to arthritis, coronary artery bypass graft, coronary artery disease, diabetes, and autonomic instability. a. Review of the clinical record on 04/07/16 at 1:54 PM, the clinical record failed to evidence home health aide visits from 06/22/15 to 07/14/15, 07/15/15, 07/16/15, and 07/18/16 to 07/27/15.	N 0533	Allstaff will be in-serviced on (Plan of Care & Periodic Review of Plan ofCare) by 6/10/16. Individual trainingsessions with Case Managers to train on POC and Periodic Review of POC whichcovers all pertinent diagnoses, including mental status, types of services andequipment required, frequency of visits, prognosis, rehabilitation potential,functional limitations, activities permitted, nutritional requirements,medications and treatments w/specific instructions, (including but not limitedto: type, frequency and duration,irrigations, ventilator (including settings / management), trach (size andtype), tube feedings, assistive devises, oxygen (settings), bowel program(detail instructions) suctioning, pulse oximetry, vents (setting/management),catheters (size and type), wounds, size, measurements, instructions forservice, any safety measures to protect against injury, instructions for timelydischarges or referral, and any other appropriate items; and promptly reportany changes to the	06/10/2016

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	b. The Administrator on 04/07/16 at 4:00 PM, and provided a typed statement indicating that employee E, a Registered Nurse / Case Manager, that the patient had been complaining about not getting all of his / her hours. The statement indicated the Administrator had spoken to employee L, a Home Health Aide and Manager of a Personal Service Agency owned by the Administrator. The statement indicated Employee L had spoken with the patient and the patient was not satisfied with the staff Employee L was sending, the patient wanted the agency to hire a family member, and was holding the agency off. The statement indicated the Administrator had left a message on the patient's phone on 7/23, 7/24, 7/27, and 7/28/15. On 7/25/15, the statement indicated the patient had emailed Employee M, also a home health aide and coordinator for both the home health agency and personal services agency, and had asked about hiring the patient's sister [name of sister was included]. The statement indicated Employee M had informed the patient that he / she was unaware of the request and would investigate it. The statement indicated the Administrator and Employee M had talked with the patient and the patient indicated "it didn't matter he / she fired us and was going with an agency that would hire his / her sister in		physician that suggest a need to alter the POC started on 5/24/16 and ongoing with theDirector of Nursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions (including but not limited to type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC. On5/25/16 and ongoing an In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all	

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	one day." The Administrator stated new staff must have orientation for approximately 1 week. c. Patient number 3 was interviewed on 04/07/16 at 7:00 PM. The patient had stated that the named sister in the statement, was a patient of the agency's and had been for many years. The patient stated he / she used to work for the agency and took care of the named sister until he / she had their own surgery in 2009. The patient stated that his / her niece currently works for the agency and was taking care of the mentioned sister. The patient stated he / she would never ask to have his / her niece removed from the sister's care. The patient stated that he / she did not want weekend staff, but wanted to take the weekend hours and apply it to the week day hours. The patient stated he / she had never canceled or refused a visit, but complained to the agency about not having home health aides to his / her home as ordered. The patient stated on one occaision, a home health aide was in an accident on his / her way to the patient's home, but the home health aide was not replaced. The patient stated the agency told him / her would need to find another agency. d. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 PM.		clients have been seen) (the committee will continue to make homevisits 10% quarterly). During the homevisit the committee member will ensure that POC is being followed anddocumented by interview with patient, review of POC, review of notes anddocumentation sheets. The committee member, when educating, will get signeddocuments of the training provided. Eachdocument signed will be placed in the staff personnel file and clientchart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved., Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence that POC which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises,	

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	The Director of Clinical Services stated she was not aware of the missing home health aide visits. The Director of Clinical Services stated she mostly manages the nursing and the Administrator, Employee L and Employee M managed the home health aides. e. Employee M and the Administrator were interviewed on 4/18/16 at 2:25 PM. Employee M stated he / she was a home health aide and nothing further. The Administrator stated Employee M did helped with coordination as well. Employee M was not able to recall the event nor conversation with the patient. After the statement was read, Employee M was not able to add any further information and indicated the statement summed up the situation. The Administrator stated the name mentioned in the statement must have been wrong. 2. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with		oxygen (settings), bowel program (detail instructions) suctioning,pulse oximetry, vents (setting/management), catheters (size and type), wounds,size, measurements, instructions for service, any safety measures to protectagainst injury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC. Stafffailing to follow POC will receive additional training with corrective actionup to termination. The Quality AssuranceCommittee, Compliance Officer, Administrator and Director of Nursing will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur. AllStaff including Home Health Aides will be in-serviced on (Assignment and Dutiesof Home Health Aide) following the POC and reporting any changes that suggest aneed to alter the POC to the Registered Nurse to report to the Physician by6/10/16. Effective 4/17/16 and ongoing10% of all clinical records will be audited quarterly for evidence of the HHA'sare following POC and reporting any changes to the Registered Nurse thatsuggest a need to alter the POC to be reported to the Physician . Effective 4/18/16 Management personnel	

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	feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. a. Review of the home health aide notes dated 02/15, 02/19, 02/20, 02/21, 02/22, 02/26, 02/29, 03/04, 03/05, 03/06, 03/07, 03/11, 03/14, 03/17, 03/18, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, and 03/28/16, the home health aide documented "NN" (Not Needed) for bathing, pericare, nail care, foot care, pm care, ambulation assist / mobility, assist with feeding, incontinent care, checking pressure areas, skin care, medication assistance, and / or making the bed / straighten patient area. The home health aide failed to follow the plan of care. b. Review of the home health aide visit notes dated 02/14/16 to 02/17/16, 02/19/16 to 03/16/16, 03/18/16 to 03/21/16, 03/23 to 03/25/16, 03/17/16, and 04/02/16, the home health aide indicated he / she had provided services to the patient from the hours of 9:00 AM. to 3:00 PM. On 02/18/16 and 03/26/16, the home health aide indicated he / she had provided services from 10:30 AM to 3:30 PM. On 03/17/16, the home health aide indicated he / she had provided		wereinstructed to transfer all complaints from patients or caregivers (includingschedules and staffing) to the Administrator or Director of Nursing ordesignee. All complaints will beinvestigated and documented with a resolution. If resolution of the complaint was not possible, the actions that wereattempted and the outcomes will be documented by ISHHA. On 5/27/16 policy was updatedto include a letter will be sent to the patient upon resolution (will includethe actions that were attempted and the outcomes). A copy of the letter will accompany the ISHHAinvestigation. On 5/25/and ongoing anIn Home Quality Assurance Committee was developed to make home visits on 10% ofclients monthly (until all clients have been seen) (the committee will continueto make home visits 10% quarterly). During home visits, thecommittee members will review the POC and HHA documentation to ensure HHA's arefollowing POC and documenting as POC states, Registered Nurse will alert thePhysician if documentation suggest a need to alter the POC. The committee member,when educating, will get signed documents of the training provided. Each document signed will be placed in thestaffs personnel file. Thecommittee will meet the first Wednesday of each	

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	services from 12:00 PM to 4:00 PM. On 03/22/16, the home health aide indicated he / she had provided services from 9:00 AM to 11:50 AM. On 03/28/16, the home health aide indicated he / she provided services from 9:00 AM to 7:25 PM. The home health aide failed to follow the plan of care. c. During a home visit on 04/12/16 at 9:00 AM., the patient's agency binder was reviewed. The binder included a page of a breakdown of home health aide and attendant care hours through the personal services agency owned by the Administrator. The page indicated 9:00 AM to 11:00 AM, 11:30 AM to 12:30 PM, 1:00 PM to 2:00 PM, and 2:15 PM to 4:15 PM, and weekends 9:00 AM to 3:00 PM services were to be home health aide hours through the home health agency. The other times 11:00 AM to 11:30 AM, 12:30 PM to 1:00 PM, and 2:00 PM to 2:15 PM, services were to be provided with the personal services agency. d. The home health aide, Employee P, was interviewed during this time. The employee stated that he / she was unfamiliar with the breakdown of time sheet and pulled the sheet from the binder. Employee P stated she works from 9:00 AM to 3:00 PM and does the		month to discuss findings andthe outcomes and to ensure that each finding was addressed and resolved. Effective 6/1/16 and ongoing a HHADocumentation Review Committee was established to audit 10% of all HHAdocumentation quarterly for evidence that the HHA's are following POC andreporting any changes that suggest a need to alter the POC to the RegisteredNurse to be documented and reported to the Physician. The committee will provide audit results tothe staff's "Point of Contact" person for re-training of HHA's, theAdministrator and DON. A trainingdocument will be placed in the personnel file. The Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur.	

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	personal care services from 3:00 PM to 4:45 PM. e. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 p.m. The Director of Nursing stated the home health aides should have been following the plan of care. 4. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and make bed / straighten patient areas. a. Review of the home health aide visit notes, the record failed to evidence a home health aide visit on 10/5/15 and 10/25. The home health aide failed to follow the plan of care. b. Review of the home health aide notes dated 10/01, 10/02, 10/06, 10/07, 10/08, 10/09, 10/12, 10/14, 10/15, 10/17, 10/18, 10/23, and 10/24/16, the home health aide documented "NN" (Not Needed) for shower, pericare, nail care, foot care, ambulation assist / mobility in			

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INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wheelchair, skin care, check pressure ulcers, and / or make bed / straighten patient areas. The home health aide failed to follow the plan of care. 5. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health aide services 3 hours per day 5 days a week to assist with bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). a. Review of the home health aide visit notes during the certification period of 08/19/15 to 10/17/15, the home health aide failed to evidence 5 visits during week 1, 1 visit during week 2, 5, and 7, and 2 visits during week 3, 4, and 6. The home health aide failed to follow the plan of care. The home health aide provided 2 extra visits during week 8 and 9. b. Review of the home health aide			

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	visit notes dated 08/27, 08/28, and 08/31/15, the home health aid provided 6 hour visits. The home health aide failed to follow the plan of care. c. Review of the home health aide notes dated 08/25 to 08/27, 09/02, 09/04, 09/09, 09/14 to 09/17, 09/22 to 09/24, 09/28 to 09/30, 10/04 to 10/17/15, the home health aide documented "NN" (Not Needed) for bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). The home health aide failed to follow the plan of care. 6. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all patient visit notes had been provided. 7. The Administrator, Alternate Administrator, Director of Clinical Services, and Assisting Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM.			

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	8. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to e provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... "			
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 Registered Nurse failed to followed the plan of care for 6 of 6 records reviewed of patients receiving services from a registered nurse in a sample of 11. (#2, 4, 6, 7, 8, 9,) Findings include: 1. The clinical record for number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders for skilled nursing. The patient's diagnoses included RSV (Respiratory Syncytial Virus), Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia,	N 0537	Allstaff will be in-serviced on (Plan ofCare) by 6/10/16. Individual trainingsessions with Case Managers to train on POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: trach, vents, cathes, g and j tubes, oxygen,suctioning, wounds, pulse oximetry–measurements and sizes) any safety measuresto protect against injury, instructions for timely discharges or referral, andany	06/10/2016

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	Development Disorder, and gastric tube feeding intolerance. a. A "Notification of Client Status" dated 02/11/16, indicated the patient had been admitted for respite nursing and "PA" (meaning prior authorization from Medicaid to provide ongoing nursing services on a routine basis). The note also indicated the parents wanted a routine nurse for overnights and no float nurses. b. The initial plan of care (undated) had orders for skilled nursing to evaluate but failed to include a nursing frequency / duration. The agency provided respite nursing visits on 02/24/16 and 02/26/16. The nurse failed to follow the plan of care. c. The second plan of care dated 03/22/16, had orders for skilled nursing 8 hours per day, 5 days a week for 9 weeks and respite nursing up to 60 hours per month for 12 months. Review of the clinical record, the agency failed to provide skilled nursing visits 8 hours a day, 5 days a week. d. The Administrator, Director of Clinical Services, and Assisting Director of Clinical Services was interviewed on 04/07/16 at 12:30 PM. The		other appropriate items started on 5/24/16 and ongoing with the Director ofNursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions (including but not limited to: type, frequency and duration, irrigations,ventilator (including settings / management), trach (size and type), tubefeedings, assistive devises, oxygen (settings), bowel program (detailinstructions) suctioning, pulse oximetry, vents (setting/management), catheters(size and type), wounds, size, measurements, instructions for service, anysafety measures to protect against injury, instructions for timely dischargesor referral, and any other appropriate items; and promptly report any changesto the physician that suggest a need to alter the POC. On 5/25/16 and ongoing an In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all clients have been seen) (the	

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	Administrator, Director of Clinical Services, and Assistant Director of Clinical Services stated that the initial plan of care was developed upon admission and the agency were to provide respite nursing services. The patient was transferred into the hospital and returned home on 3/22/16. The Administrator and Assistant Director of Clinical Services stated that Medicaid had instructed the agency to develop a new plan of care versus writing orders and updating the current plan of care. The Assistant Director of Clinical Services stated there was a delay in routine nursing services due to the father's lack of ability to provide job information. The Director of Clinical Services stated the PA (Prior Authorization) came on 3/25/16, but the mother did not want floating nurses in the home and requested that the patient be staffed with a permanent nurse. The Assistant Director of Clinical Services stated the requested visit notes may have been in the patient's home. At 1:00 PM, missed visit notes were provided and the Director of Clinical Services stated she had been interviewing for a permanent nurse and a nurse had been hired and was due to start "today." e. The parent of patient number 2 was interviewed on 04/07/16 at 3:50 PM.		committee will continue to make homevisits 10% quarterly). During the homevisit the committee member will ensure that POC is being followed anddocumented by reviewing the POC, interview of patient and notes anddocumentation sheets. The committee member, when educating, will get signeddocuments of the training provided. Eachdocument signed will be placed in the staff personnel file and clientchart. The committee members will providea written report of the visit to the Administrator and Director of Nursingwithin 24 hours. The committee willmeet the first Wednesday of each month to discuss findings and the outcomes andto ensure that each finding was addressed and resolved. Effective 4/17/16 and ongoing 10% of allclinical records will be audited quarterly for evidence that POC which coversall pertinent diagnoses, including mental status, types of services andequipment required, frequency of visits, prognosis, rehabilitation potential,functional limitations, activities permitted, nutritional requirements,medications and treatments w/specific instructions (including but not limitedto type, frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises,	

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	The parent had stated that he / she did not recall telling the agency that he / she wanted to hold services or refused services until a permanent nurse was available. The parent stated he / she preferred a permanent nurse but would have taken anyone due to the exhaustion between him / her and their spouse, need for rest during the night due to pregnancy / work, and how the patient needed constant supervision during the night due to getting the trach tubing around his / her neck. The parent indicated the patient had respite nursing a few times prior to his / her hospitalization, but when the patient came out of the hospital, his / her respite nurse was in the hospital his / herself and that a replacement respite nurse had not been provided. 2. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week. The patient diagnoses included, but limited to Multiple Sclerosis. a. Review of the skilled nursing visit notes, the skilled nurse failed to provide 2 visits during the week of 07/19 to 07/25/15 and during the week of 07/26		oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC. Stafffailing to follow POC will receive additional training with corrective actionup to termination. The Quality AssuranceCommittee, Compliance Officer, Administrator and Director of Nursing will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur. Allskilled nurses will be in-serviced on Tag G170 (Skilled Nursing Services) by6/10/16. Individual training sessionswith Skilled Nurses to train on furnishing services in accordance with the POCwhich covers all pertinent diagnoses, including mental status, types ofservices and equipment required, frequency of visits, prognosis, rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements, medications and treatments w/specific instructions, (includingbut not limited to type, frequency and duration,	

