DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K011	A. BUILDING 00 B. WING	09/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEST HOME CARE SERVICES	325 N EASTERN AVE CONNERSVILLE, IN 47331

(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 visit was for a federal and state home health recertification survey. This was a partial extended survey. Survey dates 9-18-17 - 9-22-17 Facility # 003083 Medicaid # 200367450 Skilled unduplicated 12 month census: 6 Non-skilled unduplicated 12 month census: 9 Active census: 45 Discharged in past 12 months: 16 Home Visits: 5 Charts reviewed with Home visits: 5 Discharged charts reviewed : 2 Total Charts reviewed: 10	G 0000		

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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G 0121 Bldg. 00	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. Based on observation and interview the home health agency failed to provide a policy, procedure or appropriate education to home health aides for accepted professional standards of infection control in the home for 2 of 5 home visit observed. (Patients # 4 and #5) Findings include: 1. During an a home visit for Patient # 4, on 9-19-17 at 3:30 PM, Employee Q, a home health aide, was observed to place his/her home care bag directly on the patient's kitchen table. A. Employee Q was asked if there was a specific practice he/she follows for infection control regarding the bag. Employee Q stated, "I always just sit the bag down." He/She reports this was the bag he/she takes to all patient homes. B. The clinical supervisor was present	G 0121	**G121 –** The Administrator has implemented an infection control policy that addresses proper bag technique in the home for home health aides. The Administrator and the Clinical Manager have inserviced all employees on proper infection control regarding bag technique. The Administrator has revised the current policy "Care of Suprapubic Catheter D-120" to include education & instruction regarding catheter care and safe handling of the urinary drainage bag for the home health aides. All HHAs have been inserviced on urinary catheter care and handling of the urinary drainage bag. Nursing Supervisors will continue to observe personal care given during reassessments & supervisory visits to ensure HHAs are following proper technique regarding bag techniques, catheter care and handling of the urinary drainage bag. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	11/17/2017

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	for the visit and reported there was no policy or infection control education regarding bag technique for home health aides. C. An article, "McGoldrick, M (2014). Bag Technique: Preventing and Controlling Infection in Home Care and Hospice. Home Healthcare Nurse, Vol :1 January, 2014 (39-44)", was referenced. The article stated," ... The nursing bag should be cleaned on a regular basis to reduce the bacterial load in and on the nursing bag carried by staff during patient encounters... There are no standards or guidelines for the frequency in which the nursing bag should be cleaned. Each home care and hospice organization is required to define in policy the frequency with in which the nursing bag is to be cleaned ... " D. A report from the CDC (Centers for Disease Control), "Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. Last update :February 15, 2017 (http://www/infectioncontrol/guidelines/disinfection), reported the following: "4. Selection and Use of Low-Level Disinfectants for Noncritical Patient-Care Devices ... c. Ensure that, at a minimum, noncritical patient-care devices are disinfected when visibly soiled and on a		Completion Date: 11/17/2017	

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	regular basis (such as after use on each patient or once daily or once weekly.)...." 2. A home visit was conducted on 9-20-17 at 8:00 AM for Patient # 5. The patient had a recent hospitalization from 6-26-17 to 7-4-17 for Urosepsis. Employee P, a home health aide was observed to place a urine filled suprapubic catheter drainage bag in the arms of the patient, above the level of the bladder during a hoyer lift transfer to the patients wheelchair. This practice can result in retrograde (backward) flow of urine into the bladder and increase the risk of urinary tract infection. A. An interview was conducted with the home health aide on 9-20-17 at 12:50PM. Employee P, reported he/she does not empty the catheter bag and the [other personal care agency] takes care of the intake and output from the catheter. B. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated that the home care aide should have emptied the urine from the catheter bag before transferring the patient and kept the bag below the bladder level to prevent urinary tract infections. C. A report from the CDC, " Guideline for Prevention of			

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	Catheter-Associated Urinary Tract Infection (CAUTI) 2009. (https://www.cdc.gov/infectioncontrol/guidelines/cauti) Updated 2-15-17 was reviewed. The report stated," ... microbial pathogens can enter the urinary tract by the intraluminal route, via movement along the internal lumen of the catheter from a contaminated collection bag or catheter-drainage tube junction ... administrative infrastructure ...education and training ... ensure that healthcare personnel and others who take care of catheters are given periodic in-service training regarding techniques and procedures for urinary catheter insertion, maintenance..." D. A policy titled, " Care of Suprapubic Catheter D-120" was reviewed. The policy stated, " Applies to Registered Nurses, Licensed Practical Nurses and Therapist." There policy fails to have any information regarding care or handling of the catheter drainage bag.			

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G 0131 Bldg. 00	484.14(b) GOVERNING BODY The governing body adopts and periodically reviews written bylaws or an acceptable equivalent. Based on record review and interview the governing body failed to adopt and periodically review written bylaws as evidenced by incomplete documentation of signature and dates for the bylaws and governing body meeting in 1 of 1 agency. Findings included: 1. A document titled, " By-laws of Best Home Health Care Services dba Best Home Care Services" was reviewed. The last page of the document has a signature on the line for Incorporator. The date for validation of the document is is blank. 2. A document titled," Best Home Care Services, Governing Body Meeting, February 28, 2017" was reviewed. The document had no signatures or attendees on the document to validate a meeting had been conducted. 3. An interview was conducted, on 9-22-17 at 1:32 PM, with the Employee B, the alternate administrator and nursing supervisor. He/she had unsuccessfully tried to contact Employee A, the administrator to answer questions regarding the meetings for the advisory	G 0131	**G131 –** The Administrator has been inserviced on the requirement that signatures must be obtained for all members in attendance at Governing Body & Professional Advisory Group meetings. The Administrator will be responsible for obtaining signatures of all members in attendance during all future Governing Body & Professional Advisory Group Meetings. The Administrator will be responsible for ensuring that the company bylaws are complete with both signatures and dates. The Administrator will be responsible for annual review of the bylaws. The Administrator will be responsible for ensuring that attendance signatures sheets are maintained along with the meeting minutes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	11/17/2017

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	board, governing body and professional advisory group meetings. Employee B reported he/she is not present for the board meetings, the professional advisory group meetings or the annual meeting. He/She reports meetings are held at the agency but he/she could not validate who was present for the meetings. He/ She validated the documents and meeting minutes should have been dated and had signatures of attendees.			
G 0143 Bldg. 00	484.14(g) COORDINATION OF PATIENT SERVICES All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care. Based on observation, interviews and record review the agency failed to maintain coordination of care between the home care agency, personal care agency and dialysis agency in regards to diet, fluid restriction, care of the suprapubic catheter, intake and output, allergies and medications between the	G 0143	**G143 –** The Clinical Manager has been inserviced on the requirement that the agency must maintain a liaison with all other agencies involved in the client's care to assure that care services are coordinated effectively and support the objectives outlined in the plan of care. The Clinical Manager has	11/17/2017

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	agency nurses, home health aides, the personal care agency and the dialysis agency providing care for 1 of 10 patients . (Patient # 5) Findings included : 1. A home visit was conducted on 9-20-17 at 8:00 AM for Patient # 5. The patients diagnosis included end stage renal disease with hemodialysis 3 times weekly, congestive heart failure and a recent hospitalization from 6-26-17 to 7-4-17 for Urosepsis. Employee P, a home health aide was observed to place a urine filled suprapubic catheter drainage bag in the arms of the patient, above the level of the bladder, during a hoyer lift transfer to the patient's wheelchair. A. An interview was conducted with the home health aide on 9-20-17 at 12:50 PM. Employee P, reported he/she does not empty the catheter bag and the [personal care agency] records the intake and output from the drainage bag. The home health aide reported the following: " [Patient # 5] goes to dialysis three times a week, I know he/she can't have sodium, I think [personal care agency name] monitors her liquid intake, I have not seen an I&0 (intake and output) sheet, I feed him/her eggs and 8 ounces of water for breakfast." The home health aide		established communication with the dialysis agency and the personal care agency to maintain coordination of care regarding the diet, fluid restrictions, care of the suprapubic catheter, intake & output, allergies and medications. The Clinical Manager will be responsible for ensuring the home health aide care plan identifies specific type of diet, fluid restrictions and permission & instructions for emptying and handling of the urinary drainage bag. The Clinical Manager has implemented an intake & output sheet in the client's home. The Clinical Manager has inserviced all HHAs in the home, on documenting the intake & output for the period of time that our agency is in the home. The Clinical Manager has inserviced all home health aides in the home on urinary catheter care, emptying & handling of the urinary drainage bag. The Clinical Manager will be responsible for ensuring that the HHAs are accurately recording intake & output. The Clinical Manager will be responsible for maintaining a liaison with the personal care agency & the dialysis center to ensure coordination of care. The Clinical Manager will be responsible for ensuring that the patient's plan of care and medication record includes current allergies, updated medication list, including all medications given at the dialysis center & renal diet orders from the	

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	denied knowledge of Nephro or a fluid restriction. The home health aide, in regards to care of her dialysis right arm AV fistula, reported, "I have been told not to put tight things on his/her arm." B. The home health aide care plan, last updated 8-14-17 by Employee F, a registered nurse, had assigned the following: "catheter care supra (suprapubic) QD (daily), nutrition 'per request', offer fluids, cut up food." The care plan failed to specify any type of diet, fluid restrictions or permission to empty the urinary drainage bag. C. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated that the home care aide should have emptied the urine from the catheter bag before transferring the patient and kept the bag below the bladder level to prevent urinary tract infections. The clinical supervisor reported the personal care agency is supposed to empty the catheter bag, record the patients fluid intake and output. The clinical supervisor reported he/she contacted the personal care services agency monthly to coordinate services. The personal care agency updated the agency on medication changes but he/she did not have an updated medication list from dialysis unit.		dialysis center. Nursing Supervisors will continue to observe personal care given during reassessment and supervisory visits to ensure proper infection control techniques are being used with catheter care and handling of the urinary drainage bag. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	

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	2. The personal care agency administrator was contacted on 9-20-17 at 2:15 PM. The administrator reported their agency emptied the catheter bag daily and did the patients intake and output. The administrator reported the patient was on a "renal diet". He/she reported the diet information given to his/her staff was from the Internet and not from the dietician at the dialysis center. Documents faxed from the personal care agency to the home care agency failed to have an accurate intake and output. The document titled, " Intake and Elimination Report" from 9-1-17 to 9-16-17 had no urinary output recorded for 16 days. There was no fluid intake recorded for 14 of 16 days. Neither the personal care agency or the home health agency accurately monitored the patients 24 hour fluid intake. 3. The charge nurse at the dialysis agency was interviewed 9-20-17 at 9:40 AM. He/she reported "not much interaction" with the home care agency and "some interaction" with the personal care agency. The dialysis dietician explained patient's current daily diet orders as follows: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro			

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	(renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The plan of care for 8-18-17 to 10-16-17 had the following diet listed : NAS (no added salt) 1500 cal, soft cut up food, renal diet. The agency failed to revise the patients diet to reflect current dialysis orders. 5. The home care agency medication profile and plan of care failed to include the following medications and allergy the dialysis agency reported was given at the dialysis center: Heparin 3,000 unit bolus IV at the start of dialysis treatment and 3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain. The Hepatitis B vaccination series was being given, # 2 due 10-11-17. The dialysis center has "Gadolinium listed as an allergy. 6. A policy titled, "Coordination of Patient Services" was reviewed and stated the following: "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care			

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	...after the initial assessment the admitting registered nurse/therapist shall discuss the findings of the initial visit with the clinical manager to ensure ... coordination with other agencies and institutions...."			
G 0153 Bldg. 00	484.16 GROUP OF PROFESSIONAL PERSONNEL The group of professional personnel establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency. Based on record review and interview the agency failed to ensure documentation of the professional advisory group members participation in meetings to include the quality assurance committee meetings in 1 of 1 agency. Findings Include: 1. Two documents titled, " Best Home Care Services, Professional Advisory Group Meeting, Quality Assurance	G 0153	**G153 –** The Administrator has been inserviced on the requirement that signatures must be obtained for all those in attendance at Governing Body & Professional Group Advisory meetings. The Administrator will be responsible for obtaining signatures of all members in attendance during all future Governing Body and Advisory Group meetings. The Administrator will be responsible for ensuring that attendance signature sheets are maintained along with the meeting minutes. The	11/17/2017

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	Committee Meeting , April 19, 2016 and October 18,2016 were reviewed. The documents failed to have a list of attendees or signatures to validate participation at the meeting. 2. An interview was conducted, on 9-22-17 at 1:32 PM, with the Employee B, the alternate administrator and nursing supervisor. He/she had unsuccessfully tried to contact Employee A, the administrator to answer questions regarding the meetings for the advisory board, governing body and professional advisory group meetings. Employee B reported he/she is not present for the board meetings, the professional advisory group meetings or the annual meeting. He/She reports meetings are held at the agency but could not validate who had been present for meetings. He/ She validated the documents and meeting minutes should have been dated and had signatures of attendees.		Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	
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,			

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	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, observation and interviews the home health agency failed to accurately develop the plan of treatment to include frequency and types of services, nutritional requirements, and all current medications for 6 of 10 patients. (Patients # 1,2,3,4,5 and 7) Findings included: 1. The clinical record for Patient # 1 was reviewed on 9-18-17 and 9-18-17. A document titled "Plan of Treatment", dated 8-30-17, and signed by the physician on 9-7-17, had the following order: "Pediasure (nutritional supplement) 240 cc+80 H2O, GT(gastric tube) 1 can formula +80 ml's H2O flush AM, 11 AM, and 5 PM." A. A clinical nursing note for 9-7-17 at 8:30 AM and signed by the Employee I, LPN (Licensed Practical Nurse) stated the following: "250 cc bolus fdg [feeding] of Pediasure given via GT -along c(with) approx 70 cc H2O flush." A clinical nursing note for 11 AM and signed by Employee I, stated the following: "250 cc's of Pediasure given	G 0159	**G159 –** The Registered Nurse has been inserviced on the requirement that the RN will be responsible for developing a written plan of care that includes 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. This includes all medications, allergies, diet orders & a fluid restriction ordered from other agencies obtained through coordination of care. This includes obtaining orders for wound measurements. This includes updating all medications on the medication profile and the plan of treatment and all necessary revisions. The Clinical Manager has inserviced all staff RNs on these requirements. Quarterly chart &documentation audits will be performed to ensure orders are obtained for all services, to ensure that verbal orders are obtained for any physician ordered changes regarding medications or services	11/17/2017

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	via GT-followed c 70 cc H2O flush." B. A clinical nursing note for 9-8-17 at 8:05 AM and signed by the Employee I, stated the following: "250 cc of Pediasure given via GT, following with 70 cc H2O." A clinical nursing note for 11 AM and signed by Employee I, stated the following: "250 cc's of Pediasure given via GT-followed c 70 cc H2O flush." C. An agency policy title, " Plan of Care C-580", was reviewed and stated the following ... " 2. The plan of care shall be completed in full to include: ... k. specific dietary or nutritional requirements or restrictions." D. During a home visit on 9-18-17 at 12:27 PM and on 9-19-17 at 10:45 AM, Employee I was observed to administer Pediasure by gravity into the gastric tube of Patient # 1. The label of the Pediasure was examined and the content amount was listed as 237 ml. E. An interview was conducted with Employee I, on 9-19-17 at 10:35 AM. Employee I reported he/she had given 1 can of Pediasure (237 ml) and had incorrectly documented 240 ml and 250ml in the clinical notes and gave 80 ml of water after the Pediasure and had		provided & to ensure that there is no variance between the tube feeding & flush amount listed on the plan of treatment, the can of formula & the amount documented in the clinical record. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency will not recur. Completion Date: 11/17/2017	

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	15K011	A. BUILDING 00 B. WING	09/22/2017

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	incorrectly documented 70 ml in the clinical notes. F. An interview with Employee B, the clinical manager was conducted on 9-18-17 at 1:30 PM. The clinical manager was made aware of the variance between the tube feeding amount listed on the plan of treatment, the Pediasure label and the amount documented in the clinical record. The clinical manager validated the tube feeding amount on the plan of treatment orders and the nurses notes should have been documented as 237 ml of Pediasure and 80 ml of water. 2. The clinical record for Patient # 2 was reviewed on 9-18-17. The plans of treatment for the periods of 11-29-16 to 1-27-17 and 7-27-17 to 9-24-17 have the following orders for discipline and treatments: "RN to assess, eval (evaluate), treat and obtain VS (vital signs) and O2 sat (oxygen saturation). The document fails to include SN weekly visits to measure and document wounds. A. An agency document validated skilled nurse weekly wound measurements and assessment were conducted starting on 11-29-17 to 9-15-17. B. An interview was conducted with			

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	Employee # 2, Clinical Manager on 9-21-17 at 3:30 PM. The clinical manager reported the weekly skilled nurse visit was not billable, the family does all dressing changes and he/she did not think it needed to be on plan of treatment. C. A policy titled, "Plan of Care C-580" was reviewed. The policy stated, ... " 2. The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ...." 3. The clinical record for Patient # 3 was reviewed on 9-19-17. The plan of treatment from the 7-18-17 to 9-15-17 and the medication profile last updated and signed by Employee F on 9-11-17, failed to evidence the following home OTC (over the counter) medications: Aspirin 325 mg and Daytime Cold and Flu liquid medication. A. During a home visit on 9-19-17 at 1:30 PM, the following OTC medications were observed sitting on a table by the patient: A bottle of Aspirin 325mg, which the patient reported she bought a month ago and takes one pill daily as needed for pain or headache. A bottle of liquid "Daytime Cold and Flu" medication, which the patient reports she bought about a week ago and takes 1 tablespoon daily as needed for cough.			

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	B. Employee F, a registered nurse did an assessment of the patient beside the medications in clear view during the home visit. No questions were asked regarding new medications. Employee F reported she had not been aware of the medications the patient had purchased. 4. The clinical record for Patient # 4 was reviewed on 9-19-17. A document titled "Plan of Treatment", dated 8-15-17 to 10-13-17 and signed by the physician on 8-17-17, had the following order: "Warfarin (a medication to slow blood clotting) po (orally) as directed QD (daily)." A. Clinical nurse visits notes dated 8-1-17, 8-8-17, 8-15-17 and 9-12-17 evidenced documentation of test results for PT/INR(prothrombin time and international ratio), a test to measure clotting time for patients taking Warfarin. The nurse visit notes included calling the results of the PT/INR to the physician and obtaining new orders which were discussed with the patient. The clinical record failed to have evidence of updated physician orders or changes to the medication administration record. B. An interview was conducted with the clinical supervisor and Employee F,			

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	RN on 9-22-17 at 12:55 PM. Employee F validated his/her process for the PT/INR test for Patient # 4 as follows: He/She performed the tests, called the results to the physician, obtained orders, documented in nurses notes, informed the patient of new Warfarin dose, and placed new dose of Warfarin in patient's medication planner. Employee F validated he/she did not write a verbal order, update the medication record or update the plan of treatment. 5. The plan of care for Patient # 5 dated 8-18-17 to 10-16-17 was reviewed on 9-20-17. The patient's diagnosis included, end stage renal disease with hemodialysis 3 times weekly. The plan of care failed to include all medications, renal diet, allergies and fluid restrictions the patient had ordered from the dialysis agency physician. A. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated he/she contacted the personal care services agency monthly to coordinate services, but he/she did not have an updated medication list from dialysis unit. The dialysis charge nurse was interviewed 9-20-17 at 9:40 AM and validated the following dialysis medications: Heparin 3,000 unit bolus IV at the start of dialysis treatment and			

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	3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain. The Hepatitis B vaccination series was being given, # 2 due 10-11-17, Allergy: "Gadolinium", Diet: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The home care agency failed to include these medications on the plan of care. B. The dialysis dietician was interviewed 9-20-17 at 9:40 AM. The dialysis dietician reported the patient's current diet orders were as follows: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The agency failed to coordinate care with the dialysis agency and the plan of care listed the patient's diet as follows: "no added salt, 1500 cal, soft cut up food and renal diet."			

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	6. The clinical record for Patient #7 was reviewed on 9-21-17. The medication profile last updated 12-27-16 and the plan of care dated 12-28-16 to 2-25-17 had the following documentation : "Warfarin 1mg as directed po ." The entry is incomplete with frequency for medication. A fax from the patients physician, dated 1-5-17 had the following order: "Warfarin 1 mg on Monday and 2 mg all other days. We will have mobile lab retest in 10 days." The agency failed to update the medication record with changes in Warfarin. 7. An agency policy titled, "Plan of Care C-580" was reviewed. The policy stated, "Home care services are furnished under the supervision and direction of the patient's physician ... The Plan of Care shall be completed in full to include: ... type, frequency and duration of all visits/services, medications, treatments and procedures, other appropriate items ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ... Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care .... "			

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G 0166 Bldg. 00	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services.			
	Based on record review and interview the agency failed to date the verbal orders for start of care for 9 of 10 records reviewed. (Patients # 1,2,3,4,5,6,8,9 and 10) Findings include: 1. The plan of treatment dated 8-30-17 to 10-28-17 for Patient # 1 was reviewed on 9-19-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 2. The plan of treatment dated 7-9-24 to 9-24-17 for Patient # 2 was reviewed on 9-19-17. The verbal start of care section, signed by Employee F, failed to evidence documentation of a time and date the order was received. 3. The plan of treatment dated 1-9-14 to 3-9-14 for Patient #3 was reviewed on 9-19-17. The verbal start of care section,	G 0166	**G166 –** The Clinical Manager and nursing staff have been inserviced on the requirement that all verbal orders must have a signature, date & time the order was received. Quarterly chart audits will be performed to ensure that all verbal orders have signature, date & time. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	11/17/2017