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	to 08/01/15. The skilled nurse failed to provide a 2nd visit during the week of 08/09 to 08/15/15. The skilled nurse failed to follow the plan of care. 3. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and home health aide services (2) 2 hour visits and (1) 1 hour visits per day 7 days a week. a. Review of the skilled nursing visit notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The skilled nurse failed to follow the plan of care. b. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 a.m., the employee stated he / she did not have a written plan of care to follow and did not know his / her hours of care between the home health agency and the personal service agency that was also owned by the Administrator. The patient stated that he / she had to cancel a few nursing visits due to a nurse who caused him / her pain		irrigations, ventilator(including settings / management), trach (size and type), tube feedings,assistive devises, oxygen (settings), bowel program (detail instructions)suctioning, pulse oximetry, vents (setting/management), catheters (size andtype), wounds, size, measurements, instructions for service, any safetymeasures to protect against injury, instructions for timely discharges orreferral, and any other appropriate items; and promptly report any changes tothe physician that suggest a need to alter the POC; and promptly report anychanges to the physician that suggest a need to alter the POC ; and Conformancewith Physician Orders which include all medications, treatments and servicesprovided to patients must be ordered by a physician started on 5/24/16 andongoing with the Director of Nursing, Alternate Director of Nursing/ComplianceOfficer. An all Case Manager trainingsession has been scheduled for Friday, June 17, 2016 to train on furnishingservices in accordance with the POC which covers POC which all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications	

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	during a catheterization and he / she wanted to get rid of the pain before the next catheterization. The patient also stated that he / she had a problem with nurses not coming as scheduled and would not call to let her know that they would be late. The patient stated the times should be 9:00 to 10:00 AM, 1:00 to 2:00 PM, and 5:00 to 6:00 PM. The patient stated that he / she had things to do and can't wait all day for the nurses to come. c. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 p.m. The Director of Nursing stated the home health aide new his / her schedule and a written plan of care was put in the patient's home a few weeks prior. The Director of Nursing also stated the patient had the tendency to not be home when nurses arrived even when the visits were prescheduled. 4. The clinical record for patient number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. Review of the skilled nursing visit notes dated 03/01/16 and 03/07/16, the skilled nurses failed to		andtreatments w/specific instructions, (including but not limited to: type, frequency and duration, irrigations,ventilator (including settings / management), trach (size and type), tubefeedings, assistive devises, oxygen (settings), bowel program (detailinstructions) suctioning, pulse oximetry, vents (setting/management), catheters(size and type), wounds, size, measurements, instructions for service, anysafety measures to protect against injury, instructions for timely dischargesor referral, and any other appropriate items; and promptly report any changesto the physician that suggest a need to alter the POC; and Conformance withPhysician Orders which include all medications, treatments and servicesprovided to patients must be ordered by a physician. On 5/28/16 and ongoing The "Welcome Letter"was updated to include a statement "Will you accept a FloatStaff to start your services and fill in when your permanent staff calls off."The "Welcome Letter" will require client/family signature and will be filed inclient chart and a copy in yellow folder. On 5/25/16 andongoing an In Home Quality Assurance Committee was developed to make homevisits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill	

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	assess the cardiovascular system, respiratory system, and / or failed to obtain vital signs. 5. The clinical record for patient number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. The patient also had respite nursing 1 - 30 hours for 12 months. a. Review of the skilled nursing visit notes, the skilled nurse provided 1 hour on 2/22; 3 consecutive hours on 03/08, 03/09, 03/16 (PM), 03/30 (PM); 4 consecutive hours on 03/10, 03/23, 03/30 (AM); 5 consecutive hours on 2/25, 03/03, 03/04, 03/28; 9 consecutive hours on 2/29, 03/22; 6 consecutive hours on 03/17 (PM); 7 consecutive hours on 2/23, 2/24, 03/02; 8 consecutive hours on 2/15, 2/18, 2/19, 2/25, 03/01, 02/21, 03/31, 04/01; 10 consecutive hours on 02/29; and 12 consecutive hours on 04/08/16. During week 6 (03/20 to 03/26/16), the skilled nurse only provided services for 3 days. The skilled nurse failed to follow the plan of care. 6. The clinical record for patient number 9, SOC 11/03/09, included a plan of care		ensure that the "Welcome Letter" is explained, understood and signed (acopy will be filed in client chart and a copy in yellow folder), POC is followed,follow-up on each monthly inservice, call off process, organization chart,updates on client and staff paperwork, patient rights, etc. The committee member, when educating, willget signed documents of the training provided. Each document signed will be placed in the staff personnel file andclient chart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved., Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence furnishing services in accordance with the POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: type, frequency and duration, irrigations,ventilator (including settings /	

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	established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month for 12 months. a. Review of the skilled nursing visit notes, the skilled nurse provided 3 of 5 visits each week between the dates of 02/14 to 03/12/16. b. During a home visit with the patient and Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H stated the patient attended an adult day care 3 days a week and would sometimes go with a parent to work. Employee H also stated he / she provides services to the patient on Tuesday from 3:45 to 9:00 PM and 10:00 AM to 9:00 PM on Thursday, Friday, and Saturday. The skilled nurse failed to follow the plan of care. 7. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all patient visit notes had been provided. 8. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of		management), trach (size and type), tubefeedings, assistive devises, oxygen (settings), bowel program (detailinstructions) suctioning, pulse oximetry, vents (setting/management), catheters(size and type), wounds, size, measurements, instructions for service, anysafety measures to protect against injury, instructions for timely dischargesor referral, and any other appropriate items; and promptly report any changesto the physician that suggest a need to alter the POC; and Conformance withPhysician Orders which include all medications, treatments and servicesprovided to patients must be ordered by a physician. Staff failing to follow POC will receiveadditional training with corrective action up to termination. The QualityAssurance Committee, Compliance Officer, Administrator and Director of Nursingwill be responsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur. On4/13/16 a full all staff (nurses, administration, HHA's, and ancillary staff,etc.) mandatory in-service was sent via e-mail (for all staff with emailaddresses), U.S. Post Office mailing for those without emails, along with aphone call or text explaining the urgency and severity of the mandated trainingon 4/13/16 with a	

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	Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 9. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... " 10. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Registered Nurse ... b. Regularly reevaluates the patient needs, and coordinates the necessary services .... " 11.. A policy titled Scope of Services and Core Skilled Service Provided dated 07/10/15, indicated " ... Services will be coordinated by the Registered Nurse managing the care .... " 12. 4. A policy titled Tardiness and Unplanned Absence dated 07/10/15, indicated " ... f an employee is unable to report for work, he / she must notify his or her supervisor at least four (4) hours prior to the beginning of the work shift. The team member must personally contact the supervisor .... "		mandatory responsedead line of 4/15/16. Training includesPatient Rights (including patient and/or family responsibilities, Care Plansand Clinical Documentation, Attendance and Reporting (including specific calloff procedures for all staff) along with Progressive Disciplinary Action forfailure to comply. All staff mustrespond to the e-mail (with signed receipt indicator) or personally sign, acknowledgingthey received, state they have read and understand the ISHHA policy andprocedures regarding the Mandated Training. All staff completed the training prior to being put back on theschedule. Suspension letters weremailed certified/receipt on 4/15/16 to all staff that had not completed themandatory training. Any staff on vacation, sick or did notrespond to the Mandated Training weresuspended and not allowed to return to work until the Mandated Training wascompleted. Effective 4/13/16 all staff will receive duringorientation and annually every April specific training and understanding ofPatient Rights (including patient and/or family responsibilities, Care Plansand Clinical Documentation, Attendance and Reporting (including specific calloff procedures for all staff) along with Progressive Disciplinary Action forfailure to comply, with a signed	

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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
			training sheet. Bi-weekly newsletters are submitted viaQuickBooks for all staff with an email address. A cell phone was purchased to send a text to all staff, as a reminder, to review their emailwhen newsletters and agency information is released via email. The cell phone will also provide staff, thatdon't have an email, a copy of the newsletter and all agency information. Those staff that can't receive through emailor cell phone will be mailed via US Post Office all newsletters and agencyinformation. Staff that pick upnewsletters and agency information bi-weekly will do so at the office or atdrop sites. Emails will request an acknowledgingreceipt. Text messages will require atext back of receipt. US Mail will besent receipt return. Pick up willrequire a signed receipt. A bi-weekly stafflist is generated during payroll with a column added to indicate receipt ofagency information. Newsletter andagency information will also be visually available to all staff at the officeand each drop site. On 4/18/16 and ongoing all nurses were notified, intheir method of communication, to submit nurse visit notes every Monday. Nurse visit notes are entered as receivedinto the tracker and tracked back to the schedule. A comparison report is generated on eachWednesday to determine	

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			if there are missing nurse visit notes. The staff, that have missing nursing notes,will be contacted on each Wednesday , in their method of communication and willhave until each Friday to submit. Stafffailing to submit timely will be suspended until nursing notes arereceived. Staff will be terminated afterthree untimely weeks. ISHHA will assist staffin receiving nursing notes timely by means of gas cards, gift cards, kindwords, picking them up to ensure ISHHA stays in compliance and this deficiencywill not recur. Effective 4/13/16 policywas updated to add that any staff being suspended will be notified in theirmethod of communication and also a letter will be mailed via US Post Officecertified/receipt. After theinvestigation the staff will be notifiedin their method of communication and also a letter will be mailed via US PostOffice certified/receipt of the outcome (termination or return to work). All signed receipts will be put in staffpersonnel files. Effective 4/29/16 andongoing the call off procedure with repercussions will be in eachnewsletter. All staff will bein-serviced on (Patient Rights) by 6/10/16. Education on Patient Rights and Call Off Procedures will be the June2016 in home training with clients and staff during Supervised Visits and willbe documented on the ASV by 6/30/16. Acurrent Patient Rights	

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			form dated 5/27/16 will be signed by the patient andstaff and placed in client chart and personnel file. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly) to spontaneouslycheck on staff, to follow-up on each monthly inservice, call off process,organization chart, updates on client and staff paperwork, patient rights, etc. The committee member, when educating, willget signed documents of the training provided. Each document signed will be placed in the staff personnel file andclient chart. The committee members willprovide a written report of the visit to the Administrator and Director of Nursingwithin 24 hours. The committee willmeet the first Wednesday of each month to discuss findings and the outcomes andto ensure that each finding was addressed and resolved and documented. The Quality Assurance Committee, Chart AuditCommittee, RN Case Managers, Nurse Scheduler, Office Manager, Compliance Officer, Administrator andDirector of Nursing will be responsible for monitoring these corrective actionsto ensure that this deficiency is corrected and will	

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			not recur.	
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 Registered Nurse failed to ensure the comprehensive reassessments were accurate and / or completed to support the services provided as written in the plan of care for 7 of 9 records reviewed of patients recertified for another 60 days in a sample of 11. (#1, 4, 5, 6, 7, 9, an 10) Findings include: 1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for	N 0541	Allstaff will be in-serviced on (Plan of Care) by 6/10/16. Individual training sessions with CaseManagers to train on POC which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning, pulseoximetry, vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items and promptly report any changes to	06/10/2016

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	dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension. a. Review of the comprehensive reassessment dated 03/22/16, the assessment failed to include that the patient needed to be placed on a ventilator at bedtime, failed to include settings of the ventilator, indicated the patient was short of breath in the respiratory section but indicated the patient tolerated suctioning with dyspnea, failed to include a size and type of a foley catheter used for in and out catheterizations, failed to include assessment / need for bladder irrigation, failed to include the patient was a paraplegic in the neurological assessment, indicated the patient was able to dress his / her upper and lower body, including socks and shoes, indicated the patient has a need for home health aide services and an order had been obtained, indicated a home health health aide supervisory visit was made instead of a LPN supervisory visit, failed to include		the physician that suggesta need to alter the POC. started on 5/24/16 and ongoing with theDirector of Nursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions (including but not limited to type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items and promptly report any changes to the physician that suggesta need to alter the POC. On 5/25/16 and ongoing an In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all	

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	specific detail in the teaching / training (indicated "see ASV"), and failed to include documentation in the summary section. b. A skilled nursing visit note dated 03/23/16 and 03/24/16 from 12:00 AM to 10:00 AM, indicated the skilled nurse changed out filters and tubing to the patient's vent, trach collar and canula changed out, used a 14 Fr catheter to catheterize the patient, irrigated the patient's catheter with 60 cc of unknown solution, applied Nystatin powder to the folds of the peri area and 40% zinc oxide applied to the patients buttocks. b. A skilled nursing visit note dated 03/24/16 from 4:00 PM to 7:00 PM, indicated the skilled nurse used a 16 Fr catheter to catheterize the patient and irrigated the patient's catheter with 60 cc of saline. c. A skilled nursing visit note dated 03/25/16, indicated the skilled nurse provided stand by assistance with bathing, shampooed the patient's hair, and assisted with meal prep. d. Employee E, a Registered Nurse / Case Manager, was interviewed on 04/06/16 at 3:10 PM. Employee E confirmed the patient had a ventilator but		clients have been seen) (the committee will continue to make homevisits 10% quarterly). During the homevisit the committee member will ensure that POC is being followed anddocumented by reviewing the POC, interview of patient and notes anddocumentation sheets. The committee member, when educating, will get signeddocuments of the training provided. Eachdocument signed will be placed in the staff personnel file and clientchart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved. Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence that POC which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises,	

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	did not know the settings nor did he / she try to obtain those settings from a physician. The employee stated that he / she had tried to obtain the settings from Employee K, but never did receive them. The employee also was not able to indicate what size or type of trach the patient had. e. Employee F, a Licensed Practical Nurse, was interviewed on 04/06/16 at 4:30 PM. The employee stated the patient had to be catheterized, had to be placed on the vent at night, needed suction, and assisted the patient with AM care and meals. Employee F stated he / she did not know the patient's vent settings for it was programmed on a SD (scan disk card) by the hospital during the patient's last hospitalization. The employee stated he / she had received a call from Employee E prior to surveyor's call asking about the patient's ventilator settings. The comprehensive reassessment failed to be accurate to support the written plan of care. 2. The clinical record for patient number 4, SOC 06/19/15, included a plan of care established by a physician for the certification period of 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders,		oxygen (settings), bowel program (detail instructions) suctioning, pulseoximetry, vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items. and promptly report any changes to the physician that suggesta need to alter the POC. Staff failingto follow POC will receive additional training with corrective action up totermination. The Quality AssuranceCommittee, Compliance Officer, Administrator and Director of Nursing will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur. Allstaff will be in-serviced on Tag 339 (Update of the Comprehensive Assessment) by 6/10/16. Individual trainingsessions with Case Managers to train on accuracy and completeness of detailsand Update and revise of the Comprehensive Assessment –including the administration of the OASIS – the last 5 days of every 60 daysbeginning with the start of care date (including but not limitedto: the accuracy and completeness ofdetails of the assessment to support the POC (will include specific serviceswith a written out detailed step by step	

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	Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis and constipation. a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The plan of care failed to be updated and revised to specifically indicate skilled nursing to perform a digital stimulation / bowel program as well as failed to include measurable goals for the program. b. Review of the comprehensive reassessment for recertification dated 08/17/15, indicated the patient was incontinent of bowel on a daily basis. The comprehensive reassessment failed to be accurate to support the written plan of care. 3. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with		instruction on “how to” and includesneeded supplies with specific size, type, settings, management, etc.) patient specific, current health status,information that may be used to demonstrate the patient’s progress towardachievement of desired outcomes and measurable goals, coordination of care, thecontinuing need for home care, meet the patient’s medical, nursing, rehabilitative,social, and discharge planning, type, frequency and duration,irrigations, ventilator (including settings / management), trach (size andtype), tube feedings, assistive devises, oxygen (settings), bowel program(detail instructions) suctioning, catheters (size and type), wounds, size,measurements, instructions for service, review of patient medications toidentify any potential adverse effect and drug reactions, ineffective drugtherapy, significant side effects, significant drug interactions, duplicatedrug therapy and noncompliance with drug therapy, and completing dischargeassessments/OASIS at the time of patient discharge. 6/1/16 a form was be addedas a checklist and/or auditing tool for assessments for RN, Medical RecordsSpecialist, for chart audits, etc. Theform will serve as a check and balance system by asking questions and/or	