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	signed by Employee B, failed to evidence documentation of a time and date the order was received. 4. The plan of treatment dated 12-21-16 to 2-18-17 for Patient # 5 was reviewed on 9-20-17. The verbal start of care section, signed by Employee HH, failed to evidence documentation of a time and date the order was received. 5. The plan of treatment dated 2-22-17 to 4-22-17 for Patient # 6 was reviewed on 9-21-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 6. The plan of treatment dated 8-9-17 to 10-7-17 for Patient #8 was reviewed on 9-21-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received 7. The plan of treatment dated 4-3-17 to 6-1-17 for Patient #9 was reviewed on 9-22-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 8. The plan of treatment dated 2-2-1 to 4-2-17 for Patient # 10 was reviewed on			

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	9-22-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 9. An agency policy titled, "Physician Orders C-635", stated the following: ... "When the nurse or therapist 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 ...." 10. An interview was conducted with the nursing manager on 9-18-17 at 1:30 PM. The nursing manager reported he/she was not aware the date and time were missing on the verbal start of care order on the plan of treatment.			
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 observation, record review and	G 0173	**G173** - The Registered Nurse has	11/17/2017

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	interview the RN (Registered Nurse) failed to make necessary revisions to the plan of care in 5 of 10 records reviewed. (Patients 2, 3, 4, 5, and 7) 1. The clinical record for Patient # 2 was reviewed on 9-18-17. The plans of treatment for the periods of 11-29-16 to 1-27-17 and 7-27-17 to 9-24-17 have the following orders for discipline and treatments: "RN to assess, eval (evaluate), treat and obtain VS (vital signs) and O2 sat (oxygen saturation). The document fails to include SN weekly visits to measure and document wounds. A. An agency document validated skilled nurse weekly wound measurements and assessment were conducted starting on 11-29-17 to 9-15-17. B. An interview was conducted with Employee # 2, Clinical Manager on 9-21-17 at 3:30 PM. The clinical manager reported the weekly skilled nurse visit was not billable, the family does all dressing changes and he/she did not think it needed to be on plan of treatment. 2. The clinical record for Patient # 3 was reviewed on 9-19-17. The plan of treatment from the 7-18-17 to 9-15-17		been inserviced on the requirement that the RN will be responsible for developing a written plan of care that includes 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. This includes all medications, allergies, diet orders & a fluid restriction ordered from other agencies obtained through coordination of care. This includes obtaining orders for wound measurements. This includes updating all medications on the medication record and the plan of treatment and all necessary revisions. The Clinical Manager has inserviced all staff RNs on this requirement. Quarterly chart &documentation audits will be performed to ensure orders are obtained for all services, to ensure that verbal orders are obtained for any physician ordered changes regarding medications or services provided & to ensure that there is no variance between the tube feeding & flush amount listed on the plan of treatment, the can of formula & the amount documented in the clinical record. The Clinical Manager will be responsible for	

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	and the medication profile last updated and signed by Employee F on 9-11-17, failed to evidence the following home OTC (over the counter) medications: Aspirin 325 mg and Daytime Cold and Flu liquid medication. A. During a home visit on 9-19-17 at 1:30 PM, the following OTC medications were observed sitting on a table by the patient: A bottle of Aspirin 325mg, which the patient reported she bought a month ago and takes one pill daily as needed for pain or headache. A bottle of liquid "Daytime Cold and Flu" medication, which the patient reports she bought about a week ago and takes 1 tablespoon daily as needed for cough. B. Employee F, the nurse did an assessment of the patient beside the medications in clear view during the home visit. No questions were asked regarding new medications. Employee F reported she had not been aware of the medications the patient had purchased. 3. The clinical record for Patient # 4 was reviewed on 9-19-17. A document titled "Plan of Treatment", dated 8-15-17 to 10-13-17 and signed by the physician on 8-17-17, had the following order: "Warfarin (a medication to slow blood clotting) po (orally) as directed QD		monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	

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	(daily)." A. Clinical nurse visits notes dated 8-1-17, 8-8-17, 8-15-17 and 9-12-17 evidenced documentation of test results for PT/INR(prothrombin time and international ratio), a test to measure clotting time for patients taking Warfarin. The nurse visit notes included calling the results of the PT/INR to the physician and obtaining new orders which were discussed with the patient. The clinical record failed to have evidence of updated physician orders or changes to the medication administration record. B. An interview was conducted with the clinical supervisor and Employee F, RN on 9-22-17 at 12:55 PM. Employee F validated his/her process for the PT/INR test for Patient # 4 as follows: He/She performed the tests, called the results to the physician, obtained orders, documented in nurses notes, informed the patient of new Warfarin dose, and placed new dose of Warfarin in patient's medication planner. Employee F validated he/she did not write a verbal order, update the medication record or update the plan of treatment. 4. The plan of care for Patient # 5 dated 8-18-17 to 10-16-17 was reviewed on 9-20-17. The patient's diagnosis included,			

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	end stage renal disease with hemodialysis 3 times weekly. The plan of care failed to include all medications, renal diet, allergies and fluid restrictions the patient had ordered from the dialysis agency physician. A. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated he/she contacted the personal care services agency monthly to coordinate services, but he/she did not have an updated medication list from dialysis unit. The dialysis charge nurse was interviewed 9-20-17 at 9:40 AM and validated the following dialysis medications: Heparin 3,000 unit bolus IV at the start of dialysis treatment and 3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain. The Hepatitis B vaccination series was being given, # 2 due 10-11-17, Allergy: "Gadolinium", Diet: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days			

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	and 1 can on dialysis days. The home care agency failed to include these medications on the plan of care. B. The dialysis dietician was interviewed 9-20-17 at 9:40 AM. The dialysis dietician reported the patient's current diet orders were as follows: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The agency failed to coordinate care with the dialysis agency and the plan of care listed the patient's diet as follows: "no added salt, 1500 cal, soft cut up food and renal diet." 5. The clinical record for Patient #7 was reviewed on 9-21-17. The medication profile last updated 12-27-16 and the plan of care dated 12-28-16 to 2-25-17 had the following documentation : "Warfarin 1 mg as directed po ." The entry is incomplete with frequency for medication. A fax from the patients physician, dated 1-5-17 had the following order: "Warfarin 1 mg on Monday and 2 mg all other days. We will have mobile lab retest in 10 days." The agency failed to update the medication record with changes in Warfarin.			

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	6. A policy title, "Skilled Nursing Services C-200" was reviewed and stated: "Skilled nursing services will be provided ... under the supervision of a RN and in accordance with a medically approved Plan of Care ... the registered nurse ... regularly reevaluates the patient needs, and coordinates the necessary services ... initiates the plan of care and necessary revisions and updates to the plan of care." 7. An agency policy titled, "Plan of Care C-580" was reviewed. The policy stated, "Home care services are furnished under the supervision and direction of the patient's physician ... The Plan of Care shall be completed in full to include: ... type, frequency and duration of all visits/services, medications, treatments and procedures, other appropriate items ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ... Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care .... "			

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	15K011	A. BUILDING 00 B. WING	09/22/2017

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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 observation, interview and record review the registered nurse failed to coordinate services with other agencies, the physician, and the home health aide regarding dialysis orders for diet, medication, fluid restriction and fluid management for 1 of 10 home health patients. (Patient # 5) Findings included: 1. The medical record for Patient #5 was reviewed and interviews were conducted with the dialysis agency charge nurse and dietician on 9-20-17 to ensure coordination and to obtain information to determine correct orders and treatments for the patient. A. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated he/she contacted the personal care services agency monthly to coordinate services. The personal care agency updated the home care agency on medication changes but, the registered nurse failed to obtain an updated medication list from the dialysis agency.	G 0176	**G176 –** The Clinical Manager has been inserviced on the need for coordination of care with all other agencies involved in the client's care. The Clinical Manager has established communication with the dialysis agency and the personal care agency to maintain coordination of care regarding the diet, fluid restrictions, care of the suprapubic catheter, intake & output, allergies and medications. The Clinical Manager will be responsible for ensuring the home health aide care plan identifies specific type of diet, fluid restrictions & permission & instructions for emptying and handling of the urinary drainage bag. The Clinical Manager has implemented an intake & output sheet in the client's home. The Clinical Manager will be responsible for ensuring that the HHAs are accurately recording intake & output. The Clinical Manager has inserviced all HHAs in the home, on documenting the intake & output for the period of time that our agency is in the home. The Clinical Manager has inserviced all home health aides in the home, on catheter care, emptying & handling of the urinary drainage	11/17/2017

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	B. The nurse failed to coordinate with the dialysis dietician to include the following renal diet: 1800 AK/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The plan of care for 8-18-17 to 10-16-17 had the following incorrect diet listed : NAS (no added salt) 1500 cal, soft cut up food, renal diet. C. The nurse failed to coordinate with the dialysis agency and include the following dialysis medications and an allergy on the plan of care: Heparin 3,000 unit bolus IV at the start of dialysis treatment and 3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain, Hepatitis B vaccine, and an allergy to "Gadolinium." 4. The home health aide care plan, last updated 8-14-17 by Employee F, a registered nurse, had assigned the following: "nutrition 'per request', offer		bag. The Clinical Manager will be responsible for maintaining a liaison with personal care agency & the dialysis center to ensure coordination of care. The Clinical Manager will be responsible for ensuring that the client's plan of care and medication record includes current allergies, updated medication list, including all medications given at the dialysis center & renal diet orders from the dialysis center. Nursing Supervisors will continue to observe personal care given during reassessment & supervisory visits to ensure proper infection control techniques are being used with catheter care & handling of the urinary drainage bag. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	

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	fluids, cut up food." The care plan failed to specify any type of diet or fluid restrictions. An interview was conducted with the Employee P, a home health aide regarding their knowledge of the patients care needs on 9-20-17 at 12:50 PM. Employee P, reported the following: " I know he/she can't have sodium, I think they [personal care agency] monitor her liquid intake, I have not seen an I&0 (intake and output) sheet, I feed him/her eggs and 8 ounces of water for breakfast." The home health aide denied knowledge of Nephro or a fluid restriction. The home health aide, in regards to care of the patient's right arm AV fistula, reported, "I have been told not to put tight things on his/her arm." The nurse failed to coordinate with the dialysis unit and to update the home health aide care plan to include the patients accurate diet, fluid restrictions and how to report and record accurate intake and output. 5. A policy titled, "Coordination of Patient Services" was reviewed and stated the following: "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care ...after the initial assessment the admitting registered nurse/therapist shall			

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	discuss the findings of the initial visit with the clinical manager to ensure ... coordination with other agencies and institutions...."			
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, observation and interview the LPN (Licensed Practical Nurse) failed to accurately document gastric tube feedings in the clinical notes for 1 of 10 patient records reviewed. (Patient # 1) Findings include: 1. The medical record for Patient # 1 was reviewed on 9-18-17 and 9-18-17. A. A document titled "Plan of Treatment", dated 8-30-17, and signed by the physician on 9-7-17, had the following order: "Pediasure 240 cc+8 H2O, GT(gastric tube) 1 can formula +80 ml's H2O flush AM, 11 AM, and 5 PM." B. A clinical nursing note for 9-7-17 at 8:30 AM and signed by the Employee	G 0180	**G180 –** The Clinical Manager has inserviced the LPNs on accurately documenting gastric tube feedings & flush amounts and documenting it in the clinical record. Nursing Supervisors will continue to observe tube feedings & flushes during reassessment & supervisory visits to ensure that there is no variance between the amounts being administered and the plan of treatment, the medical records, and the clinical documentation. Quarterly chart audits will ensure that gastric tube feedings are accurately recorded. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	11/17/2017