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	feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. The patient diagnoses include chronic obstructive pulmonary disease, congestive heart failure, and rheumatoid arthritis. a. During a home visit on 04/12/16 from 9:00 to 9:45 AM, at an Independent Living Apartments, the patient's room was observed to have a large bed in the living quarters with a kitchenette and bathroom. The living space was cluttered with oxygen concentrator (not in use) and other durable medical equipment between the patient bed and entry / door. The patient was observed sitting up in her bed eating a bowel of cereal while the home health aide was sitting in a chair conversing with the patient. After the patient ate, the home health aide took the bowel into the kitchenette and went into the bathroom and picked up the area. The home health aide indicated that the patient has home health aide services from 9:00 AM to 3:00 PM then personal care services from 3:00 PM to 4:45 PM. The home health aide stated that he / she assists the patient with her bathing, picks up around the apartment, runs errands, and provide companionship.		givingreminders for an accurate and detailed assessment.. A monthly required specific detail in thetraining and teaching will be established for supervisory visits (withspecifics to nursing or aide supervisory visit) started on5/24/16 and ongoing with the Director of Nursing, Alternate Director ofNursing/Compliance Officer. An all CaseManager training session has been scheduled for Friday, June 17, 2016 to trainon accuracy and completeness of details and Update and revise of the Comprehensive Assessment – including the administration of the OASIS –the last 5 days of every 60 days beginning with the start of care date (includingbut not limited to: the accuracy andcompletion of the assessment to support the POC (will include specific serviceswith a written out detailed step by step instruction on “how to” and includesneeded supplies with specific size, type, settings, management, etc.) , patientspecific, current health status, information that may be used to demonstratethe patient’s progress toward achievement of desired outcomes and measurablegoals, coordination of care, the continuing need for home care, meet thepatient’s medical, nursing, rehabilitative, social, and discharge planning,type, frequency and duration, irrigations, ventilator (including settings /management),	

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	b. Review of the comprehensive reassessment for recertification dated 01/21/16, indicated the patient had some dyspnea with exertion. The Nutritional Status assessment was left blank and did not specify if the patient has physically able to shop, cook, and or feed him / herself. The reassessment indicated the patient was continent of bowel and bladder. The fall risk assessment was left blank. The reassessment indicated the patient was able to participate in bathing self in shower or tub but required presence of another person for assistance or supervision, able to get to and from the toilet and transfer independently with or without device. The reassessment indicated the patient was able to transfer with minimal human assistance or with use of an assistive device, able to ambulate with use of a one - handed device, able to to independently walk on even and uneven surfaces and negotiate stairs with or without railings. The comprehensive reassessment failed to be accurate and completed to support the plan of care. c. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was unable to provide any further information regarding the findings referenced above when asked		trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, catheters (size andtype), wounds, size, measurements, instructions for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge assessments/OASIS at the time of patient discharge. Amonthly required specific detail in the training and teaching will beestablished for supervisory visits (with specifics to nursing or aidesupervisory visit) Effective6/1/16 a Medical Records Specialist was hired to track the follow-upcomprehensive assessment when due. Review the Comprehensive Assessment for completeness and supporting thePOC. A comprehensive tracker of patientsneeds/services will be completed by 6/30/16 to include but not limited to:patient on ventilator (setting / management), catheters (size and type), wounds(size, measurement, details of care), etc. A review of nursing notes will compare back to tracker for eachpatient. Medical Records Specialist willreview for accuracy. The tracker willnote when staff is not following POC, missing	

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	on 04/18/16 at 3:45 PM. 4. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterizations and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to assist with bed bath, assist with bath chair, pericare, nail care, foot care, pm care, assist with feeding, ambulation assist / mobility, commode, wheelchair, transfer / positioning, feeding, meal set up, oral care, encourage fluids, urine incontinence, check pressure areas, skin care, medication reminders, blood sugar reminders, make bed, and straighten patient area. The patient primary diagnoses was Rheumatoid Arthritis and Fibromyalgia. Secondary diagnoses listed in order were Bipolar Disorder, Diabetes, Sleep Apnea, Hypertension, and Urinary Retention. a. During a home visit on 04/12/16 at 10:30 AM, the patient stated that his / her daughter lived in the home but the daughter attended college during the day and provided the in and out catheterization at bedtime. The patient was then observed to transfer herself		information on assessment, andwill be reported to DON and Administrator. A ten and five day reminder will be forwarded to nurse for completion ofassessment. The staff will be notifiedof their failure to follow the POC. TheDON and/or the Administrator will contact nurse with a 24 hour turn around –suspension up to termination will follow if timelines and accuracy (notfollowing the Plan of Care) and not reporting needs of supplies to providepatient service. Effective 4/17/16 andongoing 10% of all clinical records will be audited quarterly for evidenceaccuracy and completeness of details and Update and revise of the Comprehensive Assessment – including the administration of the OASIS –the last 5 days of every 60 days beginning with the start of care date (includingbut not limited to: the accuracy andcompletion of the assessment to support the POC (will include specific serviceswith a written out detailed step by step instruction on “how to” and includesneeded supplies with specific size, type, settings, management, etc.) , patientspecific, current health status, information that may be used to demonstratethe patient’s progress toward achievement of desired outcomes and measurablegoals, coordination of care, the continuing need for home care, meet thepatient’s	

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	from the bed to a motorized wheelchair, from the motorized wheelchair to the toilet, from the toilet to the shower chair with stand by assistance from the home health aide. After the shower, the patient transferred herself from the shower chair to the toilet and dried herself off to the upper portion of the body and the home health aide dried the lower extremities. The patient transferred herself to the motorized wheelchair and was observed to dress herself with a sun dress type gown. After getting dressed, the patient operated her motorized wheelchair in the bedroom. An oxygen concentrator was observed in the room. b. Review of the start of care comprehensive assessment dated 03/17/16, the primary diagnosis was rheumatoid arthritis followed by secondary diagnoses of fibromyalgia, bipolar, diabetes mellitus, sleep apnea, hypertension, asthma, and urinary retention. The assessment did not indicate the patient had respiratory treatments used in the home. The assessment indicated the patient received meals from a community delivery service, able to take oral and injection medications independently, chairfast, unable to ambulate and is unable to wheel self, able to feed self independently, patient depends entirely		medical, nursing, rehabilitative, social, and discharge planning,type, frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, catheters (size andtype), wounds, size, measurements, instructions for service, review ofpatient medications to identify any potential adverse effect and drugreactions, ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, and completingdischarge assessments/OASIS at the time of patient discharge. TheCompliance Officer, Administrator and Director of Nursing will be responsiblefor monitoring these corrective actions to ensure that this deficiency iscorrected and will not recur.	

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	upon another person to dress the upper body, unable to get to and from the toilet but is able to use a bedside commode with or without assistance, the nutritional assessment was left blank and did not specify if the patient was physically able to shop, cook, and or feed him / herself, and the summary indicated the patient must be catheterized 4 times a day, but 3 of the 4 catheterizations were to be provided by the agency nurses. The comprehensive assessment did not include the size of the pediatric catheter. The plan of care failed to include the size of the pediatric foley catheter to be used for in and out catheterizations and failed to include coordination with Mom's meals. The comprehensive reassessment failed to be accurate and completed to support the written plan of care. 5. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. The goals indicated the patient would maintain good hygiene and comfort and patient safety would be			

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	maintained. a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities. b. Review of the comprehensive reassessment for recertification dated 03/02/16, the reassessment failed to provide a complete pain assessment, failed to include measurements to the lower extremity edema due to cellulitis, failed to provide wound bed assessment and measurement of the venous stasis ulcer to the right lower extremity as well as current treatment, failed to complete the nutritional assessment, failed to document the fall risk assessment, failed to document the psychosocial assessment, failed to answer M1840 Toilet transferring assessment, failed to document patient / caregiver / family education, and failed to document a summary / progress of the past 60 days in the summary section. The comprehensive reassessment for was			

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	incomplete and failed to support the services provided as written in the plan of care. 6. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month to assess cardiopulmonary status, evaluate nutrition / hydration / elimination, evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / fall prevention, and Oxygen at 2 liters per trach at night. The patient primary diagnosis was Cerebral Palsy, sleep apnea, cerebral vascular accident, coarotation of aorta, and urinary incontinence. a. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H was observed cooking dinner for the patient. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The plan of care			

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	failed to be updated and revised to include trach care, ventilator settings / management, preparing meals, supra pubic catheter care, and suctioning as needed. b. Review of the comprehensive reassessment for recertification dated 03/18/16, the reassessment failed to provide a complete cardiopulmonary assessment, failed to complete the nutritional status, failed to provide an assessment of the suprapubic catheter / insertion site, failed to complete the assessment to the neurological and musculoskeletal system, failed to complete patient / caregiver / family education, and failed to complete a summary of the past 60 days. The comprehensive assessment failed to be accurate and completed to support the written plan of care. 7. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week, to provide a shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, make bed / straighten patient areas. The primary diagnosis indicated			

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	carbon monoxide poisoning, followed by secondary diagnoses of lumbago, esophageal reflux, hypothyroidism, and coronary artery disease. a. A form titled "Intake / Referral" dated 03/27/15, indicated the patient was a self referral and the patient had carbon monoxide poisoning in 2011. b. A physician visit note dated 03/03/15, indicated the physician would not diagnose the patient with carbon monoxide poisoning due to the patient had been moved out of the environment and there was no labs to prove the patient had the poisoning although the patient symptom complex was similar to carbon monoxide poisoning. c. A comprehensive reassessment for recertification dated 09/22/15, indicated the patient was not short of breath, continent of both bowel and bladder. The musculoskeletal system and functional limitations, the neurological assessment, and the summary of care failed to be completed. The primary diagnosis failed to be supported by the comprehensive assessment and physician visit note. The comprehensive assessment failed to be accurate and completed to support the written plan of care.			

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	8. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 9. A policy titled Plan of Care dated 08/15/15, indicated " ... The Plan of Care is based on a comprehensive assessment and information provided y the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The Plan of Care shall be completed in full to include ... All pertinent diagnosis (es), principle and secondary ... Medications, treatments, and procedures, Medical supplies and equipment required .... " 10. A policy titled Comprehensive Patient Reassessments / Updates, Resumption of Care, SCIC (significant change in condition), and Transfer OASIS for Skilled Patients dated 08/15/15, indicated " ... 1. Patients are reassessed to determine their response to care, when significant changes occurred in their condition, their diagnosis, in their environment or support system that affect the plan of care, and when they released from the hospital ... 3. The Registered			

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	Nurse is responsible for reassessing the need for Home Care Aide services. 4. Special attention will be paid to patient - centered goal setting, clarifying the patient's personal goals and his / her expectations of the home care services. 5. The assessment will identify the problems, needs, and strengths of the patient and the care the family can provide. The ... ongoing assessments include consideration ... a. Specific individualized patient needs pertinent to the care or service being provided. b. Description of any applicable strength the patient has including physical, psychosocial, and or spiritual resources that increase their ability to respond effectively to treatment and the ability to learn ... d. Appropriateness of the level of care provided by the family or support system to safely meet the patient needs ... f. Need for continuing home care services. g. Ability / willingness of the patient / family to assume responsibility for healthcare needs .... "			
N 0542 Bldg. 00	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions.			

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	Based on record review and interview, the Registered Nurse failed to ensure that the plan of care was supported by the comprehensive assessment for 5 of 11 records reviewed (#5, 6, 7, 9, and 10), failed to update and revise the plan of care to include specific instructions for a bowel program for 1 of 1 record reviewed of patients with bowel program (#4), failed to include the type, frequency and duration of services to be provided (#2), ventilator settings, size of trach, frequency and instruction of trach care to be provided in 3 of 3 records reviewed of patients with trach's (#1, 2, and 9), failed to include directions for application of braces in 1 of 1 record reviewed of patients with braces (#2), failed to include the type of feeding, rate, and frequency of gastrointestinal tube feedings in 2 of 2 records reviewed of patients with tube feedings (#2 and 8), failed to include the size of foley catheters for in out catheterizations in 2 of 2 records reviewed with patients receiving in and out catheterizations (#1 and 6), failed to include the size / frequency of changes for suprapubic catheter in 1 of 1 record reviewed for patients with suprapubic catheters (#9), failed to include instructions for foley catheter flushes in 1 of 1 record reviewed of patients with foley catheter irrigations (#1), failed to include instructions for	N 0542	Allstaff will be in-serviced on (Plan ofCare) by 6/10/16. Individual trainingsessions with Case Managers to train on POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to: type, frequency and duration, irrigations,ventilator (including settings / management), trach (size and type), tubefeedings, assistive devises, oxygen (settings), bowel program (detailinstructions) suctioning, pulse oximetry, vents (setting/management), catheters(size and type), wounds, size, measurements, instructions for service, anysafety measures to protect against injury, instructions for timely dischargesor referral, and any other appropriate items and promptly report any changes tothe physician that suggest a need to alter the POC. started on 5/24/16 and ongoing with theDirector of Nursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC which covers all pertinentdiagnoses,	06/10/2016

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	wound treatments in 1 of 1 records reviewed of patients with wound treatments (#7), failed to include the location for the application of powder and ointments in 1 of 1 records reviewed of patients receiving medicated powder and ointments, and failed to include instruction for bathing and meal preps in 1 of 11 records reviewed of patients receiving assistance with bathing and meal prep. (# 1) Findings include: 1. The clinical record for patient number 1, SOC 01/20/15, included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing " to ... O2 [oxygen] at 0.5 - 6 liters 1 minute [per minute] ... administer tach [sic] care, change trach collar QD [every day], suction trach ... I & O cath [in and out catheter] TID [three times a day] and prn [as needed]. Goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. A skilled nursing visit note dated 03/23/16 and 03/24/16 from 12:00 AM to 10:00 AM, indicated the skilled nurse changed out filters and tubing to the patient's vent, trach collar and canula		including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions (including but not limited to type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items and promptly report any changes to the physician that suggesta need to alter the POC. On 5/25/16 and ongoing an In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all clients have been seen) (the committee will continue to make homevisits 10% quarterly). During the homevisit the committee member will ensure that POC is being followed anddocumented by reviewing the POC, interview of patient and notes anddocumentation sheets. The committee member, when	

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	changed out, used a 14 Fr catheter to catheterize the patient, irrigated the patient's catheter with 60 cc of unknown solution, applied Nystatin powder to the folds of the peri area and 40% zinc oxide applied to the patients buttocks. b. A skilled nursing visit note dated 03/24/16 from 4:00 PM to 7:00 PM, indicated the skilled nurse used a 16 Fr catheter to catheterize the patient and irrigated the patient's catheter with 60 cc of saline. c. A skilled nursing visit note dated 03/25/16, indicated the skilled nurse provided stand by assistance with bathing, shampooed the patient's hair, and assisted with meal prep. d. Employee E, a Registered Nurse / Case Manager, was interviewed on 04/06/16 at 3:10 PM. Employee E confirmed the patient had a ventilator but did not know the settings nor did he / she try to obtain those settings from a physician. The employee stated that he / she had tried to obtain the settings from Employee K, but never did receive them. The employee also was not able to indicate what size or type of trach the patient had. e. Employee F, a Licensed		educating, will get signeddocuments of the training provided. Eachdocument signed will be placed in the staff personnel file and clientchart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved. Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence that POC which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning, pulseoximetry, vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any	

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	Practical Nurse, was interviewed on 04/06/16 at 4:30 PM. The employee stated the patient had to be catheterized, had to be placed on the vent at night, needed suction, and assisted the patient with AM care and meals. Employee F stated he / she did not know the patient's vent settings for it was programmed on a SD (scan disk card) by the hospital during the patient's last hospitalization. The employee stated he / she had received a call from Employee E prior to surveyor's call asking about the patient's ventilator settings. The plan of care failed to include instructions for trach care, size of foley catheter to use for catheterizations, instructions for foley catheter irrigation, vent settings, specific treatment areas for the application of zinc oxide and Nystatin powder, and instructions for assistance with bathing and meal preps. The goals on the plan of care failed to be reflective of the patient's current status and treatment. 2. The clinical record for patient number 2, SOC 02/11/16, included a plan of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders for skilled nursing to" ... administer flushes as ordered, O2 [oxygen] during naps / bedtime,		otherappropriate items. and promptly report any changes to the physician that suggesta need to alter the POC. Staff failingto follow POC will receive additional training with corrective action up totermination. The Quality AssuranceCommittee, Compliance Officer, Administrator and Director of Nursing will beresponsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur. Allstaff will be in-serviced on (Periodic Review of Plan of Care) by 6/10/16. Individual training sessions with CaseManagers to train on Periodic Review of POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures	

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	administer trach care ... administer feedings." The patient's diagnoses included Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance. a. A start of care comprehensive assessment dated 02/11/16, indicated Pediasure 1.0, 720 milliliters through out the night, Pediasure 410 [sic] milliliters per hour, and Pediasure 1.5, 4 ounce bolus 4 times a day, the patient had both a gastric and jejunostomy feeding tubes, the patient was receiving bolus and continuous feedings, with 35 milliliter flushes of water to the gastric feeding tube and 10 milliliter flushes of water to the jejunostomy feeding tube after night feedings, NPO (nothing by mouth) a 4 x 4 dressing under the patient's trach with 1 liter of oxygen via concentrator when sleeping, the patient had a trach, humidifier for oxygen, ventilator, pulse oximetry to be done every visit and "AFO in progress." b. Section 16 of the initial plan of care titled "Nutritional Req [requirements]" indicated Pediasure 1.0, 720 milliliters overnight. c. Section 18 of the initial plan of care titled "Activities Permitted"		to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items.and promptly report any changes to the physician that suggesta need to alter the POC started on 5/24/16 and ongoing with the Director ofNursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions (including but not limited to: type, frequency and duration, irrigations,ventilator (including settings / management), trach (size and type), tubefeedings, assistive devises, oxygen (settings), bowel program (detailinstructions) suctioning, pulse oximetry, vents (setting/management), catheters(size and type), wounds, size, measurements, instructions for service, anysafety measures to protect against injury, instructions for timely dischargesor referral, and any other appropriate items and promptly report any changes tothe physician that suggest a	

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	indicated AFOs [braces] were in progress. 1. The plan of care failed to be updated and revised to include the type, amount, and frequency of "flushes", failed to include the route of oxygen usage, failed to include the type of trach and frequency of trach care [including suctioning protocols], failed to include ventilator settings and management of the ventilator, failed to include the management of the humidifier, failed to include pulse oximetry, failed to include the amount of flushes and frequency to both gastric and jejunostomy feeding tubes, failed to include both types of Pediasure feedings along with the the specific tube used for feedings, the amount and rate of all tube feedings, failed to include that the patient was NPO, and failed to indicate the location and frequency of the AFOs to be placed and worn by the patient. 3. The clinical record for patient number 4, SOC 06/19/15, included a plan of care established by a physician for the certification period of 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per		need to alter the POC. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill ensure that POC is being followed and documented by interview withpatient, review of POC, review of notes and documentation sheets. The committeemember, when educating, will get signed documents of the trainingprovided. Each document signed will beplaced in the staff personnel file and client chart. The committee members will provide a writtenreport of the visit to the Administrator and Director of Nursing within 24hours. The committee will meet thefirst Wednesday of each month to discuss findings and the outcomes and toensure that each finding was addressed and resolved., Effective 4/17/16 andongoing 10% of all clinical records will be audited quarterly for evidence thatPOC which covers all pertinent diagnoses, including mental status, types ofservices and equipment required, frequency of visits, prognosis, rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements,	

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	day 7 days a week. The patient diagnoses included, but limited to Multiple Sclerosis and constipation. a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The plan of care failed to be updated and revised to specifically indicate skilled nursing to perform a digital stimulation / bowel program as well as failed to include measurable goals for the program. b. Review of the comprehensive reassessment for recertification dated 08/17/15, indicated the patient was incontinent of bowel on a daily basis. The plan of care failed to be supported by the comprehensive assessment. 4. The clinical record for patient number 5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care,		medications and treatments w/specific instructions (including butnot limited to: type, frequency andduration, irrigations, ventilator (including settings / management), trach(size and type), tube feedings, assistive devises, oxygen (settings), bowelprogram (detail instructions) suctioning, pulse oximetry, vents (setting/management),catheters (size and type), wounds, size, measurements, instructions forservice, any safety measures to protect against injury, instructions for timelydischarges or referral, and any other appropriate items and promptly report anychanges to the physician that suggest a need to alter the POC. Staff failing to follow POC will receiveadditional training with corrective action up to termination. The Quality Assurance Committee, ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur. Allskilled nurses will be in-serviced on (Skilled Nursing Services) by6/10/16. Individual training sessionswith Skilled Nurses to train on furnishing services in accordance with the POCwhich covers all pertinent diagnoses, including mental status, types ofservices and equipment required, frequency of visits, prognosis,	

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	medication reminders, make bed, and straighten patient area. The patient diagnoses include chronic obstructive pulmonary disease, congestive heart failure, and rheumatoid arthritis. a. During a home visit on 04/12/16 from 9:00 to 9:45 AM, at an Independent Living Apartments, the patient's room was observed to have a large bed in the living quarters with a kitchenette and bathroom. The living space was cluttered with oxygen concentrator (not in use) and other durable medical equipment between the patient bed and entry / door. The patient was observed sitting up in her bed eating a bowel of cereal while the home health aide was sitting in a chair conversing with the patient. After the patient ate, the home health aide took the bowel into the kitchenette and went into the bathroom and picked up the area. The home health aide indicated that the patient has home health aide services from 9:00 AM to 3:00 PM then personal care services from 3:00 PM to 4:45 PM. The home health aide stated that he / she assists the patient with her bathing, picks up around the apartment, runs errands, and provide companionship. b. Review of the comprehensive reassessment for recertification dated		rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements, medications and treatments w/specific instructions, (includingbut not limited to type, frequency and duration, irrigations, ventilator(including settings / management), trach (size and type), tube feedings,assistive devises, oxygen (settings), bowel program (detail instructions)suctioning, pulse oximetry, vents (setting/management), catheters (size andtype), wounds, size, measurements, instructions for service, any safetymeasures to protect against injury, instructions for timely discharges orreferral, and any other appropriate items; and promptly report any changes tothe physician that suggest a need to alter the POC ; and Conformance withPhysician Orders which include all medications, treatments and servicesprovided to patients must be ordered by a physician started on 5/24/16 andongoing with the Director of Nursing, Alternate Director of Nursing/ComplianceOfficer. An all Case Manager trainingsession has been scheduled for Friday, June 17, 2016 to train on furnishingservices in accordance with the POC which covers POC which all pertinent diagnoses,including mental status, types of services and equipment required, frequency	

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	01/21/16, indicated the patient had some dyspnea with exertion. The Nutritional status assessment was left blank and did not specify if the patient has physically able to shop, cook, and or feed him / herself. The reassessment indicated the patient was continent of bowel and bladder. The fall risk assessment was left blank. The reassessment indicated the patient was able to participate in bathing self in shower or tub but required presence of another person for assistance or supervision, able to get to and from the toilet and transfer independently with or without device. The reassessment indicated the patient was able to transfer with minimal human assistance or with use of an assistive device, able to ambulate with use of a one - handed device, able to to independently walk on even and uneven surfaces and negotiate stairs with or without railings. The plan of care failed to be supported by the comprehensive assessment. c. The Administrator, Director of Nursing, and Assistant Director of Nursing was unable to provide any further information regarding the findings referenced above when asked on 04/18/16 at 3:45 PM. 6. The clinical record for patient number 6, SOC 03/17/16, included a plan of care		ofvisits, prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning, pulseoximetry, vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. On 5/28/16 andongoing The "Welcome Letter" was updated to include a statement "Willyou accept a Float Staff to start your services and fill in when your permanentstaff calls off." The "Welcome Letter" will require client/family signature andwill be filed in client chart and a copy in yellow folder. On 5/25/16 and ongoing an In Home Quality AssuranceCommittee was developed to make home visits on 10% of clients monthly (untilall	

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	established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterizations and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to assist with bed bath, assist with bath chair, pericare, nail care, foot care, pm care, assist with feeding, ambulation assist / mobility, commode, wheelchair, transfer / positioning, feeding, meal set up, oral care, encourage fluids, urine incontinence, check pressure areas, skin care, medication reminders, blood sugar reminders, make bed, and straighten patient area. The patient primary diagnoses was Rheumatoid Arthritis and Fibromyalgia. Secondary diagnoses listed in order were Bipolar Disorder, Diabetes, Sleep Apnea, Hypertension, and Urinary Retention. a. During a home visit on 04/12/16 at 10:30 AM, the patient stated that his / her daughter lived in the home but the daughter attended college during the day and provided the in and out catheterization at bedtime. The patient was then observed to transfer herself from the bed to a motorized wheelchair, from the motorized wheelchair to the toilet, from the toilet to the shower chair with stand by assistance from the home		clients have been seen) (the committee will continue to make home visits10% quarterly). During the home visitthe committee member will ensure that the “Welcome Letter” is explained,understood and signed (a copy will be filed in client chart and a copy inyellow folder), POC is followed, follow-up on each monthly inservice, call offprocess, organization chart, updates on client and staff paperwork, patientrights, etc. The committee member, wheneducating, will get signed documents of the training provided. Each document signed will be placed in thestaff personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesday ofeach month to discuss findings and the outcomes and to ensure that each findingwas addressed and resolved., Effective 4/17/16 and ongoing 10% of all clinicalrecords will be audited quarterly for evidence furnishing services inaccordance with the POC which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including	

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	health aide. After the shower, the patient transferred herself from the shower chair to the toilet and dried herself off to the upper portion of the body and the home health aide dried the lower extremities. The patient transferred herself to the motorized wheelchair and was observed to dress herself with a sun dress type gown. After getting dressed, the patient operated her motorized wheelchair in the bedroom. An oxygen concentrator was observed in the room. b. Review of the start of care comprehensive assessment dated 03/17/16, the primary diagnosis was rheumatoid arthritis followed by secondary diagnoses of fibromyalgia, bipolar, diabetes mellitus, sleep apnea, hypertension, asthma, and urinary retention. The assessment did not indicate the patient had respiratory treatments used in the home. The assessment indicated the patient received meals from a community delivery service, able to take oral and injection medications independently, chairfast, unable to ambulate and is unable to wheel self, able to feed self independently, patient depends entirely upon another person to dress the upper body, unable to get to and from the toilet but is able to use a bedside commode with or without assistance, the nutritional		but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning, pulseoximetry, vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. Staff failing tofollow POC will receive additional training with corrective action up totermination. The Quality Assurance Committee, Compliance Officer, Administratorand Director of Nursing will be responsible for monitoring these correctiveactions to ensure that this deficiency is corrected and will not recur. Allskilled nurses will be in-serviced on (Duties of the Registered Nurse) by6/10/16. Individual training sessionswith Registered Nurses to train on comprehensive reassessments and furnishingservices in	

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	assessment was left blank and did not specify if the patient was physically able to shop, cook, and or feed him / herself, and the summary indicated the patient must be catheterized 4 times a day, but 3 of the 4 catheterizations were to be provided by the agency nurses. The comprehensive assessment did not include the size of the pediatric catheter. The plan of care failed to be supported by the comprehensive assessment. The plan of care failed to include the size of the pediatric foley catheter to be used for in and out catheterizations and failed to include coordination with Mom's meals. 7. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. The goals indicated the patient would maintain good hygiene and comfort and patient safety would be maintained. a. Review of the comprehensive reassessment for recertification dated 03/02/16, the reassessment failed to		accordance with the POC which covers all pertinent diagnoses,including mental status, types of services and equipment required, frequency ofvisits, prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning, pulseoximetry, vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician started on 5/24/16 and ongoing with the Director ofNursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on	

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	provide a complete pain assessment, failed to include measurements to the lower extremity edema due to cellulitis, failed to provide wound bed assessment and measurement of the venous stasis ulcer to the right lower extremity, failed to complete the nutritional assessment, failed to document the fall risk assessment, failed to document the psychosocial assessment, failed to answer M1840 Toilet transferring assessment, failed to document patient / caregiver / family education, and failed to document a summary / progress of the past 60 days in the summary section. The comprehensive reassessment for recertification was incomplete and failed to support the services provided as written in the plan of care. The plan of care failed to be supported by the comprehensive assessment. b. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final wrap with coban dressing to the bilateral lower extremities.		comprehensive reassessments andfurnishing services in accordance with the POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functional limitations,activities permitted, nutritional requirements, medications and treatmentsw/specific instructions, (including but not limited to: type, frequency and duration, irrigations,ventilator (including settings / management), trach (size and type), tubefeedings, assistive devises, oxygen (settings), bowel program (detailinstructions) suctioning, pulse oximetry, vents (setting/management), catheters(size and type), wounds, size, measurements, instructions for service, anysafety measures to protect against injury, instructions for timely dischargesor referral, and any other appropriate items; and promptly report any changesto the physician that suggest a need to alter the POC ; and Conformance withPhysician Orders which include all medications, treatments and servicesprovided to patients must be ordered by a physician. On 5/28/16 and ongoing The "Welcome Letter"was updated to include a statement "Will you accept a FloatStaff to start your services and fill in when your permanent staff calls	

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	c. The plan of care failed to be updated and revised to include type of solution to cleanse the lower extremities and the location of wounds to be treated. The goals on the plan of care failed to be reflective of the patient's current status and treatment. 8. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days to to administer medication as ordered, administer gastric tube feedings / flushes as ordered. a. The plan of care failed to be updated and revised to include the amount of tube feeding to be provided, as well as the amount and frequency of flushes. 9. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month to assess cardiopulmonary status, evaluate nutrition / hydration / elimination,		off."The "Welcome Letter" will require client/family signature and will be filed inclient chart and a copy in yellow folder. On 5/25/16 andongoing an In Home Quality Assurance Committee was developed to make homevisits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill ensure that the comprehensive reassessments and furnishing services inaccordance with the POC which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning, pulseoximetry, vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to	

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	evaluate for signs and symptoms of infections and standard precautions, teach disease process, teach diet, teach home safety / fall prevention, and Oxygen at 2 liters per trach at night. The patient primary diagnosis was Cerebral Palsy, sleep apnea, cerebral vascular accident, coarotation of aorta, and urinary incontinence. a. During a home visit with the patient and Employee H on 04/12/16 at 4:40 PM, Employee H was observed cooking dinner for the patient. Employee H also stated that he / she puts the patient on the ventilator at bedtime at times, provides trach care 1 - 2 times a day, suctions the patient as needed, and provides supra pubic care 1 - 2 times a day and as needed. The plan of care failed to be updated and revised to include trach care, ventilator settings / management, preparing meals, supra pubic catheter care, and suctioning as needed. b. Review of the comprehensive reassessment for recertification dated 03/18/16, the reassessment failed to provide a complete cardiopulmonary assessment, failed to complete the nutritional status, failed to provide an assessment of the suprapubic catheter / insertion site, failed to complete the		the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. The committee member, when educating, will getsigned documents of the training provided. Each document signed will be placed in the staff personnel file andclient chart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved., Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence of comprehensive reassessments and furnishing services in accordancewith the POC which 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 w/specific instructions,(including but not limited to type, frequency and duration, irrigations,ventilator (including settings / management), trach (size and	

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	assessment to the neurological and musculoskeletal system, failed to complete patient / caregiver / family education, and failed to complete a summary of the past 60 days. The plan of care failed to be supported by the comprehensive assessment. 10. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week, to provide a shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, make bed / straighten patient areas. The primary diagnosis indicated carbon monoxide poisoning, followed by secondary diagnoses of lumbago, esophageal reflux, hypothyroidism, and coronary artery disease. a. A form titled "Intake / Referral" dated 03/27/15, indicated the patient was a self referral and the patient had carbon monoxide poisoning in 2011. b. A physician visit note dated 03/03/15, indicated the physician would not diagnose the patient with carbon monoxide poisoning due to the patient had been moved out of the environment		type), tubefeedings, assistive devises, oxygen (settings), bowel program (detailinstructions) suctioning, pulse oximetry, vents (setting/management), catheters(size and type), wounds, size, measurements, instructions for service, anysafety measures to protect against injury, instructions for timely dischargesor referral, and any other appropriate items; and promptly report any changesto the physician that suggest a need to alter the POC ; and Conformance withPhysician Orders which include all medications, treatments and servicesprovided to patients must be ordered by a physician. Staff failing to follow procedure willreceive additional training with corrective action up to termination. The QualityAssurance Committee, Compliance Officer, Administrator and Director of Nursingwill be responsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur. Allstaff will be in-serviced on (Update of the Comprehensive Assessment) by6/10/16. Individualtraining sessions with Case Managers to train on Update and revise theComprehensive Assessment (including butnot limited to: the accuracy andcompletion of the assessment to support the POC, patient specific, currenthealth	