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	I, LPN (Licensed Practical Nurse) stated the following: "250 cc bolus fdg [feeding] of Pediasure given via GT -along c[with] approx 70 cc H2O flush." A clinical nursing note for 11 AM, signed by Employee I, stated the following: "250 cc's of Pediasure given via GT-followed c 70 cc H2O flush." C. A clinical nursing note for 9-8-17 at 8:05 AM, signed by the Employee I, stated the following: "250 cc of Pediasure given via GT, following with 70 cc H2O." A clinical nursing note for 11 AM, signed by Employee I, stated the following: "250 cc's of Pediasure given via GT-followed c 70 cc H2O flush." D. During a home visits on 9-18-17 at 12:27 PM and on 9-19-17 at 10:45 AM, Employee I was observed to administer Pedisure by gravity into the gastric tube of Patient # 1. The label of the Pediasure was examined and the content amount was listed as 237 ml. E. An interview was conducted with Employee I, on 9-19-17 at 10:35 AM. Employee I reported he/she had given 1 can of Pedisure (237 ml) and had incorrectly documented 240/ 250 ml in the clinical notes and gave 80 ml of water after the Pedisure and had incorrectly documented 70 ml in the clinical notes.			

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	F. An interview with Employee B, the clinical manager was conducted on 9-18-17 at 1:30 PM. The clinical manager validated the tube feeding amount on the plan of treatment orders and the nurses documentation should have been 237 ml of Pedisure and 80 ml of water.			
G 0224 Bldg. 00	484.36(c)(1) ASSIGNMENT & DUTIES OF HOME HEALTH AIDE Written patient care instructions for the home health aide must be prepared by the registered nurse or other appropriate professional who is responsible for the supervision of the home health aide under paragraph (d) of this section. Based on observation, interview and record review the registered nurse failed to prepare complete and accurate home health aide patient care instructions for 1 of 10 records reviewed. (Patient # 5) Findings include:	G 0224	**G224 –** The Administrator has revised the current policy “Care of Suprapubic Catheter D-120” to include education & instruction regarding catheter care and safe handling of the urinary drainage bag. The Clinical Manager has established an intake & output	11/17/2017

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	1. A home visit was conducted on 9-20-17 at 8:00 AM for Patient # 5. The patient's diagnosis included, end stage renal disease with dialysis 3 times weekly and a recent hospitalization from 6-26-17 to 7-4-17 for Urosepsis. Employee P, a home health aide was observed to place a urine filled suprapubic catheter drainage bag in the arms of the patient, above the level of the bladder during a hoyer lift transfer to the patients wheelchair. A. An interview was conducted with the home health aide on 9-20-17 at 12:50PM. Employee P, reported he/she does not empty the catheter bag and the [other personal care agency] takes care of the intake and output from the catheter. B. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated that the home care aide should have emptied the urine from the catheter bag before transferring the patient and kept the bag below the bladder level to prevent urinary tract infections. C. The aide care plan listed the following instructions for elimination: "suprapubic catheter care daily and incontinence care daily". The nurse failed to include instructions to empty the catheter drainage bag or measure intake		record in the home & has provided education to HHAs regarding catheter care, emptying the urinary drainage bag, safe handling of the urinary drainage bag, fluid restriction, special diet requirements & information and care of the dialysis shunt and AV fistula. The Clinical Manager will ensure that all Home Health Aide care plans reflect all of the above measures. Quarterly chart audits will ensure that Home Health Aide care plans include all the above measures and that all measures are documented in the HHA clinical notes. Quarterly chart audits will ensure that HHAs are not providing services that are not authorized on the HHA care plan. Supervising Nurses will continue to observe personal care given during reassessments & supervisory visits to ensure HHAs are following the HHA care plan. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	

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	and output. 2. . The home health aide care plan, last updated 8-14-17 by Employee F, a registered nurse, had assigned the following for nutrition: "nutrition 'per request', offer fluids, cut up food." The care plan failed to specify any type of diet or fluid restrictions. The dialysis dietician was interviewed 9-20-17 at 9:40 AM. He/She reported the patient's current diet orders as follows: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The plan of care for 8-18-17 to 10-16-17 had the following diet listed : NAS (no added salt) 1500 cal, soft cut up food, renal diet. The nurse failed to coordinate with the dialysis agency to update the home health aide plan of care with the accurate renal diet. A. An interview was conducted with the Employee P, a home health aide regarding their knowledge of the patients dietary needs on 9-20-17 at 12:50 PM. Employee P, reported the following: " I know he/she can't have sodium, I think they [personal care agency] monitor her liquid intake, I have not seen an I&0 (intake and output) sheet, I feed him/her			

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	eggs and 8 ounces of water for breakfast." He/she denied writing down the amount the patient drinks or communication with the personal care agency regarding intake or output. The home health aide denied knowledge of Nephro or a fluid restriction. 3. The patient had a left subclavin dialysis catheter and an immature right arm AV fistula. Employee P reported on 9-2017 at 12:50 PM, "I have been told not to put tight things on his/her arm" and denied any instructions regarding the dialysis catheter. The nurse failed to include instructions on the home health aide care plan on safety and precautions for the right arm fistula or the dialysis catheter. 4. A policy titled, " Home Health Aide Supervision" was reviewed and stated: " Agency shall provide home health aide services under the direction and supervision of a registered professional nurse/therapist when personal care services are indicated and ordered by a physician ... the registered nurse will give the home health aide direction for patient care by way of the home health aide care plan .... a copy of this written plan is to be left in the patient's home and revised ... if the care plan is complex ... the registered nurse will personally supervise			

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	and instruct the home health aide on the first day of the assignment and from then on, as often as necessary ... the aide visit record is reviewed by the supervising nurse to assure services are being provided according to the care plan. "			
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 observation, interview and record review the agency failed to assure the home health aide provided services that are in the plan of care for 1 of 10 records reviewed. (Patient #5) Findings include: 1. The home health aide care plan for Patient # 5 was last updated by the registered nurse on 8-14-17. The patient's diagnosis included end stage renal disease and dialysis 3 times weekly, left subclavin dialysis catheter and right arm AV graft. The nurse instructions on the care plan included daily suprapubic catheter care and incontinent care. There were no instructions to empty the urinary drainage bag or record intake and output	G 0225	**G225 –** The Administrator has revised the current policy "Care of Suprapubic Catheter D-120" to include education & instruction regarding catheter care and safe handling of the urinary drainage bag. The Clinical Manager has established an intake & output record in the home & has provided education to HHAs regarding catheter care, emptying the urinary drainage bag, safe handling of the urinary drainage bag, fluid restriction, special diet requirements & information and care of the dialysis shunt and AV fistula. The Clinical Manager will ensure that all Home Health Aide care plans include all the above measures and that all measures are documented in the HHA clinical notes. Quarterly chart audits will ensure that HHAs are not	11/17/2017

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	on a dialysis patient. A. The home health aide visit note failed to include documentation for suprapubic catheter care ordered on the care plan on 8-18-17, 8-19-17, 8-21-17, 8-25-17, 8-26-17, 8-27-17, 8-28-17, 8-30-17, 8-31-17, 9-1-17, 9-2-17, 9-4-17, 9-8-17, 9-9-17, 9-10-17. B. The home health aide care plan did not include instructions to empty the catheter drainage bag. The home health aide visit note documented emptied catheter drainage bag on 8-25-17, 8-26-17, 8-28-17, 9-1-17, 9-2-17, 9-9-17, 9-10-17. 2. A policy titled, " Home Health Aide Services C-220" was reviewed and stated: " Home Health aide services will be provided ... under the direct supervision of an agency registered nurse ... the aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising nurse ... all services provided by the home health aide shall be documented in the the clinical records. 3. A policy titled, " Home Health Aide Supervision" was reviewed and stated: " Agency shall provide home health aide services under the direction and		providing services that are not authorized on the HHA care plan. Supervising Nurses will continue to observe personal care given during reassessment & supervisory visits to ensure HHAs are following the HHA care plan. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	

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	supervision of a registered professional nurse/therapist when personal care services are indicated and ordered by a physician ... the registered nurse will give the home health aide direction for patient care by way of the home health aide care plan .... a copy of this written plan is to be left in the patient's home and revised ... if the care plan is complex ... the registered nurse will personally supervise and instruct the home health aide on the first day of the assignment and from then on, as often as necessary ... the aide visit record is reviewed by the supervising nurse to assure services are being provided according to the care plan. "			
G 0236 Bldg. 00	484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary. Based on record review and interview the agency failed to complete the clinical	G 0236	**G236** – The Clinical Manager and the nursing staff has been inserviced on the requirement that all verbal	11/17/2017

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	record to include dates and signatures for all verbal order and discharge summaries, updated and current drug profile and dietary orders in 9 of 10 records reviewed. (Patient # 1, 2, 3, 5, 6, 7, 8, 9,10) Findings include: 1. The plan of treatment dated 8-30-17 to 10-28-17 for Patient # 1 was reviewed on 9-19-17. The verbal start of care section, signed by Employee B, failed to have documentation of a time and date the order was received. A. The nutritional orders were as follows: "Pediasure 240 cc+8 H2O, GT(gastric tube) 1 can formula +80 ml's H2O flush AM, 11 AM, and 5 PM." On 9-18-17 during a home visit the correct amount of 237 ml was observed on the Pediasure label. B. An interview with Employee B, the clinical manager was conducted on 9-18-17 at 1:30 PM. The clinical manager validated the tube feeding amount on the plan of treatment orders should have been 237 ml of Pedisure. 2. The plan of treatment dated 7-9-24 to 9-24-17 for Patient # 2 was reviewed on 9-19-17. The verbal start of care section,		orders and discharge summaries must have a signature, date & time the order was obtained or the summary was written. The Clinical Manager & the nursing staff have been inserviced on the requirement that the written plan of care must include all medications, allergies, drug dosages, nutrition orders special diet orders & fluid restrictions. This includes all orders obtained from other agencies in coordination of care. This also includes orders for wound measurements. This includes the requirement that the plan of treatment & the medication record will be updated with all necessary revisions. Quarterly chart audits will ensure that RNs have put date, time & signature on all orders & discharge summaries. Quarterly chart audits of the plan of treatment and medication records will ensure all orders related to medications, dosages, allergies, nutrition, special diet orders & fluid restrictions are not omitted. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	