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	and there was no labs to prove the patient had the poisoning although the patient symptom complex was similar to carbon monoxide poisoning. c. A comprehensive reassessment for recertification dated 09/22/15, indicated the patient was not short of breath, continent of both bowel and bladder, failed to complete the musculoskeletal system and functional limitations, failed to complete the neurological assessment, and failed to complete the summary of care (including progress toward goals to date. The primary diagnosis and plan of care failed to be supported by the comprehensive assessment and physician visit note 11. The Administrator, Alternate Administrator, Director of Nursing, and Assistant Director of Nursing was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 12. A policy titled Plan of Care dated 08/15/15, indicated " ... The Plan of Care is based on a comprehensive assessment and information provided y the patient / family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided ... The Plan of		status, information that may be used to demonstrate the patient'sprogress toward achievement of desired outcomes, the continuing need for homecare, meet the patient's medical, nursing, rehabilitative, social, anddischarge planning, review of patient medications to identify any potentialadverse effect and drug reactions, ineffective drug therapy, significant sideeffects, significant drug interactions, duplicate drug therapy andnoncompliance with drug therapy, and completing discharge/transfer assessments/administrationof OASIS at the time of patient discharge/transfer within 48 hours of(knowledge) started on 5/24/16 and ongoing with the Director of Nursing,Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on Update and review theComprehensive Assessment (including but not limited to: the accuracy and completion of the assessmentto support the POC, patient specific, current health status, information thatmay be used to demonstrate the patient's progress toward achievement of desiredoutcomes, the continuing need for home care, meet the patient's medical,nursing, rehabilitative, social, and discharge planning, review of patientmedications to identify any potential adverse	

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	Care shall be completed in full to include ... All pertinent diagnosis (es), principle and secondary ... Medications, treatments, and procedures, Medical supplies and equipment required .... " 13. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Registered Nurse ... c. Initiates the Plan of Care and necessary revisions and updates to the plan care and the care plan .... " 14. A policy titled Scope of Services and Core Skilled Service Provided dated 07/10/15, indicated " ... Services will be coordinated by the Registered Nurse managing the care. This will include implementing, revising, and updating the Plan of Care .... " 15. A policy titled Comprehensive Patient Reassessments / Updates, Resumption of Care, SCIC (significant change in condition), and Transfer OASIS for Skilled Patients dated 08/15/15, indicated " ... 1. Patients are reassessed to determine their response to care, when significant changes occurred in their condition, their diagnosis, in their environment or support system that affect the plan of care, and when they released from the hospital ... 3. The Registered Nurse is responsible for reassessing the		effect and drug reactions,ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge/transfer assessments/administration of the OASIS at thetime of patient discharge/transfer within 48 hours of (knowledge). Effective6/1/16 a Medical Records Specialist is hired to track update and revisions(including the administration of OASIS) at discharges/transfers to be completedwithin 48 hours. The staff will notifythe DON and Administrator if 48 hours is not met. The DON and/or the Administrator will contactnurse with a 24 hour turn around – suspension up to termination will follow iftimelines not met. Effective 4/17/16 andongoing 10% of all clinical records will be audited quarterly for evidenceUpdate and review of the Comprehensive Assessment (including but not limitedto: the accuracy and completion of theassessment to support the POC, (including but not limited to: the accuracy and completion of the assessmentto support the POC, patient specific, current health status, information thatmay be used to demonstrate the patient's progress toward achievement of desiredoutcomes, the continuing need for home care, meet the patient's	

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	need for Home Care Aide services. 4. Special attention will be paid to patient - centered goal setting, clarifying the patient's personal goals and his / her expectations of the home care services. 5. The assessment will identify the problems, needs, and strengths of the patient and the care the family can provide. The ... ongoing assessments include consideration ... a. Specific individualized patient needs pertinent to the care or service being provided. b. Description of any applicable strength the patient has including physical, psychosocial, and or spiritual resources that increase their ability to respond effectively to treatment and the ability to learn ... d. Appropriateness of the level of care provided by the family or support system to safely meet the patient needs ... f. Need for continuing home care services. g. Ability / willingness of the patient / family to assume responsibility for healthcare needs .... "		medical,nursing, rehabilitative, social, and discharge planning, review of patientmedications to identify any potential adverse effect and drug reactions,ineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy and noncompliance with drug therapy, andcompleting discharge/transfer assessments/administration of the OASIS at thetime of patient discharge/transfer within 48 hours of (knowledge). The ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur.	
N 0544 Bldg. 00	410 IAC 17-14-1(a)(1)(E) Scope of Services Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on observation, record review and interview, the Registered Nurse failed to	N 0544	Allskilled nurses will be in-serviced on (Skilled Nursing	06/10/2016

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	document a description / assessment of wounds being treated and failed to document the treatment provided for 2 of 2 records reviewed and 1 of 1 home visit of patients with wounds in a sample of 11. (# 7 and 8) Findings include: 1. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The patient's diagnoses were venous stasis ulcer and cellulitis. a. Review of the comprehensive reassessment for recertification dated 03/02/16, indicated the patient had stasis ulcers and wound #1 indicated left lower extremity had cellulitis, with edema, moderate amount of clear, thick drainage. Wound #2 indicated the right lower extremity had venous ulcer cellulitis, with edema, moderate amount of clear, thick drainage. The assessment failed to include measurements of the lower extremities as well as measurements and appearance of the venous ulcer.		Services) by 6/10/16. Individual training sessions with SkilledNurses to train on furnishing services in accordance with the POC which coversall pertinent diagnoses, including mental status, types of services andequipment required, frequency of visits, prognosis, rehabilitation potential,functional limitations, activities permitted, nutritional requirements,medications and treatments w/specific instructions, (including but not limitedto type, frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician started on 5/24/16 and ongoing with the Director ofNursing, Alternate Director of	

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	b. Review of the skilled nursing notes dated 03/01, 03/04, 03/05, 03/07, and 03/08/16, indicated the treatments were done as ordered. The RN failed to include a description / assessment of the wounds being treated and description of the treatment being provided. The RN also failed to provide weekly measurements of the venous stasis ulcer. 2. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. a. A skilled nursing visit note dated 02/18/16, indicated the patient recently had surgery to remove two loose pins and replaced it with a rod from the hip to knee in the right leg. The following skilled nursing visits failed to document a complete assessment to the incisional area - 02/18, 02/20, 02/22, 02/23, 02/24, 02/25, 02/26, 02/29, 03/02, 03/03, 03/04, 03/07, 03/08, 03/09, 03/10, and 03/11/16. 3. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing stated that the expectation for the nurse to document		Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on furnishing services inaccordance with the POC which covers POC which all pertinent diagnoses,including mental status, types of services and equipment required, frequency ofvisits, prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning, pulseoximetry, vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. On 5/28/16 andongoing The “Welcome Letter” was updated to	

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	treatments provided was "as ordered" in regards to clinical record number 7. The Director of Nursing was not able to provide any further documentation or comments in regards to clinical record number 8. 4. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse: a. Performs the initial assessment visit. b. Regularly reevaluates the patient needs, and coordinates the necessary services. c. Initiates the Plan of Care an necessary revisions and updates to the plan of care and the care plan. d. Provides services requiring specialized nursing skill and initiates appropriate preventative and rehabilitative nursing procedures. e. informs the physician and other personnel of changes in the patient condition and needs ... g. Prepares clinical and progress notes .... "		include a statement "Willyou accept a Float Staff to start your services and fill in when your permanentstaff calls off." The "Welcome Letter" will require client/family signature andwill be filed in client chart and a copy in yellow folder. On 5/25/16 and ongoing an In Home Quality AssuranceCommittee was developed to make home visits on 10% of clients monthly (untilall clients have been seen) (the committee will continue to make home visits10% quarterly). During the home visitthe committee member will ensure that the "Welcome Letter" is explained,understood and signed (a copy will be filed in client chart and a copy inyellow folder), POC is followed, follow-up on each monthly inservice, call offprocess, organization chart, updates on client and staff paperwork, patientrights, etc. The committee member, wheneducating, will get signed documents of the training provided. Each document signed will be placed in thestaff personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesday ofeach month to discuss findings and the outcomes and to ensure that each findingwas addressed and resolved., Effective 4/17/16 and ongoing 10% of all clinicalrecords will be audited quarterly for evidence furnishing services	

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			inaccordance with the POC which covers all pertinent diagnoses, including mentalstatus, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning, pulseoximetry, vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. Staff failing tofollow POC will receive additional training with corrective action up totermination. The Quality Assurance Committee, Compliance Officer, Administratorand Director of Nursing will be responsible for monitoring these	

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			correctiveactions to ensure that this deficiency is corrected and will not recur.	
N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel. Based on record review and interview, the Registered Nurse failed to ensure skilled nurses notified the physician in relation to discharges for 1 of 5 (# 4) records reviewed of patients discharged by the agency, failed to notify the physician in relation to elevated blood pressures for 1 of 6 records reviewed of active / current patients in a sample of 11 (# 6), failed to ensure that all treatments provided had a physician's order for 2 of 2 records reviewed of patients with wounds (#7 and 8) and 1 of 1 records reviewed of patients receiving a bowel program in a sample of 11. (# 4) Findings include: 1. The clinical record for patient number	N 0546	Allstaff will be in-serviced on (Conformance with Physician Orders) by6/10/16. Individual training sessionswith Case Managers to train on Conformance with Physician Orders which includeall medications, treatments and services provided to patients must be orderedby a physician started on 5/24/16 and ongoing with the Director of Nursing,Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on Conformance with PhysicianOrders which all medications, treatments and services provided to patients mustbe ordered by a physician. On5/25/16 and ongoing an In	06/10/2016

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	4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week to " ... administer suppository per MD orders, Teach Bowel Regime [sic] .... " and home health aide services (3) 2 hour visits per day 7 days a week. a. Review of the skilled nursing visit notes dated 08/04, 08/17, 08/20, 08/25, 08/27, and 09/08/15, indicated the skilled nurse was performing a digital stimulation / bowel program. The agency failed to ensure physician orders had been obtained prior to digital stimulation / conducting a bowel program. b. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15. c. Review of skilled nursing visit notes, a discharge comprehensive assessment was made on 08/26/15, but the last skilled nursing visit note was dated 09/15/15. d. Review of the home health aide		Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all clients have been seen) (the committee will continue to make homevisits 10% quarterly). During the homevisit the committee member will ensure that POC is being followed anddocumented by interview with patient, review of POC, notes and documentationsheets that conform to Physician Orders. The committee member, when educating,will get signed documents of the training provided. Each document signed will be placed in thestaff personnel file and client chart. The committee members will provide a written report of the visit to theAdministrator and Director of Nursing within 24 hours. The committee will meet the first Wednesdayof each month to discuss findings and the outcomes and to ensure that eachfinding was addressed and resolved., Effective 4/17/16 and ongoing 10% of allclinical records will be audited quarterly for evidence that Conformance withPhysician Orders which include all medications, treatments and servicesprovided to patients must be ordered by a physician. Staff failing to follow POC will receiveadditional training with corrective action up to termination. The Quality Assurance Committee,	

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	visit notes, the last home health aide visit note was dated 09/08/15. e. The clinical record failed to evidence a physician's order to discontinue services on 08/31/15 as anticipated in the patient's discharge letter, failed to evidence an order to stopped home health aide services on 09/08/15, and failed to evidence an order to discharge skilled nursing services on 09/15/15. f. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator did not provided further information or documentation in regards to notifying the physician of an impending discharges. 2. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention. a. Review of the skilled nursing visit		ComplianceOfficer, Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur. Allskilled nurses will be in-serviced on (Skilled Nursing Services) by6/10/16. Individual training sessions with SkilledNurses to train on POC, Periodic Review of POC which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Training on	

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	notes, the skilled nurse failed to make 3 visits on 03/18, 03/19, 03/20, 03/21, 03/24/16, and failed to make 1 visit on 2/23/16, and 2 visits on 3/25 and 03/26/16. The agency failed to provide documentation that the physician had been notified of the missed visits. b. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified. c. Review of a skilled nursing visit note on 03/23/16 at 10:00 AM, the skilled nurse documented the patient had a blood pressure of 149/101. The clinical record failed to evidence that the physician had been notified. 3. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school days and (1) 11 hour day on non school days. a. A skilled nursing visit note dated 02/18/16, indicated the patient recently had surgery to remove two loose pins and		Conformance with PhysicianOrders which include all medications, treatments and services provided topatients must be ordered by a physician started on 5/24/16 and ongoing with theDirector of Nursing, Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to train on POC, Periodic Review of POCwhich covers all pertinent diagnoses, including mental status, types ofservices and equipment required, frequency of visits, prognosis, rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements, medications and treatments w/specific instructions, (includingbut not limited to: type, frequency andduration, irrigations, ventilator (including settings / management), trach(size and type), tube feedings, assistive devises, oxygen (settings), bowelprogram (detail instructions) suctioning, pulse oximetry, vents (setting/management),catheters (size and type), wounds, size, measurements, instructions forservice, any safety measures to protect against injury, instructions for timelydischarges or referral, and any other appropriate items; and promptly reportany changes to the physician that suggest a need to	

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	replaced it with a rod from the hip to knee in the right leg. Skilled nursing visit notes dated 03/09 and 03/10/16, indicated that the patient's surgical incision dressing had been changed. The clinical record failed to include a physician's order for the treatment to be provided. 4. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing did not have any further information or documentation in relation to physician orders for wound treatments. 5. A policy titled Physician Orders dated 07/10/15, indicated "All medications, treatments and services provided to patients must be ordered by a physician 6. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The registered nurse informs the physician and other personnel of changes in the patient condition of needs .... "		alter the POC ; and Trainingon Conformance with Physician Orders which include all medications, treatmentsand services provided to patients must be ordered by a physician. On 5/25/16 and ongoing an In Home Quality Assurance Committee was developed to makehome visits on 10% of clients monthly (until all clients have been seen) (thecommittee will continue to make home visits 10% quarterly). During the home visit the committee memberwill ensure that POC is being followed and documented by interview withpatient, review of POC, Physician Orders, notes and documentation sheets. The committee member, when educating, will getsigned documents of the training provided. Each document signed will be placed in the staff personnel file andclient chart. The committee members willprovide a written report of the visit to the Administrator and Director ofNursing within 24 hours. The committeewill meet the first Wednesday of each month to discuss findings and theoutcomes and to ensure that each finding was addressed and resolved., Effective4/17/16 and ongoing 10% of all clinical records will be audited quarterly forevidence on POC, Periodic Review of POC which covers all pertinent diagnoses,including mental status, types of services	

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			and equipment required, frequency ofvisits, prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning, pulseoximetry, vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Training on Conformance with PhysicianOrders which include all medications, treatments and services provided topatients must be ordered by a physician. Staff failing to follow POC will receiveadditional training with corrective action up to termination. The QualityAssurance Committee, Compliance Officer, Administrator and Director of Nursingwill be responsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

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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 Licensed Practical Nurse [licensed practical nurse] failed to ensure assessments / visit notes were clear, complete and accurate for 3 of 5 records reviewed with LPN providing services in a sample of 11. (#1, 2, and 7) Findings include: 1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week, to evaluate cardiopulmonary status, nutrition / hydration / elimination status, signs and symptoms of infection and standard precautions, teach disease process, diet, home safety / falls prevention, pulse oximetry every visit and as needed for dyspnea, oxygen at 0.5 to 6 liters per minute, teach oxygen use / precautions, administer trach care, change trach collar every day, suction trach, check pressure	N 0554	AllLicensed Practical Nurses will be in-serviced on (Duties of the Licensed Practical Nurse) preparingclinical and progress notes, reports findings and observations to theRegistered Nurse and other members of the team to assure coordination andtimely response to client changes or needs by 6/10/16. On 4/13/16 all staff (nurses (RN and LPN),administration, HHA's, and ancillary staff, etc.) mandatory in-service was sentvia e-mail (for all staff with email addresses), U.S. Post Office mailing forthose without emails, along with a phone call or text explaining the urgencyand severity of the mandated training on 4/13/16 with a mandatory response dead line of4/15/16. Training includes PatientRights (including patient and/or family responsibilities, Care Plans andClinical Documentation, Attendance and Reporting (including specific call offprocedures for all staff) along with Progressive Disciplinary Action forfailure to comply. Effective4/18/16 and ongoing the Director of Nursing, Alternate	06/10/2016

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	points, pericare, incontinent care, in and out catheterizations three times a day and as needed. The patient diagnoses included, but limited to spina bifida, paraplegia, sleep apnea, and hypertension. a. The clinical record of patient number 1 was reviewed on 04/06/16 at 12:40 PM and indicated the following: 1. The OASIS discharge assessment dated 03/29/16, the summary indicated the patient was found dead at his / her home at 08:00 AM. The patient was in his wheelchair at the kitchen table. 2. Review of the nursing visit notes on 04/06/16 at 12:40 PM, the clinical record failed to contain visit notes 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16. b. An agency investigation note dated 03/29/16 at 9:57 AM, was reviewed and indicated the Director of Clinical Services had taken a phone call from Employee F, LPN (Licensed Practical Nurse) at 9:30 AM. Employee F reported that he / she had developed a fever and did not feel that he / she should come to work. Employee F asked the patient if he / she would like for Employee F to notify the office and the		Director ofNursing/Compliance Officer will review clinical and progress notes everyWednesday to ensure LPN's are following POC and reporting findings andobservations to the Registered Nurse and other members of the team to assurecoordination and timely response to client changes or needs. Effective 4/17/16 and ongoing 10% of all clinicalrecords will be audited quarterly for evidence of the that the LPN's ispreparing clinical and progress notes, reporting findings and observations tothe RN and other members of the team to assure coordination and timelyresponses to client changes or needs. Effective 6/1/16 a Medical Records Specialistis hired to review nursing notes (front and back) and POC has date for verbalorders, and back-up filer to ensure notes are accurate and complete in medicalrecords within 14 days, etc. A weeklyreport will be generated and submitted to DON, ADON, Alt. Adm, Administratorand Compliance Officer on missing paperwork and incomplete/inaccuratepaperwork. Staff will be given five(5) days to correct and be re-trained on incomplete paperwork – ongoing. Failure to meet timeline will result insuspension until complete up to termination. The Compliance Office, Administratorand Director of Nursing will be responsible for monitoring these	

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	patient replied that he / she did not want any of the nurses from the office because of previous issues. Employee F indicated he / she had spoken to the patient around midnight on the phone and messaged with him / her on facebook around 3:00 AM. Employee F indicated he / she had called the patient to let him / her know that he / she was coming to assist him / her around 7:00 AM but the employee got no answer. When Employee F arrived at the patient's home around 8:00 AM, he / she did not get an answer at the door and someone had to let him / her in and that was when Employee F found the patient sitting in his wheelchair at the kitchen table. Employee F called 911. Employee F indicated he / she was trying to follow the client's wishes. The Director of Clinical Services informed Employee F of the immediate suspension pending the investigation. c. The Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was interviewed on 04/06/16 at 1:40 PM. The Director of Clinical Services stated Employee F had failed to return phone calls and text messages, so a letter of termination had gone out to him / her in the mail. At 3:40 PM, the Administrator, Director of Clinical Services, and Assistant Director of Clinical Services were interviewed		correctiveactions to ensure that this deficiency is corrected and will not recur.	

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	again. To prevent this occurrence from happening again, measures that had been put into place included reiterating to patients to contact the office when staff fails to show up and there was a live person to take calls 24/7. Another measure included retraining the staff to notify the office for call offs. The Director of Clinical Services stated there was not a sign-in sheet of the staff training. The Director of Nursing stated Employee F knew he / she needed to call in, for he / she had called off a few weeks ago. d. Employee F was interviewed on 04/06/16 at 4:30 PM. The employee stated he / she did not show up at the patient's home as scheduled and did not notify the office of his / her absence per patient wishes. Employee F stated he / she did notify the office and spoke with the Director of Clinical Services in regards to the absence and death. Employee F did confirmed the typed conversation with the Director of Clinical Services with the exception that he / she observed the patient's facebook as "active" at 3:00 AM, but did not speak with the patient at this time. The Employee also stated he / she was not placed on suspension, but was allowed time off to grieve due to the close relationship he / she had with the patient.			

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	The employee stated he / she had not received any text messages or phone calls from the Director of Clinical Services. Employee F stated he / she was contacted today by Employee R, a Registered Nurse / Case Manager, but also stated he / she had another death in the family and had been out of town where phone reception was poor. The employee stated that a scheduler had reached out to him / her on 03/31/16, about taking another case and was planning to send him / her the plan of care. e. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. The Administrator stated Employee F did notify the office the previous evening. The Administrator stated the employee was still fired. The Administrator provided an employee list of names that the Director of Clinical Services produced, of staff who had been in-serviced on call offs. At 10:30 AM, the Administrator provided Employee F's missing visit notes of patient number 1 and also provided a business news letter. The Administrator stated the news letter went out with payroll, which was within the same week of the patient's death. The news letter stressed the importance of calling the office for call offs and failure			

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	to follow the agency policy would result in termination. The 03/27 and 03/28/16 skilled nursing visit notes were not provided. f. On 04/08/16 at 3:00 PM, Employee F was interviewed in person. Employee F provided a text message between him / herself and the patient on 03/28/16, indicating that Employee F continued to be ill and the patient declined to have a replacement nurse. Employee F stated the patient was able to take him / herself off the vent but felt better if someone was there due to random episodes of desaturation when removed and at times, would become unresponsive for a few minutes then return to normal. Both agreed for Employee F to follow up with the patient in the morning of 03/29/16. Employee F provided a text message between him / herself and the Administrator dated 04/07/16 at 5:15 PM. The message indicated "you are suspended pending investigation. Client died and you did not cover the shift or call the office as policy states." Employee F provided a text message dated 03/31/16, from an unknown scheduler in regards to taking on a new case and another text message dated 04/02/16, indicating the plan of care was going to be sent out. Employee F was questioning why he / she was			

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	asked to take on a new client if he / she was suspended. Employee F provided a text dated 04/04/16, where he / she had made contact with the office requesting information about the new case. Employee F also stated that when he / she met with the Alternate Administrator on 04/07/16, he had provided him / her with a $20 gift card for meeting with him. Employee F stated the missing 03/27 and 03/28/16 skilled nursing visit notes were not provided to the Alternate Administrator because the visit notes were to be turned in with the next payroll. Employee F stated he / she had thought he / she would have them to turn in with the new case. g. During a home visit with Employee P, home health aide, on 04/12/16 at 9:00 AM, Employee P was interviewed and had stated he / she had never seen a company newsletter, but then the agency did not have his / her correct address. Employee P also stated he / she had not been told or reminded about notifying the office about call offs and the repercussions. h. During a home visit with Employee I, a home health aide, on 04/12/16 at 10:30 AM, Employee I was interviewed and had stated he / she had never seen a company newsletter, nor had			

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	he / she been told or reminded about notifying the office about calls offs and the repercussions. i. During a home visit with Employee J, a LPN, on 04/12/16 at 1:40 PM, Employee J was interviewed and stated he / she had not received a company newsletter, but did receive a text from the office the previous week about calls offs, but was unable to remember the specific details of the text nor the date received. j. During a home visit with Employee K, a Registered Nurse on 04/12/16 at 3:40 PM, Employee K was interviewed and stated that he / she would get a company newsletter in an email sometimes but had not received an email within the past few weeks. Employee K stated he / she did get a text the previous week to contact the Director of Nursing for call offs but unable to provide a specific date. k. During a home visit with Employee H, a Registered Nurse on 04/12/16 at 4:40 PM, Employee H was interviewed. Employee H stated that he / she had not received a company newsletter and could not remember the last time he / she had received one. Employee H recalled hearing about call			

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	offs a few weeks prior, but don't recall specifics or repercussions. l. The Administrator was interviewed on 04/13/16 at 4:00 PM. The Administrator was in agreement that the text message to Employee F on 04/07/16 at 5:15 PM, had taken place. The Administrator stated she had did that because she had felt bad for the employee and wanted cooperation to get the visit notes. The Administrator had no explanation of the field staff interviews on 04/12/16 in regards to the newsletter and the lack of knowledge of the call off policy and repercussions. m. The detective involved in the patient's death investigation was interviewed on 04/18/16 at 10:16 AM. The Detective stated the initial findings was asphyxiation due to a mucous plug, but the final coroners report would take anywhere from 2 to 3 weeks. The time of death usually would be upon arrival of the coroner, but was unsure at this time. The projected time of death was anticipated between 6:00 AM to 7:00 AM. The Detective also stated that there was a video that put Employee F's arrival time to the patient's home at 8:35 AM on 03/29/16. The Detective stated Employee M, a home health aide / administrative assistant, came by the			

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	police station the previous week and obtained a copy of the report. 2. The clinical record for number 2, SOC 02/11/16, included two plans of care established by a physician for the certification period of 02/11/16 to 04/10/16, with orders to" ... administer flushes as ordered, O2 [oxygen] during naps / bedtime, administer trach care ... administer feedings." The patient's diagnoses included Bronchopulmonary Dysplasia, Chronic Aspiration, Tracheomalacia, Development Disorder, and gastric tube feeding intolerance. a. A nursing visit note dated 2/24/16, failed to include a cardiovascular assessment, the type and rate of tube feedings [elaborate the meaning "2 hrs [hours] 6 hrs > slow feed"] if the patient was having feeding intolerance's, flushes, a skin assessment, a pain assessment, if trach care had been provided, and the number of incontinent episodes of urine. b. A nursing visit note dated 2/26/16, failed to properly identify if the patient had a g/tube (gastric feeding tube) and / or j/tube (jejunostomy feeding tube), if the feedings had been provided and tolerance of feedings, flushes, if trach care had been provided, the number of			

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	incontinent episodes / assessment of the genitourinary (number of incontinent of urine episodes) and digestive system (bowel sounds and bowel movements). c. A nursing visit note dated 03/01/16, failed to properly identify if the patient had a g/tube and / or j/tube, the rate, frequency, and duration of the feedings, tolerance of feedings, if trach care had been provided, and assessment of the digestive system (bowel sounds and bowel movements). d. A nursing visit note dated 03/03/16, failed to properly identify if the patient had a g/tube and / or j/tube, the rate and duration of the feedings, tolerance feedings, an assessment of the digestive system (bowel sounds and bowel movements), assessment of the neurosensory system, and if trach care had been provided. e. The Assistant Director of Clinical Services was interviewed on 04/13/16 at 2:15 PM, and stated the patient had a j/tube. f. The Director of Clinical Services was interviewed on 04/13/16 at 2:25 PM, and stated the patient had both g/tube and j/tube.			

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356	

(X4) ID 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
	3. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. a. Review of the skilled nursing notes dated 03/02, 03/06, 03/09 to 03/12/16, the LPN failed to include a description / assessment of the wounds being treated and description of the treatment being provided. 4. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing stated the visit notes should have included an assessment of the wounds. 5. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Licensed Practical Nurse: a. Provides service in accordance with ISHHA [Individual Services Home Health Agency] policy and nursing standards of practice ... d. Reports findings and observations to the Registered Nurse and other members of the team to assure coordination and timely response to client changes or needs. e. Prepares clinical and progress			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K025	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

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	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 Licensed Practical Nurse (Licensed Practical Nurse) failed to ensure that all treatments provided had a physician's order for 2 of 2 records reviewed of patients with wounds in a sample of 11. (# 6 and 7) Findings include: 1. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention. a. Review of a skilled nursing visit note on 03/22/16 at 2:00 PM, the	N 0555	All skilled nurses will be in-serviced on (Duties of theRegistered Nurse reporting to Physician, Licensed Practical Nurse and otherteam member reporting to RN) by 6/10/16. Individual training sessions with Registered Nurses to ensure that theRN (LPN and other team members are furnishing to the RN) is furnishing, documentingand assessing services requiring substantial and specialized nursing skill asthe plan of care is implemented, revised, and updated by Registered Nurse andis supported by the comprehensive assessment which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to type,frequency and duration, irrigations, ventilator	06/10/2016

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356	

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	skilled nurse documented the patient blood pressure was 208/109. The clinical record failed to evidence that the physician had been notified. b. Review of a skilled nursing visit note on 03/25/16 at 9:00 PM, the skilled nurse documented no urine output. The clinical record failed to evidence that the physician had been notified. 2. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week to assess cardiopulmonary status and to provide daily wound care. The treatment orders indicated to cleanse the lower extremities and pat dry, apply silver sulfadizaine cream to wounds, wrap with gauze dressing. a. During a home visit on 04/12/16 at 12:20 PM, Employee J, a LPN (Licensed Practical Nurse) was observed to cleaning the bilateral lower extremities with soap and water, applied silvadene cream to the bilateral lower extremities, applied 4 x 4 gauze, ABD pads and foam dressing pads, wrapped with cling, followed by kerlix, and final		(including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician started on 5/24/16 and ongoing with the Director of Nursing,Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to ensure that the RN (LPN and other teammembers are furnishing to the RN) isfurnishing, documenting and assessing services requiring substantial andspecialized nursing skill as the plan of care is implemented, revised, andupdated by Registered Nurse and is supported by the comprehensive assessmentwhich covers all pertinent diagnoses, including mental status, types ofservices	

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	wrap with coban dressing to the bilateral lower extremities. The clinical record failed to include a physician's order for the treatment that had been provided. 3. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing did not have any further information or documentation. 4. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Licensed Practical Nurse: a. Provides service in accordance with ISHHA [Individual Services Home Health Agency] policy and nursing standards of practice ... d. Reports findings and observations to the Registered Nurse and other members of the team to assure coordination and timely response to client changes or needs .... "		and equipment required, frequency of visits, prognosis, rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements, medications and treatments w/specific instructions, (includingbut not limited to: type, frequency andduration, irrigations, ventilator (including settings / management), trach(size and type), tube feedings, assistive devises, oxygen (settings), bowelprogram (detail instructions) suctioning, pulse oximetry, vents(setting/management), catheters (size and type), wounds, size, measurements,instructions for service, any safety measures to protect against injury,instructions for timely discharges or referral, and any other appropriateitems; and promptly report any changes to the physician that suggest a need toalter the POC ; and Conformance with Physician Orders which include allmedications, treatments and services provided to patients must be ordered by aphysician. On 5/25/16 and ongoing an In Home Quality AssuranceCommittee was developed to make home visits on 10% of clients monthly (untilall clients have been seen) (the committee will continue to make home visits10% quarterly). During the home visitthe committee member will ensure	

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	15K025		04/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

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			that the RN (LPN and other team members are furnishingto the RN) is furnishing, documenting and assessing services requiringsubstantial and specialized nursing skill as the plan of care is implemented,revised, and updated by Registered Nurse and is supported by the comprehensiveassessment which covers all pertinent diagnoses, including mental status, typesof services and equipment required, frequency of visits, prognosis,rehabilitation potential, functional limitations, activities permitted,nutritional requirements, medications and treatments w/specific instructions,(including but not limited to: type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all	

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			medications, treatments and services provided to patients must beordered by a physician. The committeemember, when educating, will get signed documents of the trainingprovided. Each document signed will beplaced in the staff personnel file and client chart. The committee members will provide a writtenreport of the visit to the Administrator and Director of Nursing within 24hours. The committee will meet thefirst Wednesday of each month to discuss findings and the outcomes and toensure that each finding was addressed and resolved., Effective 4/17/16 and ongoing10% of all clinical records will be audited quarterly for evidence of the thatthe RN (LPN and other team members are furnishing to the RN) is furnishing, documenting and assessingservices requiring substantial and specialized nursing skill as the plan ofcare is implemented, revised, and updated by Registered Nurse and is supportedby the comprehensive assessment which covers all pertinent diagnoses, includingmental status, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type,	

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			frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions) suctioning,pulse oximetry, vents (setting/management), catheters (size and type), wounds,size, measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. Staff failing tofollow procedure will receive additional training with corrective action up totermination. The Quality Assurance Committee, Compliance Officer, Administratorand Director of Nursing will be responsible for monitoring these correctiveactions to ensure that this deficiency is corrected and will not recur.	
N 0559 Bldg. 00	410 IAC 17-14-1(a)(2)(G) Scope of Services Rule 14 Sec. 1(a) (2) (G) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (G) Inform the physician, dentist,			