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	signed by Employee F, failed to evidence documentation of a time and date the order was received. 3. The plan of treatment dated 1-9-14 to 3-9-14 for Patient #3 was reviewed on 9-19-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the was received. 4. The plan of treatment dated 12-21-17 to 2-18-17 for Patient # 5 was reviewed on 9-20-17. The verbal start of care section, signed by Employee HH, failed to evidence documentation of a time and date the order was received A. The medication profile and plan of care failed to include the following medications and allergy the dialysis agency reported: Heparin 3,000 unit bolus IV at the start of dialysis treatment and 3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain. The Hepatitis B vaccination series was being given, # 2 due 10-11-17. The dialysis center has			

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	"Gadolinium" listed as an allergy. The home health agency has listed "NKDA"(no known drug allergies). B. The dialysis dietician explained patient's current daily diet orders as follows: 1800 AK/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The plan of care for 8-18-17 to 10-16-17 had the following diet listed : NAS (no added salt) 1500 cal, soft cut up food, renal diet. The agency failed to revise the patients diet to reflect current dialysis orders. 5. The plan of treatment dated 2-22-17 to 4-22-17 for Patient # 6 was revived on 9-21-17. The verbal start of care section , signed by Employee B, failed to evidence documentation of a time and date the order was received. The discharge summary failed to have a signature, date or time when the summary was completed. 6. The clinical record for Patient #7 was reviewed on 9-21-17. The medication profile last updated 12-27-16 and the plan of care dated 12-28-16 to 2-25-17 had the following documentation : "Warfarin 1 mg as directed po ." The			

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	entry is incomplete with frequency for medication. A fax from the patients physician, dated 1-5-17 had the following order: "Warfarin 1 mg on Monday and 2 mg all other days. We will have mobile lab retest in 10 days." The agency failed to update the medication record with changes in Warfarin. The discharge summary for Patient # 7 failed to have a signature, date and time when the summary was completed. 7. The plan of treatment dated 8-9-17 to 10-7-17 for Patient #8 was reviewed on 9-21-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 8. The plan of treatment dated 4-3-17 to 6-1-17 for Patient #9 was reviewed on 9-22-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 9. The plan of treatment dated 2-2-17 to 3-1-17 for Patient #10 was reviewed on 9-22-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 10. An agency policy titled, "Plan of Care			

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	C-580" was reviewed. The policy stated, "Home care services are furnished under the supervision and direction of the patient's physician ... The Plan of Care shall be completed in full to include: ... type, frequency and duration of all visits/services, medications, treatments and procedures, other appropriate items ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ... Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care .... "			

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G 0239 Bldg. 00	484.48(b) PROTECTION OF RECORDS Clinical record information is safeguarded against loss or unauthorized use. Based on observation, interview and record review, the agency failed to safeguard records stored in an outside building from loss in 1 of 1 agency. Findings include: 1. An observation of the agency medical records storage was conducted on 9-22-17 at 2:54 PM. The small wood constructed building is behind the agency with a lock on the double door. The west side of the building had loosened boards and nails around the base of the frame. Patient medical records area were stored in multiple plastic containers on the floor. Several of the containers and lids were broken or warped, which prevented them being sealed against water, dirt and animals. The inside west ceiling of the building had deteriorated wood eroding away. There were weeds around the north side of the building and several large spiders and spider webs were noted. 2. On 9-22-17 at 3:20 PM, Employee E	G 0239	**G239 –** The storage unit has been secured against any rain or snow leakage. Animals have never been able to get into our storage unit. Shelves have been built to get storage totes off the ground. Damaged storage totes have been replaced. The Administrator will be responsible for monitoring the integrity of the storage shed to ensure that all medical records are stored in a secure & safe manner & this deficiency is corrected and will not recur. Completion Date: 11/17/2017	11/17/2017

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	reported there had been cats inside the records storage building. 3. The clinical nurse supervisor was present at the time of the observation 9-22-17 at 2:54 PM. He/She validated the containers were not sealed and needed to be replaced to secure the records. 4. An agency policy titled, "Clinical Records/Medical Record Retention C-870" was reviewed on 9-22-17. The policy states, "The clinical record information shall be safeguarded against loss ...stored in a secure area .... "			
G 0245 Bldg. 00	484.52 EVALUATION OF THE AGENCY'S PROGRAM The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective and efficient. Surveyor: Monroe, Clara Based on observation of staff practice during home visits, record review and interview the agency's annual evaluation	G 0245	**G245 – Step 1:** The Administrator has inserviced clinical nursing staff regarding monitoring & tracking infection control. The Administrator will be responsible for ensuring that	11/17/2017

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	failed to assess and accurately report the extent the agency's program appropriately evaluated urinary tract infections trends issues with patient satisfaction surveys, effectively coordinated care with staff and other agencies, and adequately performed chart reviews in 1 of 1 agency. Findings included: 1. A document titled, "2016 Quality Assurance Infection Control Report" was reviewed. There were 14 documented infections for 2016, 10 of the 14 infections were UTI's (urinary tract infections)(71%). The two documents titled Quality Assurance Committee Meetings and dated 4-19-16 ad 10-18-16 both reported as follows: "infection control log-[administrators name] a. no trends noted." There are 15 infections recorded from 1-3-17 to 9-10-17, 12 of 15 are UTI's (80%) The agency failed to appropriately acknowledge the high percentage of urinary tract infections. 2. The agency nursing supervisor and chart audits failed to ensure the home health aides followed the nursing plan of care and the registered nurse updated the plan of care to include all services to be performed for Patient # 5.		all infection control issues are reviewed on a monthly basis and tracked accordingly. The Administrator has inserviced the Office Manager on reporting issues & comments received from the monthly QA surveys. The Administrator will be responsible for ensuring that responses from QA surveys are reviewed monthly and tracked accordingly. The Administrator has inserviced the Clinical Manager & nursing staff on the requirements that the home health aide plan of care must be updated with all changes regularly and includes all services to be performed & the home health aide must follow the plan of care. The HHAs are only allowed to provide services that are listed on the care plan and they must document all services provided. The Administrator has inserviced the Clinical Manager on the Coordination of Care requirements. The Administrator & Clinical Manager will be responsible for ensuring that all care is coordinated between Best Home Care Services and any other agencies providing services to our clients. The agency must include all medications & renal diet orders that the client receives during dialysis, on the medication record & plan of treatment. The Clinical Manager has established coordination of care with the personal care services agency & the dialysis center. The Clinical	

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	A. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated the home care aide should have emptied the urine from the catheter bag. B. The nursing care plan listed the following instructions for elimination: "suprapubic catheter care daily and incontinence care daily". The nurse failed to include instructions to empty the catheter drainage bag. C. The home health aide visit notes for Patient # 5 were reviewed and failed to include documentation for suprapubic catheter care on 8-18-17, 8-19-17, 8-21-17, 8-25-17, 8-26-17, 8-27-17, 8-28-17, 8-30-17, 8-31-17, 9-1-17, 9-2-17, 9-4-17, 9-8-17, 9-9-17, 9-10-17. D. The home health aide visit notes for Patient #5 were reviewed. The care plan did not include instructions to empty the catheter drainage bag. The home health aide visit note documented emptied catheter drainage bag on 8-25-17, 8-26-17, 8-28-17, 9-1-17, 9-2-17, 9-9-17, 9-10-17. 2. The agency failed to evaluate the lack of coordination of care between the home care agency, personal care agency and dialysis agency. The chart audits did not identify lack of coordination such as		Manager & nursing staff have compiled an information binder, and placed in home of Client #5, that includes the HHA care plan & all instructions related to infection control, renal diet, fluid restrictions, intake/output measuring, suprapubic catheter care, dialysis shunt & AV fistula care. The nursing staff has been inserviced on the requirement to obtain signed orders whenever a verbal order has been received and the plan of treatment & medication record must be updated to reflect the most recent changes. The Administrator will be responsible for reporting all issues related to Quality Assurance to the Governing Body & Professional Advisory Group. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017 **G245 – Step 2** The Administrator will be revising the current chart audit form to incorporate the above areas that the agency failed to recognize. The Administrator will ensure that all findings & trends regarding infection control, QA survey findings, missing dates, times, signatures, issues with coordination of care are reported in the agency's annual evaluation and are reported	

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	missing dialysis medications and specific diet and fluid orders not listed on the home health aide assignment nursing care plans. A. An interview was conducted with the home health aide on 9-20-17 at 12:50 PM. Employee P, reported the following: " [Patient # 5] he/she goes to dialysis three times a week, I know he/she can't have sodium, I think they [personal care agency] monitor her liquid intake, I have not seen an I&0 (intake and output) sheet, I feed him/her eggs and 8 ounces of water for breakfast." The home health aide denied knowledge of Nephro or a fluid restriction. The home health aide, in regards to care of her dialysis right arm AV fistula, reported, "I have been told not to put tight things on his/her arm." B. The nursing care plan for patient #5, last updated 8-14-17 by Employee F, a registered nurse, assigned the following: nutrition 'per request', offer fluids, cut up food." The care plan failed to specify any type of diet, fluid restrictions. C. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated he/she contacted the personal care services agency monthly to coordinate services for Patient #5. The		to the Governing Body & Professional Advisory Group at meetings held in the future. Completion Date: 2/01/2018	

personal care agency updated the agency on medication changes but he/she did not have an updated medication list from dialysis unit.

D.. The personal care agency administrator was contacted on 9-20-17 at 2:15 PM and Patient# 5 was on a "renal diet". He/she reported the diet information given to his/her staff was from the Internet and not from the dietician at the dialysis center.

E. The dietician at the dialysis agency was interviewed 9-20-17 at 9:40 AM. He/she reported Patient #5's diet orders as follows: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The plan of care for 8-18-17 to 10-16-17 had the following diet listed : NAS (no added salt) 1500 cal, soft cut up food, renal diet. The agency failed to identify special orders and needs of a dialysis patient.