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	chiropractor, podiatrist, or optometrist of changes in the patient's condition and needs after consulting with the supervising registered nurse. Based on record review and interview, the agency Licensed Practical Nurse failed to notify the physician after informing the Registered Nurse in relation to no urine output after in and out catheterizations for 1 of 6 records reviewed of active / current patients in a sample of 11. (# 6) Findings include: 1. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification periods of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 hour visits per day 7 days a week for in and out catheterizations and evaluation of the patients cardiopulmonary status. The patient diagnoses include, but not limited to, Right Kidney Nephrectomy, Diabetes, Hypertension, and Urinary Retention. a. Review of a skilled nursing visit note on 03/22/16 at 6:00 PM, the skilled nurse documented no urine output after 2 attempts of catheterizations. The clinical record failed to evidence that the physician had been notified.	N 0559	All skilled nurses will be in-serviced on (Duties of theRegistered Nurse reporting to Physician, Licensed Practical Nurse and otherteam member reporting to RN) by 6/10/16. Individual training sessions with Registered Nurses to ensure that theRN (LPN and other team members are furnishing to the RN) is furnishing, documentingand assessing services requiring substantial and specialized nursing skill asthe plan of care is implemented, revised, and updated by Registered Nurse andis supported by the comprehensive assessment which covers all pertinentdiagnoses, including mental status, types of services and equipment required,frequency of visits, prognosis, rehabilitation potential, functionallimitations, activities permitted, nutritional requirements, medications andtreatments w/specific instructions, (including but not limited to type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters	06/10/2016

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	b. Review of a skilled nursing visit note on 03/25/16 at 9:00 PM, the skilled nurse documented no urine output. The clinical record failed to evidence that the physician had been notified. 3. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services did not have any further information or documentation. 4. A policy titled Skilled Nursing Services dated 07/10/15, indicated " ... The Licensed Practical Nurse ... Reports findings and observations to the Registered Nurse and other members of the team to assure coordination and timely response to client changes or needs .... "		(size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician started on 5/24/16 and ongoing with the Director of Nursing,Alternate Director of Nursing/Compliance Officer. An all Case Manager training session has beenscheduled for Friday, June 17, 2016 to ensure that the RN (LPN and other teammembers are furnishing to the RN) isfurnishing, documenting and assessing services requiring substantial andspecialized nursing skill as the plan of care is implemented, revised, andupdated by Registered Nurse and is supported by the comprehensive assessmentwhich covers all pertinent diagnoses, including mental status, types ofservices and equipment required, frequency of visits, prognosis, rehabilitationpotential, functional limitations, activities permitted, nutritionalrequirements, medications and treatments w/specific instructions,	

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			(includingbut not limited to: type, frequency andduration, irrigations, ventilator (including settings / management), trach(size and type), tube feedings, assistive devises, oxygen (settings), bowelprogram (detail instructions) suctioning, pulse oximetry, vents(setting/management), catheters (size and type), wounds, size, measurements,instructions for service, any safety measures to protect against injury,instructions for timely discharges or referral, and any other appropriateitems; and promptly report any changes to the physician that suggest a need toalter the POC ; and Conformance with Physician Orders which include allmedications, treatments and services provided to patients must be ordered by aphysician. On 5/25/16 and ongoing an In Home Quality AssuranceCommittee was developed to make home visits on 10% of clients monthly (untilall clients have been seen) (the committee will continue to make home visits10% quarterly). During the home visitthe committee member will ensure that the RN (LPN and other team members are furnishingto the RN) is furnishing, documenting and assessing services requiringsubstantial and specialized nursing skill as the plan of care is	

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			implemented,revised, and updated by Registered Nurse and is supported by the comprehensiveassessment which covers all pertinent diagnoses, including mental status, typesof services and equipment required, frequency of visits, prognosis,rehabilitation potential, functional limitations, activities permitted,nutritional requirements, medications and treatments w/specific instructions,(including but not limited to: type,frequency and duration, irrigations, ventilator (including settings /management), trach (size and type), tube feedings, assistive devises, oxygen(settings), bowel program (detail instructions) suctioning, pulse oximetry,vents (setting/management), catheters (size and type), wounds, size,measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. The committeemember, when educating, will get signed documents of the trainingprovided. Each document	

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			signed will beplaced in the staff personnel file and client chart. The committee members will provide a writtenreport of the visit to the Administrator and Director of Nursing within 24hours. The committee will meet thefirst Wednesday of each month to discuss findings and the outcomes and toensure that each finding was addressed and resolved., Effective 4/17/16 and ongoing10% of all clinical records will be audited quarterly for evidence of the thatthe RN (LPN and other team members are furnishing to the RN) is furnishing, documenting and assessingservices requiring substantial and specialized nursing skill as the plan ofcare is implemented, revised, and updated by Registered Nurse and is supportedby the comprehensive assessment which covers all pertinent diagnoses, includingmental status, types of services and equipment required, frequency of visits,prognosis, rehabilitation potential, functional limitations, activitiespermitted, nutritional requirements, medications and treatments w/specificinstructions, (including but not limited to: type, frequency and duration, irrigations, ventilator (includingsettings / management), trach (size and type), tube feedings, assistivedevises, oxygen (settings), bowel program (detail instructions)	

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			suctioning,pulse oximetry, vents (setting/management), catheters (size and type), wounds,size, measurements, instructions for service, any safety measures to protect againstinjury, instructions for timely discharges or referral, and any otherappropriate items; and promptly report any changes to the physician thatsuggest a need to alter the POC ; and Conformance with Physician Orders whichinclude all medications, treatments and services provided to patients must beordered by a physician. Staff failing tofollow procedure will receive additional training with corrective action up totermination. The Quality Assurance Committee, Compliance Officer, Administratorand Director of Nursing will be responsible for monitoring these correctiveactions to ensure that this deficiency is corrected and will not recur.	
N 0596 Bldg. 00	410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on record review and interview,	N 0596	All Staff including Home Health	06/10/2016

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INDIVIDUAL SUPPORT HOME HEALTH AGENCY	1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356

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	the agency failed to ensure that the home health aide skills competency check offs provided documentation of tasks, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient for 3 of 3 home health aides hired in 2015. (Employees I, N, S) Findings include: 1. The agency personnel files was reviewed on 04/15/16 at 1:30 PM. The files indicated the following: a. Employee I, Date of Hire (DOH) 05/12/14, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient.		Aides will bein-serviced on Tag G210 (Home Health Aide Training – Documentation, SkillsCompetency CheckList) by 6/10/16. AllHHA's have and were trained on the skills competency check list using apatient. Effective 5/27/16 the skillscompetency check offs will include a client ID for proof that all Home HealthAides training has been performed on a patient. Agency policy was updated on 5/27/16 toinclude skills competency check offs will include a client ID. A client ID key will be initiated on 5/27/16by the Administrator. 5/27/16 the ClientID key was shared with the BusinessAssociate Agreement and Registered Nurse The client ID key will be updated asnecessary. On 5/27/16 the review ofClient ID's listed on employee competency check offs was added to the review ofnew hire packets, and quarterly review of personnel files. On 5/27/16 staff were in-serviced on thechange in policy to include Client ID's listed on the employee competency checkoffs. The Administrator and Director ofNursing will be responsible for monitoring these corrective actions to ensurethat this deficiency is corrected and will not recur.	

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NAME OF PROVIDER OR SUPPLIER INDIVIDUAL SUPPORT HOME HEALTH AGENCY		STREET ADDRESS, CITY, STATE, ZIP CODE 1006 WEST MILL STREET SUITE B MIDDLETOWN, IN 47356	

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	b. Employee N, DOH 08/18/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. c. Employee S, DOH 02/24/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. 2. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services did not provide any further information by the end of the exit conference on 04/18/16 at 03:40 PM.			
N 0598	410 IAC 17-14-1(l)(2)			

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Bldg. 00	Scope of Services Rule 14 Sec. 1(l)(2) The home health agency shall maintain documentation which demonstrates that the requirements of this subsection and subsection (h) of this rule were met. Based on record review and interview, the agency failed to ensure that the home health aide skills competency check offs provided documentation of tasks, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient for 3 of 3 home health aides hired in 2015. (Employees I, N, S) Findings include: 1. The agency personnel files was reviewed on 04/15/16 at 1:30 PM. The files indicated the following: a. Employee I, Date of Hire (DOH) 05/12/14, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath),	N 0598	AllStaff including Home Health Aides will be in-serviced on Tag G212 (CompetencyEvaluation and In-Service Training) by 6/10/16. All HHA's have and were trainedon the skills competency check list using a patient. Effective 5/25/16 and ongoing the CompetencyEvaluation and In-Service Training will include a client ID for proof that allHome Health Aides training has been performed on a patient. Agency policy was updated on 5/27/16 toinclude Competency Evaluation and In-Service Training will include a clientID. A client ID key was initiated on5/27/16 by the Administrator. 5/27/16the Client ID key was shared with theBusiness Associate Agreement and Registered Training Nurse. The key will be updated as necessary. On 5/27/16 the review of Client ID's listedon employee Competency Evaluation and In-Service Training was added to thereview of new hire packets, and quarterly review of personnel files. On 5/27/16 staff were in-serviced on thechange in policy to include Client ID's listed on the employee CompetencyEvaluation and In-Service Training. TheAdministrator and Director of	06/10/2016

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	shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. b. Employee N, DOH 08/18/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. c. Employee S, DOH 02/24/15, failed to indicate that the home health aide skills competency check off, such as reading and recording temperature, pulse, and respiration, bed bath, sponge (tub or shower bath), shampoo (sink, tub, or bed), nail and skin care, oral hygiene, toileting and elimination, safe transfer techniques, ambulation, and normal range of motion and positioning, had been performed on a patient. 2. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of		Nursing will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

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	Clinical Services did not provide any further information by the end of the exit conference on 04/18/16 at 03:40 PM.			
N 0606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on record review and interview, the agency failed to ensure the home health aide followed the plan of care for 4 of 4 records reviewed with home health aide services in a sample of 11. (#3, 5, 10, and 11) Findings include: 1. The clinical record for number 3, SOC 06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health aide services 14 hours per week, 1 - 2 hours per day, 7 days a week for 9 weeks. The patient diagnoses included, but limited to arthritis, coronary artery bypass graft, coronary artery disease, diabetes,	N 0606	AllStaff including Home Health Aides will be in-serviced on (Assignment and Dutiesof Home Health Aide) following the POC and reporting any changes that suggest aneed to alter the POC to the Registered Nurse to report to the Physician by6/10/16. Effective 4/17/16 and ongoing 10%of all clinical records will be audited quarterly for evidence of the HHA's arefollowing POC and reporting any changes to the Registered Nurse that suggest aneed to alter the POC to be reported to the Physician . Effective 4/18/16 Management personnel wereinstructed to transfer all complaints from patients or caregivers (includingschedules and staffing) to the Administrator or Director of Nursing or designee. All complaints will be investigated	06/10/2016

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	and autonomic instability. a. Review of the clinical record on 04/07/16 at 1:54 PM, the clinical record failed to evidence home health aide visits from 06/22/15 to 07/14/15, 07/15/15, 07/16/15, and 07/18/16 to 07/27/15. b. The Administrator on 04/07/16 at 4:00 PM, and provided a typed statement indicating that employee E, a Registered Nurse / Case Manager, that the patient had been complaining about not getting all of his / her hours. The statement indicated the Administrator had spoken to employee L, a Home Health Aide and Manager of a Personal Service Agency owned by the Administrator. The statement indicated Employee L had spoken with the patient and the patient was not satisfied with the staff Employee L was sending, the patient wanted the agency to hire a family member, and was holding the agency off. The statement indicated the Administrator had left a message on the patient's phone on 7/23, 7/24, 7/27, and 7/28/15. On 7/25/15, the statement indicated the patient had emailed Employee M, also a home health aide and coordinator for both the home health agency and personal services agency, and had asked about hiring the patient's sister [name of sister was included]. The statement indicated		anddocumented with a resolution. Ifresolution of the complaint was not possible, the actions that were attemptedand the outcomes will be documented by ISHHA. On 5/27/16 policy was updated toinclude a letter will be sent to the patient upon resolution (will include theactions that were attempted and the outcomes). A copy of the letter will accompany the ISHHA investigation. On 5/25/and ongoing an In Home QualityAssurance Committee was developed to make home visits on 10% of clients monthly(until all clients have been seen) (the committee will continue to make homevisits 10% quarterly). During home visits, thecommittee members will review the POC and HHA documentation to ensure HHA's arefollowing POC and documenting as POC states, Registered Nurse will alert thePhysician if documentation suggest a need to alter the POC. The committee member,when educating, will get signed documents of the training provided. Each document signed will be placed in thestaffs personnel file. Thecommittee will meet the first Wednesday of each month to discuss findings andthe outcomes and to ensure that each finding was addressed and resolved. Effective 6/1/16 and ongoing a HHA DocumentationReview Committee was established to audit 10% of all HHA	

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	Employee M had informed the patient that he / she was unaware of the request and would investigate it. The statement indicated the Administrator and Employee M had talked with the patient and the patient indicated "it didn't matter he / she fired us and was going with an agency that would hire his / her sister in one day." The Administrator stated new staff must have orientation for approximately 1 week. c. Patient number 3 was interviewed on 04/07/16 at 7:00 PM. The patient had stated that the named sister in the statement, was a patient of the agency's and had been for many years. The patient stated he / she used to work for the agency and took care of the named sister until he / she had their own surgery in 2009. The patient stated that his / her niece currently works for the agency and was taking care of the mentioned sister. The patient stated he / she would never ask to have his / her niece removed from the sister's care. The patient stated that he / she did not want weekend staff, but wanted to take the weekend hours and apply it to the week day hours. The patient stated he / she had never canceled or refused a visit, but complained to the agency about not having home health aides to his / her home as ordered. The patient stated on one occaision, a home		documentationquarterly for evidence that the HHA's are following POC and reporting anychanges that suggest a need to alter the POC to the Registered Nurse to bedocumented and reported to the Physician. Thecommittee will provide audit results to the staff's "Point of Contact" personfor re-training of HHA's, the Administrator and DON. A training document will be placed in thepersonnel file. The Administrator andDirector of Nursing will be responsible for monitoring these corrective actionsto ensure that this deficiency is corrected and will not recur.	

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	health aide was in an accident on his / her way to the patient's home, but the home health aide was not replaced. The patient stated the agency told him / her would need to find another agency. d. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 PM. The Director of Clinical Services stated she was not aware of the missing home health aide visits. The Director of Clinical Services stated she mostly manages the nursing and the Administrator, Employee L and Employee M managed the home health aides. e. Employee M and the Administrator were interviewed on 4/18/16 at 2:25 PM. Employee M stated he / she was a home health aide and nothing further. The Administrator stated Employee M did helped with coordination as well. Employee M was not able to recall the event nor conversation with the patient. After the statement was read, Employee M was not able to add any further information and indicated the statement summed up the situation. The Administrator stated the name mentioned in the statement must have been wrong. 2. The clinical record for patient number			

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	5, SOC 03/01/10, included plans of care established by a physician for the certification periods of 01/27/16 to 03/26/16 and 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week to provide bathing, pericare, nail care, foot care, pm care, assist with feeding, mobility, transfers and positioning, encourage fluids, incontinent care, check pressure areas, skin care, medication reminders, make bed, and straighten patient area. a. Review of the home health aide notes dated 02/15, 02/19, 02/20, 02/21, 02/22, 02/26, 02/29, 03/04, 03/05, 03/06, 03/07, 03/11, 03/14, 03/17, 03/18, 03/19, 03/20, 03/21, 03/22, 03/23, 03/24, 03/25, 03/26, 03/27, and 03/28/16, the home health aide documented "NN" (Not Needed) for bathing, pericare, nail care, foot care, pm care, ambulation assist / mobility, assist with feeding, incontinent care, checking pressure areas, skin care, medication assistance, and / or making the bed / straighten patient area. The home health aide failed to follow the plan of care. b. Review of the home health aide visit notes dated 02/14/16 to 02/17/16, 02/19/16 to 03/16/16, 03/18/16 to 03/21/16, 03/23 to 03/25/16, 03/17/16,			

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	and 04/02/16, the home health aide indicated he / she had provided services to the patient from the hours of 9:00 AM. to 3:00 PM. On 02/18/16 and 03/26/16, the home health aide indicated he / she had provided services from 10:30 AM to 3:30 PM. On 03/17/16, the home health aide indicated he / she had provided services from 12:00 PM to 4:00 PM. On 03/22/16, the home health aide indicated he / she had provided services from 9:00 AM to 11:50 AM. On 03/28/16, the home health aide indicated he / she provided services from 9:00 AM to 7:25 PM. The home health aide failed to follow the plan of care. c. During a home visit on 04/12/16 at 9:00 AM., the patient's agency binder was reviewed. The binder included a page of a breakdown of home health aide and attendant care hours through the personal services agency owned by the Administrator. The page indicated 9:00 AM to 11:00 AM, 11:30 AM to 12:30 PM, 1:00 PM to 2:00 PM, and 2:15 PM to 4:15 PM, and weekends 9:00 AM to 3:00 PM services were to be home health aide hours through the home health agency. The other times 11:00 AM to 11:30 AM, 12:30 PM to 1:00 PM, and 2:00 PM to 2:15 PM, services were to be provided with the personal services agency.			

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	d. The home health aide, Employee P, was interviewed during this time. The employee stated that he / she was unfamiliar with the breakdown of time sheet and pulled the sheet from the binder. Employee P stated she works from 9:00 AM to 3:00 PM and does the personal care services from 3:00 PM to 4:45 PM. e. The Director of Clinical Services was interviewed on 4/18/16 at 1:00 p.m. The Director of Nursing stated the home health aides should have been following the plan of care. 4. The clinical record for patient number 10, SOC 03/27/15, included a plan of care established by a physician for the certification period of 09/23/15 to 11/21/15, with orders for home health aide services 1 hour a day 7 days a week to provide shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and make bed / straighten patient areas. a. Review of the home health aide visit notes, the record failed to evidence a home health aide visit on 10/5/15 and 10/25. The home health aide failed to follow the plan of care.			

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	b. Review of the home health aide notes dated 10/01, 10/02, 10/06, 10/07, 10/08, 10/09, 10/12, 10/14, 10/15, 10/17, 10/18, 10/23, and 10/24/16, the home health aide documented "NN" (Not Needed) for shower, pericare, nail care, foot care, ambulation assist / mobility in wheelchair, skin care, check pressure ulcers, and / or make bed / straighten patient areas. The home health aide failed to follow the plan of care. 5. The clinical record for patient number 11, SOC 02/20/15, included a plan of care established by a physician for the certification period of 08/19/15 to 10/17/15, with orders for home health aide services 3 hours per day 5 days a week to assist with bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). a. Review of the home health aide visit notes during the certification period of 08/19/15 to 10/17/15, the home health			

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	aide failed to evidence 5 visits during week 1, 1 visit during week 2, 5, and 7, and 2 visits during week 3, 4, and 6. The home health aide failed to follow the plan of care. The home health aide provided 2 extra visits during week 8 and 9. b. Review of the home health aide visit notes dated 08/27, 08/28, and 08/31/15, the home health aid provided 6 hour visits. The home health aide failed to follow the plan of care. c. Review of the home health aide notes dated 08/25 to 08/27, 09/02, 09/04, 09/09, 09/14 to 09/17, 09/22 to 09/24, 09/28 to 09/30, 10/04 to 10/17/15, the home health aide documented "NN" (Not Needed) for bedbath (as needed), tub / shower, bath / chair, pericare (as needed), nail care (clean / observe), foot care (clean / observe), ambulation (cane / commode / wheelchair / shower chair), transfers / positioning, feeding, oral care, encourage fluids, incontinent (bowel / urine), check pressure areas, skin care (lotion), and make bed / straighten client area, range of motion exercises (all extremities). The home health aide failed to follow the plan of care. 6. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all patient visit notes			

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	had been provided. 7. The Administrator, Alternate Administrator, Director of Clinical Services, and Assistant Director of Clinical Services was not able to provide any further information or documentation when asked on 04/18/16 at 3:10 PM. 8. A policy titled Plan of Care, dated 08/15/15, indicated " ... Planning for care is a dynamic process that addresses the care, treatment and services to e provided ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care .... "			
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			

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	person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the agency failed to ensure the missed visit notes (#3 and 11) and supervisory visits forms (#3) were filled out accurately for 2 of 11 records reviewed, failed to ensure nursing visit notes that were faxed to the office, were faxed in its entirety (#1 and 8) for 2 of 11 records reviewed, failed to ensure the plan of care included a date of the verbal order (#8) for 1 of 11 records reviewed, and failed to incorporate visit notes into the medical record within 14 days of the visit for 6 of 11 records reviewed. (#1, 5, 6, 7, 9, and 11) Findings include: 1. The clinical record for number 1, SOC (start of care) 01/28/15 , included a plan of care established by a physician for the certification period of 03/23/16 to 05/21/16, with orders for skilled nursing (1) 13 hour day 7 days a week and (1) 3 hour day 5 days a week. a. Review of the skilled nursing visit notes between March 1, 2016 to March 26, 2016, the clinical record failed to evidence the back pages of the skilled nursing visit notes on 03/02/16 from	N 0608	AllStaff will be in-serviced on Tag G236 (Clinical Records) by 6/10/16 (includedbut not limited to: documentation willbe completed and accurate for each service rendered on the day the service, willbe filed in medical record within 14 days, documentation will show interchange,reporting and coordination of patient care that occurred, documentation will belegible, documentation errors will be have one line through the entry in such away that the written information underneath may still be read, initial and dateentry, write corrected information near entry or where the correct entry can befound and Physician Orders will include date, specific order, signed with fullname and title of the person receiving the order. On5/27/16 staff processing documentation sheets were trained on proper, legibledocumentation and error correction. A weekly report will be generated andsubmitted to DON, ADON, Alt. Adm, Administrator and Compliance Officer onmissing paperwork and incomplete/inaccurate paperwork. Staff will be given five (5) days tocorrect and be re-trained on incomplete paperwork – ongoing. Failure to meet timeline will result insuspension up to termination	06/10/2016

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	12:00 AM to 10:00 AM and 04:00 PM to 07:00 PM, 03/03/16 from 04:00 PM to 07:00 PM, 03/05/16 from 09:00 PM to 12:00 AM, 03/06/16 from 12:00 AM to 10:00 AM and 09:00 PM to 12:00 AM, 03/07/16 from 12:00 AM to 10:00 AM, 06:00 PM to 09:00 PM, and 09:00 PM to 12:00 AM, and 03/08/16 from 12:00 AM to 10:00 AM. b. The clinical record was reviewed on 04/06/16 at 12:40 PM. The clinical record failed to evidence visit notes from Employee F on 03/21, 03/22, 03/24, 03/25, 03/26, 03/27 and 03/28/16. c. On 04/07/16 at 10:00 AM, the Administrator stated the Alternate Administrator was meeting Employee F to pick up the missing visit notes. At 10:30 AM, the Administrator provided Employee F's missing visit notes of patient number 1. Skilled nursing visit notes dated 03/27 and 03/28/16 continued to be missing. 2. The clinical record for number 3, SOC 06/22/15, included a plan of care established by a physician for the certification period of 06/22/15 to 08/20/15, with orders for home health aide services 14 hours per week, 1 - 2 hours per day, 7 days a week for 9 weeks.		until complete. ISHHAwill assist staff in receiving notes/paperwork by means of gas cards, giftcards, kind words, picking them up to ensure ISHHA stays in compliance and thisdeficiency will not recur. Effective 6/1/16 a Medical Records Specialist washired to track missing and inaccurate/incomplete documentation forms, verbalPhysician Orders missed visit notes and supervisory visit from are filled outin their entirety and accurate, nurse visit notes are received front and backand complete and accurate, and the POC have dates included for verbal ordersand all notes are in medical record within 14 days, etc. A weekly report will be generated andsubmitted to DON, ADON, Alt. Adm, Administrator and Compliance Officer onmissing paperwork and incomplete paperwork. Staff will be given five (5) days to correct and be re-trained onincomplete paperwork – ongoing. Failureto meet timeline will result in staff suspensionupt to termination untilcomplete. Effective 4/17/16 and ongoing 10%of all clinical records will be audited quarterly for evidence of missing,inaccurate, incomplete documentation forms Orders missed visit notes andsupervisory visit from are filled out in their entirety and accurate, nursevisit notes are received front and back and complete and accurate, and	

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	a. A form titled "Aide Supervision Note" dated 07/22/15, the note indicated the home health aide was present and the assessment of care given to the patient was good. The supervisory note failed to include the name of the home health aide present during the supervisory visit. A form titled "Missed Visit Report" indicated the patient had missed visits per patient request between 07/18/15 to 07/24/15. Review of the home health aide visit notes, the record failed to include a home health aide visit note for the date of 07/22/15. b. The patient was interviewed on 04/07/16 at 7:00 PM. The patient stated he / she did not cancel or refused services from the agency. c. The Director of Clinical Services was interviewed on 04/18/16 at 1:00 PM. The Director of Clinical Services did not have any further information or documentation when asked. 3. The clinical record for patient number 4, SOC 06/19/15, included plans of care established by a physician for the certification periods of 06/19/15 to 08/17/15 and 08/18/15 to 10/16/15, with orders for skilled nursing 1 - 2 hours a day 2 days a week and home health aide		the POChave dates included for verbal orders and all notes are in medical recordwithin 14 days, etc.filed in medical record within 14 days and verbal ordersand written orders to follow within 21 days. The Administrator and Director of Nursing will be responsible formonitoring these corrective actions to ensure that this deficiency is correctedand will not recur.	

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	services (3) 2 hour visits per day 7 days a week. a. Review of the clinical record, the agency provided a letter containing a notice of discharge on 08/21/15, due to the patient continuing to refuse home health aides. The letter indicated a discharge date of 08/31/15. b. Review of skilled nursing visit notes, a discharge comprehensive assessment was made on 08/26/15, but the last skilled nursing visit note was dated 09/15/15. c. Review of the home health aide visit notes, the last home health aide visit note was dated 09/08/15. d. The clinical record failed to evidence a physician's order to discontinue services on 08/31/15 as anticipated in the patient's discharge letter, failed to evidence an order to stopped home health aide services on 09/08/15, and failed to evidence an order to discharge skilled nursing services on 09/15/15. The record also failed to include a discharge OASIS assessment on or after 09/15/15. e. An interview with patient number 4 on 04/12/16 at 7:30 PM, the			

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	patient indicated he / she had received two letters of discharge. The patient stated he / she did not refuse nursing nor did he / she refused home health aides. The patient stated he / she did not like the team leaders that came into his / her home and his / her last complaint was over a home health aide that spit over his / her food when he / she spoke. The patient stated he / she had to be fed and he / she would lose his / her appetite and couldn't eat. f. The Director of Nursing was interviewed on 04/18/16 at 1:00 PM. The Director of Nursing stated the discharge comprehensive assessment was for the discontinuation of nursing only and home health aide to continue beyond the assessment date. g. The Administrator was interviewed on 04/18/16 at 2:25 PM. The Administrator stated the patient constantly wanted team leaders and refused the home health aides. The Administrator did not provided further information or documentation in regards to continuing services and providing the patient with a new discharge date. 4. The clinical record for patient number 5, SOC 03/01/10, included a plan of care established by a physician for the			

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	certification period of 03/27/16 to 05/25/16, with orders for home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week . The clinical record failed to include visit notes after 03/28/16. 5. The clinical record for patient number 6, SOC 03/17/16, included a plan of care established by a physician for the certification period of 03/17/16 to 05/15/16, with orders for skilled nursing (3) 1 - 2 hours per day 7 days a week to provide in and out catheterization and home health aide services (2) 2 hour and (2) 1 hour visits daily 7 days a week. The clinical record failed to include visit notes after 03/26/16. 6. The clinical record for number 7, SOC 09/08/15, included a plan of care established by a physician for the certification period of 03/06/16 to 05/04/16, with orders for skilled nursing (1) 1 hour a day 7 days a week. The clinical record failed to include visit notes after 03/12/16. 7. The clinical record for number 8, SOC 05/14/12, included a plan of care established by a physician for the certification period of 02/13/16 to 04/12/16, with orders for skilled nursing (2) 2 hours a day 5 days a week on school			

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	days and (1) 11 hour day on non school days. a. Review of the skilled nursing visit notes from 02/13 to 03/11/16, the progress notes on the back side of the assessment page contained information of care that the skilled nurse provided through out his / her visit. Skilled nursing visit notes after 03/14 to 03/23/16 failed to include progress notes on the back side of the assessment notes. 8. The clinical record for patient number 9, SOC 11/03/09, included a plan of care established by a physician for the certification period of 01/21/16 to 03/20/16, with orders for skilled nursing 1 to 6 hour visits 1 day a week, 1 to 10 hour visits 5 days a week, and respite nursing up to 40 hours a month . a. Review of the comprehensive reassessment for recertification dated 03/18/16 and review of the plan of care, the Registered Nurse failed to document date of the verbal accepted by the physician for the patient's recertification. b. The clinical record failed to include visit notes after 03/12/16. 9. The clinical record for patient number 11, SOC 02/20/15, included two plans of			

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	care established by a physician for the certification periods of 08/19/15 to 10/17/15 and 10/18/15 to 12/16/15, with orders for home health aide services. a. A form titled "Missed Visit Report" dated 10/06/15, indicated there would be missed visits from 10/07/15 to 11/22/15, per family request due to a fall break. Review of the home health aide visit notes, the home health aide made visits from 10/07/15 to 10/17/15. The agency failed to ensure the clinical record contained accurate information. b. A form titled "Missed Visit Report" dated 10/24/15, indicated there would be missed visits from 10/25/15 to 10/27/15, per family request due to the holidays. Another form titled "Missed Visit Report" dated 10/26/15, indicated there would be missed visits from "10-18/26/15" and visits were rescheduled for 10/27/15, per family request. The agency failed to ensure missed visits missed visits were written in a timely manner and written in a clear understanding. c. A form titled "Missed Visit Report" dated 11/06/15, indicated there would be a missed visit on 11/06/15, per family request. Review of the home health aide visit notes, a home health aide visit was made on 11/06/15. The agency			

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	failed to ensure the clinical record contained accurate information. d. A form titled "Missed Visit Report" dated 11/10/15, indicated there would be a missed visit on 11/10/15. The form failed to include if the cancellation was per family request or for other reasons. e. A form titled "Missed Visit Report" dated 11/13/15, indicated there would be a missed visit on 11/13/15. The form failed to include if the cancellation was per family request or for other reason. 13. A form titled "Missed Visit Report" dated 11/06/15, indicated there would be a missed visit on 11/06/15, per family request. Review of the home health aide visit notes, a home health aide visit was made on 11/06/15. The agency failed to ensure the clinical record contained accurate information. 10. On 04/15/16 at 10:10 AM, the Administrator was asked to verify with medical records that all clinical visit notes to date had been provided to the surveyor and nothing was waiting to be filed. By 4:00 PM, no further notes had been provided by the Administrator.			

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	11. The Administrator was interviewed on 04/18/15 at 2:25 PM. The Administrator had indicated that the patient / caregiver could have changed his / her mind about the missed visit after calling to cancel the visit. 12. On 04/18/16 at 3:10 PM, the Assistant Director of Nursing had indicated the expectation of notes faxed from outlying areas, would be mailed to the office and the faxed note would be replaced with the original note. 13. 12. A policy titled "Medical Record Management, Documentation of Changes, Confidentiality and Retention of Clinical Records" dated 07/10/15, indicated " ... Clinical Record ... Required documentation for each service or care provided must be completed on the day the services is rendered and filed in the clinical record within fourteen (14) days ... Documentation shall show effective interchange, reporting, and coordination of patient care that occurred. All documentation must be legible ... There shall be no obliteration of entries by erasures, whiting - out, and pasting over, et., in the patient's medical record. To correct an error in the clinical record, the following method should be used: a. Draw a single line though the entry in such a way that the written information			

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	underneath may still be read. Initial and date the entry. b. Write corrected information near the entry or where the correct information is found .... " 14. A policy titled "Physician Orders" dated 07/10/15, indicated " ... When the nurse receives a verbal order from the physician, he / she shall write the order as given ... The order must include the date, specific order, be signed with the full name and title of the person receiving the order .... "			