F. Patient # 5's medication profile and plan of care failed to include the following medications and allergy the dialysis agency reported was given at the dialysis center: Heparin 3,000 unit bolus IV at the start of dialysis treatment and

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	3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain. The Hepatitis B vaccination series had been started and the second dose was due 10-11-17. The dialysis center had "Gadolinium" listed as an allergy. The agency failed to ensure chart audits identified dialysis medications and all allergies. 3. The clinical record for Patient #4 was reviewed on 9-19-17. The medication profile had the following medication listed: " Warfarin as directed PO (orally) QD(daily)." Chart audits failed to identify the Warfarin did not have frequency and changes in doses updated on the medication administration record and physician orders. A. Clinical nurse visits notes dated 8 -1-17, 8-8-17, 8-15-17 and 9-12-17 evidenced documentation of test results for PT/INR(prothrombin time and international ratio), a test to measure clotting time for patients taking Warfarin. The nurse visit notes included calling the results of the PT/INR to the physician			

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	and obtaining new orders which were discussed with the patient. The clinical record failed to have evidence of updated physician orders or changes to the medication administration record. B. An interview was conducted with the clinical supervisor and Employee F, RN on 9-22-17 at 12:55 PM. Employee F validated his/her process for the PT/INR test for Patient # 4 as follows: He/She performed the tests, called the results to the physician, obtained orders, documented in nurses notes, informed the patient of new Warfarin dose, and placed new dose of Warfarin in patient's medication planner. Employee F validated he/she did not write a verbal order, update the medication record or update the plan of treatment. 4. The agency failed to accurately report trends in patient care surveys used for Quality Improvement to the Professional Advisory Group. A. A document titled Best Home Care Services Professional Advisory Group Meeting/ Quality Assurance Committee Meeting dated October 18,2016 reported the following: "Quality Assurance Satisfaction Surveys a. Office Manager continues to mail surveys on a monthly basis, to a random 5% of current			

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	client population and all discharged clients ... The most common complaints & /or negative comments were regarding clients not being notified of schedule changes or staffing cancellations" B. A document titled," Best home Care services Quality Assurance Survey Quarterly Summary , 1-1-17 to 3-31-17 stated the following: "... A total of 24 surveys were mailed to clients during the first calendar quarter. 15 surveys were returned ... Clients rate their answers to the following statements with Strongly agree, Somewhat Agree, Agree ,Somewhat disagree or Strongly Disagree ... Summary : Best Home Care received no complaints or concerns from the survey results that need to be addressed. Clients are satisfied with services." B. Patient surveys during that time were reviewed. Survey question # 9 included: Before services started, the home care agency clearly explained the type of services, the number of hours approved for services and my liability for payment: (2 patients answered) "somewhat disagree" (2 patient answered) "strongly disagree". Survey results for question # 9 showed a trend when 4 patients answered negatively they do not feel they have adequate information on the type of services, the			

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	number of hours approved for services and liability for payment. This was not communicated to the Professional Advisory Group or addressed as a concern for performance and quality improvement in the admissions process.			
G 0334 Bldg. 00	484.55(b)(1) COMPLETION OF THE COMPREHENSIVE ASSESSMENT The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based or record review and interview the agency failed to complete the comprehensive assessment within 5 days after the start of care for 7 of 10 patients records reviewed (Patients # 1,2,3,4,8,9,10) Findings included: 1. The clinical record of Patient # 1 was reviewed on 9-19-17, with a start of care date listed as 8-30-17. , A. The comprehensive assessment	G 0334	**G334 –** The Administrator has inserviced the Clinical Manager & nursing staff regarding the requirement that the comprehensive assessment must be completed in a timely manner, consistent with the client's immediate needs, but no later than 5 calendar days after the start of care. Quarterly chart audits will ensure that the comprehensive assessment is completed within 5 calendar days. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency will not recur.	11/17/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was dated 8-30-17 and signed by the clinical manager. B. The first billable, start of care visit, was conducted by the LPN on 9-7-17. 2. The clinical record of Patient #2 was reviewed on 9-19-17, with a start of care date listed as 11-29-17. A. The comprehensive assessment was dated 11-29-17 and signed by Employee II, a RN. B. The first billable, start of care visit, was conducted by a home health aide on 12-1-16. 3. The clinical record of Patient #3 was reviewed on 9-19-17, with a start of care date listed as 1-9-14. A. A comprehensive assessment was dated 1-9-14 and signed by Employee B, a RN. B. The first billable, start of care visit, was conducted by a home health aide on 1-10-14. 4. The clinical record of Patient # 4 was reviewed on 9-19-17, with a start of care date listed as 9-30-17.		Completion Date: 11/17/2017	

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	15K011	A. BUILDING 00 B. WING	09/22/2017

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	A. A comprehensive assessment was dated 9-30-17 and signed by Employee B, a RN. B. The first billable, start of care visit, was conducted by a home health aide on 10-2-14. 5. The clinical record of Patient # 8 was reviewed on 9-21-17, with a start of care date listed as 8-9-17. A. A comprehensive assessment was dated 8-9-17 and signed by Employee B, a RN. B. The first billable, start of care visit, was conducted by a home health aide on 8-13-17. 6. The clinical record of Patient # 9 was reviewed on 9-22-17, with a start of care date listed as 4-3-17. A. A comprehensive assessment was dated 4-3-17 and was signed by Employee B, a RN. B. The first billable, start of care visit, was conducted by a home health aide on 4-6-17. 7. The clinical record of Patient # 10 was reviewed on 9-22-17 with a start of care			

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	dated listed as 2-2-17. A. A comprehensive assessment was dated 2-2-17 and was signed by Employee B, a RN. B. The first billable, start of care visits, was conducted by a home health aide on 2-9-17 An agency Policy titled, "Comprehensive Patient Assessment C-149", was reviewed on 9-19-17. The policy stated, "A thorough, well-organized, comprehensive and accurate assessment, consistent with the patient's immediate needs will be completed for all patients in a timely manner, but no later than five (5) calendar days after start of care.". An interview with the clinical manager was conducted on 9-18-17 at 3:17 PM. He/she had not been aware the comprehensive assessment had to be conducted within 5 days after the start of care. He\she indicated all comprehensive assessments had been done directly after the initial assessment on all patients and the start of care date on the plans of treatment were incorrect.			

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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 observation, record review and interview the agency failed to include all medication, the dosages and update any changes the patient is currently taking on the medication administration record for 4 of 10 records reviewed. (Patients # 3, 4,5,7) Findings included: 1. The clinical record for Patient # 3 was reviewed on 9-19-17. A. During a home visit on 9-19-17 at 1:30 PM, the OTC medications were observed on a table by the patient: A bottle of Aspirin 325mg, which the patient reported she bought a month ago and takes one pill daily as needed for pain or headache and a bottle of liquid	G 0337	**G337 –** The Administrator has inserviced the Clinical Manager & nursing staff on the requirement that all medication, the dosages and times must be listed on the medication record and plan of treatment & such must be updated with any new changes including OTC medications. The nursing staff has been instructed to ask clients, at all visits, if they have started or stopped any medications since the last visit. They are to specifically ask the client about any OTC medications they may have purchased & started without notifying the agency. The nursing staff has been inserviced that all verbal orders obtained from the physician must be written & sent for signature and the plan of treatment & medication record must be updated. The Clinical Manager will	11/17/2017

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	"Daytime Cold and Flu" medication, which the patient reported she bought about a week ago and takes 1 tablespoon daily as needed for cough. B. During the home visit Employee F was observed to assess the patient, beside the table, where the medications were in clear view. Employee F did not inquire about any changes or new medications. Employee F was asked about the medications sitting on the table, he/she reported not being aware of the medications. C. The comprehensive assessment completed 7-13-17 failed to have evidence of Aspirin and Daytime Cold and Flu medication the patient was currently taking. There was no evidence of a current order for those medications in the patient record. D. The medication profile last updated and signed by Employee F on 9-11-17, failed to evidence the following OTC (over the counter) medications: Aspirin 325 mg and Daytime Cold and Flu liquid medication. 2. The clinical record for Patient #4 was reviewed on 9-19-17. A. The medication profile had the		be responsible for monitoring these corrective actions to ensure that this deficiency will not recur. Completion Date: 11/17/2017	

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following medication listed: " Warfarin as directed PO (orally) QD(daily)."

B. Clinical nurse visits notes dated 8-1-17, 8-8-17, 8-15-17 and 9-12-17 evidenced documentation of test results for PT/INR(prothrombin time and international ratio), a test to measure clotting time for patients taking Warfarin. The nurse visit notes included calling the results of the PT/INR to the physician and obtaining new orders which were discussed with the patient. The clinical record failed to have evidence of updated physician orders or changes to the medication administration record.

C. An interview was conducted with the clinical supervisor and Employee F, RN on 9-22-17 at 12:55 PM. Employee F validated his/her process for the PT/INR test for Patient # 4 as follows: He/She performed the tests, called the results to the physician, obtained orders, documented in nurses notes, informed the patient of new Warfarin dose, and placed new dose of Warfarin in patient's medication planner. Employee F validated he/she did not write a verbal order, update the medication record or update the plan of treatment.

3. The clinical record for Patient # 5 was reviewed on 9-20-17. The medication

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	profile and plan of care failed to include the following medications and allergy the dialysis agency reported: Heparin 3,000 unit bolus IV at the start of dialysis treatment and 3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain. The Hepatitis B vaccination series was being given, # 2 due 10-11-17. The dialysis center has "Gadolinium" listed as an allergy. The home health agency has listed no known drug allergies. A. . The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated he/she contacted the personal care services agency monthly to coordinate services. The personal care agency updated the home care agency on medication changes but, the home care agency did not have an updated medication list from the dialysis agency. 4. The clinical record for Patient #7 was reviewed on 9-21-17. The medication profile last updated 12-27-16 and the plan of care dated 12-28-16 to 2-25-17 had the following documentation :			

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	"Warfarin 1mg as directed po ." The entry is incomplete with frequency for medication. A fax from the patients physician, dated 1-5-17 had the following order: "Warfarin 1 mg on Monday and 2 mg all other days. We will have mobile lab retest in 10 days." The agency failed to update the medication record with changes in Warfarin. An agency policy titled, "Plan of Care C-580" was reviewed. The policy stated, "Home care services are furnished under the supervision and direction of the patient's physician ... The Plan of Care shall be completed in full to include: ... medications, treatments and procedures ... Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care .... " An agency policy titled " Medication Profile" was reviewed. The policy stated, " The Registered Nurse or Therapist will complete a medication profile for each patient ... The medication profile shall include all prescriptions and nonprescription's ... the profile will be reviewed and updated as needed to reflect current medication the patient is taking ...Special Instructions ... The nurse /therapist shall record on the medication profile all prescribed and OTC medication the patient is currently			

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	taking... the medication profile shall document ... allergies,.date medication ordered, medication name, medication dosage, ... discontinuation date ... if the physician changes the medication orders, the nurse must add newly ordered drugs or medication changes to the medication profile... discontinued medications shall be highlighted and documented as DC with appropriate date ...."			
N 0000 Bldg. 00	This visit was for a federal and state home health recertifcation survey. This was a fully extended survey. Survey dates 9-18-17 - 9-22-17 Facility # 003083 Medicaid # 200367450 Skilled unduplicated 12 month census: 6	N 0000		

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	Non-skilled unduplicated 12 month census: 9 Active census: 45 Discharged in past 12 months: 16 Home Visits: 5 Charts reviewed with Home visits: 5			
N 0442 Bldg. 00	410 IAC 17-12-1(b) Home health agency administration/management Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency.			
	Based on record review and interview the governing body failed to adopt and periodically review written bylaws as evidenced by incomplete documentation of the bylaws and governing body meeting in 1 of 1 agency. Findings included: 1. A document titled, " By-laws of Best Home Health Care Services dba Best Home Care Services" was reviewed. The	N 0442	**N442** - The Administrator has been inserviced on the requirement that signatures must be obtained for all members in attendance at Governing Body & Professional Advisory Group meetings. The Administrator will be responsible for obtaining signatures of all members in attendance during all future Governing Body & Professional Advisory Group Meetings. The Administrator will be responsible for ensuring that the company bylaws are complete with both signatures	11/17/2017

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	last page of the document has a signature on the line for Incorporator. The date for validation of the document is is blank. 2. A document titled," Best Home Care Services, Governing Body Meeting, February 28, 2017" was reviewed. The document had no signatures or attendees on the document to validate a meeting had been conducted. 3. An interview was conducted, on 9-22-17 at 1:32 PM, with the Employee B, the alternate administrator and nursing supervisor. He/she had unsuccessfully tried to contact Employee A, the administrator to answer questions regarding the meetings for the advisory board, governing body and professional advisory group meetings. Employee B reported he/she is not present for the board meetings, the professional advisory group meetings or the annual meeting. He/She reports meetings are held at the agency but he/she could not validate who was present for the meetings. He/ She validated the documents and meeting minutes should have been dated and had signatures of attendees.		and dates. The Administrator will be responsible for annual review of the bylaws. The Administrator will be responsible for ensuring that attendance signatures sheets are maintained along with the meeting minutes. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	

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N 0464 Bldg. 00	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin			

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	test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review, and interview, the agency failed to ensure personnel files of direct care providers contained a valid negative TB skin test within the prior 12 months; to include documentation of the date and time of administration, and the date and time of reading/ interpretation, for 1 of 7 employees whose personnel files were reviewed (Employee B). The findings included: 1. The personnel health file of Employee B, the nursing supervisor evidenced a TB skin test report with date of administration of 3-13-17 at 9:00 AM. The test was read on 3-15-17 and failed to evidence documentation of the time of reading. The result was 0 mm induration. Because the test results failed to evidence	N 0464	**N464 –** The Administrator has inserviced the Clinical Manager & nursing staff on the requirement that all administered TB test must include the date & time the test was administered and the date & time the result was read. The Administrator will be responsible for ensuring that quarterly personnel file audits including verifying that the TB test form has both dates & times for when the test was administered & read. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	11/17/2017

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	documentation of the time of administration and the time of reading, it could not be reliably determined the TB skin test had been read/interpreted between 48 and 72 hours. 2. A policy titled, "Health Screening D-240" was reviewed and stated ,"...TB skin test results shall be evaluated by a Registered Nurse or Licensed Practical Nurse, within 48 to 72 hours and documented ... in millimeters of induration."			
N 0486 Bldg. 00	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient.			
	Based on observation, interviews and record review the agency failed to maintain coordination of care between the home care agency, personal care agency and dialysis agency in regards to diet, fluid restriction, care of the suprapubic catheter, intake and output, allergies and medications between the agency nurses, home health aides, the personal care agency and the dialysis agency providing care for 1 of 10 patients . (Patient # 5) Findings included :	N 0486	**N486 -** The Clinical Manager has been inserviced on the requirement for coordination of care with all other agencies involved in the client's care. The Clinical Manager has established communication with the dialysis agency and the personal care agency to maintain coordination of care regarding the diet, fluid restrictions, care of the suprapubic catheter, intake & output, allergies and medications. The Clinical Manager will be responsible for ensuring the home health aide care plan identifies specific type of diet, fluid restrictions	11/17/2017

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	1. A home visit was conducted on 9-20-17 at 8:00 AM for Patient # 5. The patients diagnosis included end stage renal disease with hemodialysis 3 times weekly, congestive heart failure and a recent hospitalization from 6-26-17 to 7-4-17 for Urosepsis. Employee P, a home health aide was observed to place a urine filled suprapubic catheter drainage bag in the arms of the patient, above the level of the bladder, during a hoyer lift transfer to the patient's wheelchair. A. An interview was conducted with the home health aide on 9-20-17 at 12:50 PM. Employee P, reported he/she does not empty the catheter bag and the [personal care agency] records the intake and output from the drainage bag. The home health aide reported the following: " [Patient # 5] he/she goes to dialysis three times a week, I know he/she can't have sodium, I think they [personal care agency] monitor her liquid intake, I have not seen an I&0 (intake and output) sheet, I feed him/her eggs and 8 ounces of water for breakfast." The home health aide denied knowledge of Nephro or a fluid restriction. The home health aide, in regards to care of her dialysis right arm AV fistula, reported, "I have been told not to put tight things on his/her arm."		& permission & instructions for emptying and handling of the urinary drainage bag. The Clinical Manager has implemented an intake & output sheet in the client's home. The Clinical Manager has inserviced all HHAs on documenting the intake & output for the period of time that our agency is in the home. The Clinical Manager has inserviced all home health aides in the home on catheter care, emptying & handling of the urinary drainage bag. The Clinical Manager and nursing staff have compiled an information binder & placed in the home of client #5, that includes the HHA care plan & all instructions related to infection control, renal diet, fluid restrictions, intake/output measuring, suprapubic catheter care, dialysis shunt & AV fistula care. The Clinical Manager will be responsible for maintaining a liaison with the personal services agency & the dialysis center to ensure coordination of care. The Clinical Manager will be responsible for ensuring that the client's plan of care and medication record includes current allergies, updated medication list, including all medications given at the dialysis center & renal diet orders from the dialysis center. The Clinical Manager will be responsible for ensuring that the HHAs are accurately recording intake & output. Nursing Supervisors will continue to observe personal care given during	

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BEST HOME CARE SERVICES	325 N EASTERN AVE CONNERSVILLE, IN 47331

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	B. The home health aide care plan, last updated 8-14-17 by Employee F, a registered nurse, had assigned the following: "catheter care supra (suprapubic) QD (daily), nutrition 'per request', offer fluids, cut up food." The care plan failed to specify any type of diet, fluid restrictions or permission to empty the urinary drainage bag. C. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated that the home care aide should have emptied the urine from the catheter bag before transferring the patient and kept the bag below the bladder level to prevent urinary tract infections. The clinical supervisor reported the personal care agency is supposed to empty the catheter bag, record the patients fluid intake and output. The clinical supervisor reported he/she contacted the personal care services agency monthly to coordinate services. The personal care agency updated the agency on medication changes but he/she did not have an updated medication list from dialysis unit. 2. The personal care agency administrator was contacted on 9-20-17 at 2:15 PM. The administrator reported their agency emptied the catheter bag daily and did the		reassessment and supervisory visits to ensure proper technique is being used with catheter care and handling of the urinary drainage bag. Completion Date: 11/17/2017	

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	patients intake and output. The administrator reported the patient was on a "renal diet". He/she reported the diet information given to his/her staff was from the Internet and not from the dietician at the dialysis center. Documents faxed from the personal care agency to the home care agency failed to have an accurate intake and output. The document titled, " Intake and Elimination Report" from 9-1-17 to 9-16-17 had no urinary output recorded for 16 days. There was no fluid intake recorded for 14 of 16 days. 3. The charge nurse at the dialysis agency was interviewed 9-20-17 at 9:40 AM. He/she reported "not much interaction" with the home care agency and some interaction with the personal care agency. The dialysis dietician explained patient's current daily diet orders as follows: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The plan of care for 8-18-17 to 10-16-17 had the following diet listed : NAS (no added salt) 1500 cal, soft cut up food, renal diet. The agency failed to revise the patients diet to reflect current dialysis orders.			

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	5. The home care agency medication profile and plan of care failed to include the following medications and allergy the dialysis agency reported was given at the dialysis center: Heparin 3,000 unit bolus IV at the start of dialysis treatment and 3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain. The Hepatitis B vaccination series was being given, # 2 due 10-11-17. The dialysis center has "Gadolinium listed as an allergy. 6. A policy titled, "Coordination of Patient Services" was reviewed and stated the following: "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care ...after the initial assessment the admitting registered nurse/therapist shall discuss the findings of the initial visit with the clinical manager to ensure ... coordination with other agencies and institutions...."			

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N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.			
	Based on record review, observation and interviews the home health agency failed to accurately develop the plan of treatment to include frequency and types of services, nutritional requirements, and all current medications for 6 of 10 patients. (Patients # 1,2,3,4,5 and 7) Findings included:	N 0524	**N524 –** The Administrator has inserviced the Clinical Manager & Registered Nurses on the requirement that the RN will be responsible for developing a written plan of care that includes all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations,	11/17/2017

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	1. The clinical record for Patient # 1 was reviewed on 9-18-17 and 9-18-17. A document titled "Plan of Treatment", dated 8-30-17, and signed by the physician on 9-7-17, had the following order: "Pediasure (nutritional supplement) 240 cc+80 H2O, GT(gastric tube) 1 can formula +80 ml's H2O flush AM,11 AM, and 5 PM." A. A clinical nursing note for 9-7-17 at 8:30 AM and signed by the Employee I, LPN (Licensed Practical Nurse) stated the following: "250 cc bolus fdg [feeding] of Pediasure given via GT -along c(with) approx 70 cc H2O flush." A clinical nursing note for 11 AM and signed by Employee I, stated the following: "250 cc's of Pediasure given via GT-followed c 70 cc H2O flush." B. A clinical nursing note for 9-8-17 at 8:05 AM and signed by the Employee I, stated the following: "250 cc of Pediasure given via GT, following with 70 cc H2O." A clinical nursing note for 11 AM and signed by Employee I, stated the following: "250 cc's of Pediasure given via GT-followed c 70 cc H2O flush." C. An agency policy title, " Plan of Care C-580", was reviewed and stated the		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. This includes all medications, allergies, diet orders & fluid restrictions ordered from other agencies obtained through coordination of care. This includes obtaining orders for wound measurements. This includes updating all medications on the medication record and the plan of treatment and all necessary revisions. The nursing staff has been instructed to ask clients, at all visits, if they have started or stopped any medications since the last visit. They are to specifically ask the client about any OTC medications they may have purchased & started without notifying the agency. Quarterly chart &documentation audits will be performed to ensure orders are obtained for all services, to ensure that verbal orders are obtained for any physician ordered changes regarding medications or services provided & to ensure that there is no variance between the tube feeding & flush amount listed on the plan of treatment, the can of formula & the amount documented in the clinical record. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

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	following ... " 2. The plan of care shall be completed in full to include: ... k. specific dietary or nutritional requirements or restrictions." D. During a home visit on 9-18-17 at 12:27 PM and on 9-19-17 at 10:45 AM, Employee I was observed to administer Pediasure by gravity into the gastric tube of Patient # 1. The label of the Pediasure was examined and the content amount was listed as 237 ml. E. An interview was conducted with Employee I, on 9-19-17 at 10:35 AM. Employee I reported he/she had given 1 can of Pediasure (237 ml) and had incorrectly documented 240 ml in the clinical notes and gave 80 ml of water after the Pediasure and had incorrectly documented 70 ml in the clinical notes. F. An interview with Employee B, the clinical manager was conducted on 9-18-17 at 1:30 PM. The clinical manager was made aware of the variance between the tube feeding amount listed on the plan of treatment, the Pediasure label and the amount documented in the clinical record. The clinical manager validated the tube feeding amount on the plan of treatment orders and the nurses notes should have been documented as 237 ml of Pediasure and 80 ml of water.		Completion Date: 11/17/2017	

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2. The clinical record for Patient # 2 was reviewed on 9-18-17. The plans of treatment for the periods of 11-29-16 to 1-27-17 and 7-27-17 to 9-24-17 have the following orders for discipline and treatments: "RN to assess, eval (evaluate), treat and obtain VS (vital signs) and O2 sat (oxygen saturation). The document fails to include SN weekly visits to measure and document wounds.

A. An agency document validated skilled nurse weekly wound measurements and assessment were conducted starting on 11-29-17 to 9-15-17.

B. An interview was conducted with Employee # 2, Clinical Manager on 9-21-17 at 3:30 PM. The clinical manager reported the weekly skilled nurse visit was not billable, the family does all dressing changes and he/she did not think it needed to be on plan of treatment.

C. A policy titled, "Plan of Care C-580" was reviewed. The policy stated, ... " 2. The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ...."

3. The clinical record for Patient # 3 was reviewed on 9-19-17. The plan of

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	treatment from the 7-18-17 to 9-15-17 and the medication profile last updated and signed by Employee F on 9-11-17, failed to evidence the following home OTC (over the counter) medications: Aspirin 325 mg and Daytime Cold and Flu liquid medication. A. During a home visit on 9-19-17 at 1:30 PM, the following OTC medications were observed sitting on a table by the patient: A bottle of Aspirin 325mg, which the patient reported she bought a month ago and takes one pill daily as needed for pain or headache. A bottle of liquid "Daytime Cold and Flu" medication, which the patient reports she bought about a week ago and takes 1 tablespoon daily as needed for cough. B. Employee F, the nurse did an assessment of the patient beside the medications in clear view during the home visit. No questions were asked regarding new medications. Employee F reported she had not been aware of the medications the patient had purchased. 4. The clinical record for Patient # 4 was reviewed on 9-19-17. A document titled "Plan of Treatment", dated 8-15-17 to 10-13-17 and signed by the physician on 8-17-17, had the following order: "Warfarin (a medication to slow blood			

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	clotting) po (orally) as directed QD (daily)." A. Clinical nurse visits notes dated 8-1-17, 8-8-17, 8-15-17 and 9-12-17 evidenced documentation of test results for PT/INR(prothrombin time and international ratio), a test to measure clotting time for patients taking Warfarin. The nurse visit notes included calling the results of the PT/INR to the physician and obtaining new orders which were discussed with the patient. The clinical record failed to have evidence of updated physician orders or changes to the medication administration record. B. An interview was conducted with the clinical supervisor and Employee F, RN on 9-22-17 at 12:55 PM. Employee F validated his/her process for the PT/INR test for Patient # 4 as follows: He/She performed the tests, called the results to the physician, obtained orders, documented in nurses notes, informed the patient of new Warfarin dose, and placed new dose of Warfarin in patient's medication planner. Employee F validated he/she did not write a verbal order, update the medication record or update the plan of treatment. 5. The plan of care for Patient # 5 dated 8-18-17 to 10-16-17 was reviewed on			

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	9-20-17. The patient's diagnosis included, end stage renal disease with hemodialysis 3 times weekly. The plan of care failed to include all medications, renal diet, allergies and fluid restrictions the patient had ordered from the dialysis agency physician. A. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated he/she contacted the personal care services agency monthly to coordinate services, but he/she did not have an updated medication list from dialysis unit. The dialysis charge nurse was interviewed 9-20-17 at 9:40 AM and validated the following dialysis medications: Heparin 3,000 unit bolus IV at the start of dialysis treatment and 3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain. The Hepatitis B vaccination series was being given, # 2 due 10-11-17, Allergy: "Gadolinium", Diet: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal			

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	supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The home care agency failed to include these medications on the plan of care. B. The dialysis dietician was interviewed 9-20-17 at 9:40 AM. The dialysis dietician reported the patient's current diet orders were as follows: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The agency failed to coordinate care with the dialysis agency and the plan of care listed the patient's diet as follows: "no added salt, 1500 cal, soft cut up food and renal diet." 6. The clinical record for Patient #7 was reviewed on 9-21-17. The medication profile last updated 12-27-16 and the plan of care dated 12-28-16 to 2-25-17 had the following documentation : "Warfarin 1 mg as directed po ." The entry is incomplete with frequency for medication. A fax from the patients physician, dated 1-5-17 had the following order: "Warfarin 1 mg on Monday and 2 mg all other days. We will have mobile lab retest in 10 days." The agency failed to update the medication record with changes in Warfarin.			

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	7. An agency policy titled, "Plan of Care C-580" was reviewed. The policy stated, "Home care services are furnished under the supervision and direction of the patient's physician ... The Plan of Care shall be completed in full to include: ... type, frequency and duration of all visits/services, medications, treatments and procedures, other appropriate items ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ... Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care .... "			
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. Based on observation, record review and interview the RN (Registered Nurse) failed to make necessary revisions to the plan of care in 5 of 10 records reviewed.	N 0542	**N542 –** The Administrator has inserviced the Clinical Manager & Registered Nurses on the requirement that the RN will be responsible for developing a written plan of care that includes all	11/17/2017

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	(Patients 2, 3, 4, 5, and 7) 1. The clinical record for Patient # 2 was reviewed on 9-18-17. The plans of treatment for the periods of 11-29-16 to 1-27-17 and 7-27-17 to 9-24-17 have the following orders for discipline and treatments: "RN to assess, eval (evaluate), treat and obtain VS (vital signs) and O2 sat (oxygen saturation). The document fails to include SN weekly visits to measure and document wounds. A. An agency document validated skilled nurse weekly wound measurements and assessment were conducted starting on 11-29-17 to 9-15-17. B. An interview was conducted with Employee # 2, Clinical Manager on 9-21-17 at 3:30 PM. The clinical manager reported the weekly skilled nurse visit was not billable, the family does all dressing changes and he/she did not think it needed to be on plan of treatment. 2. The clinical record for Patient # 3 was reviewed on 9-19-17. The plan of treatment from the 7-18-17 to 9-15-17 and the medication profile last updated and signed by Employee F on 9-11-17, failed to evidence the following home		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. This includes all medications, allergies, diet orders & fluid restrictions ordered from other agencies obtained through coordination of care. This includes obtaining orders for wound measurements. This includes updating all medications on the medication record and the plan of treatment and all necessary revisions. The nursing staff has been instructed to ask clients, at all visits, if they have started or stopped any medications since the last visit. They are to specifically ask the client about any OTC medications they may have purchased & started without notifying the agency. Quarterly chart &documentation audits will be performed to ensure orders are obtained for all services, to ensure that verbal orders are obtained for any physician ordered changes regarding medications or services provided & to ensure that there is no variance between the tube feeding & flush amount listed on the plan of treatment, the can of formula & the amount documented	

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	OTC (over the counter) medications: Aspirin 325 mg and Daytime Cold and Flu liquid medication. A. During a home visit on 9-19-17 at 1:30 PM, the following OTC medications were observed sitting on a table by the patient: A bottle of Aspirin 325mg, which the patient reported she bought a month ago and takes one pill daily as needed for pain or headache. A bottle of liquid "Daytime Cold and Flu" medication, which the patient reports she bought about a week ago and takes 1 tablespoon daily as needed for cough. B. Employee F, the nurse did an assessment of the patient beside the medications in clear view during the home visit. No questions were asked regarding new medications. Employee F reported she had not been aware of the medications the patient had purchased. 3. The clinical record for Patient # 4 was reviewed on 9-19-17. A document titled "Plan of Treatment", dated 8-15-17 to 10-13-17 and signed by the physician on 8-17-17, had the following order: "Warfarin (a medication to slow blood clotting) po (orally) as directed QD (daily)." A. Clinical nurse visits notes dated 8		in the clinical record. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	

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	-1-17, 8-8-17, 8-15-17 and 9-12-17 evidenced documentation of test results for PT/INR(prothrombin time and international ratio), a test to measure clotting time for patients taking Warfarin. The nurse visit notes included calling the results of the PT/INR to the physician and obtaining new orders which were discussed with the patient. The clinical record failed to have evidence of updated physician orders or changes to the medication administration record. B. An interview was conducted with the clinical supervisor and Employee F, RN on 9-22-17 at 12:55 PM. Employee F validated his/her process for the PT/INR test for Patient # 4 as follows: He/She performed the tests, called the results to the physician, obtained orders, documented in nurses notes, informed the patient of new Warfarin dose, and placed new dose of Warfarin in patient's medication planner. Employee F validated he/she did not write a verbal order, update the medication record or update the plan of treatment. 4. The plan of care for Patient # 5 dated 8-18-17 to 10-16-17 was reviewed on 9-20-17. The patient's diagnosis included, end stage renal disease with hemodialysis 3 times weekly. The plan of care failed to include all medications, renal diet,			

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	allergies and fluid restrictions the patient had ordered from the dialysis agency physician. A. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated he/she contacted the personal care services agency monthly to coordinate services, but he/she did not have an updated medication list from dialysis unit. The dialysis charge nurse was interviewed 9-20-17 at 9:40 AM and validated the following dialysis medications: Heparin 3,000 unit bolus IV at the start of dialysis treatment and 3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain. The Hepatitis B vaccination series was being given, # 2 due 10-11-17, Allergy: "Gadolinium", Diet: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The home care agency failed to include these medications on the plan of care.			

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B. The dialysis dietician was interviewed 9-20-17 at 9:40 AM. The dialysis dietician reported the patient's current diet orders were as follows: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The agency failed to coordinate care with the dialysis agency and the plan of care listed the patient's diet as follows: "no added salt, 1500 cal, soft cut up food and renal diet."

5. The clinical record for Patient #7 was reviewed on 9-21-17. The medication profile last updated 12-27-16 and the plan of care dated 12-28-16 to 2-25-17 had the following documentation : "Warfarin 1mg as directed po ." The entry is incomplete with frequency for medication. A fax from the patients physician, dated 1-5-17 had the following order: "Warfarin 1 mg on Monday and 2 mg all other days. We will have mobile lab retest in 10 days." The agency failed to update the medication record with changes in Warfarin.

6. A policy title, "Skilled Nursing Services C-200" was reviewed and stated: "Skilled nursing services will be

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	provided ... under the supervision of a RN and in accordance with a medically approved Plan of Care ... the registered nurse ... regularly reevaluates the patient needs, and coordinates the necessary services ... initiates the plan of care and necessary revisions and updates to the plan of care and the care plan." 7. An agency policy titled, "Plan of Care C-580" was reviewed. The policy stated, "Home care services are furnished under the supervision and direction of the patient's physician ... The Plan of Care shall be completed in full to include: ... type, frequency and duration of all visits/services, medications, treatments and procedures, other appropriate items ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ... Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care .... "			
N 0545 Bldg. 00	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health			

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	setting, the registered nurse shall do the following: (F) Coordinate services. Based on observation, interview and record review the registered nurse failed to coordinate services with other agencies, the physician, and the home health aide regarding dialysis orders for diet, medication, fluid restriction and fluid management for 1 of 10 home health patients. (Patient # 5) Findings included: 1. The medical record for Patient #5 was reviewed and interviews were conducted with the dialysis agency charge nurse and dietician on 9-20-17 to obtain information to determine correct orders and treatments for the patient. A. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated he/she contacted the personal care services agency monthly to coordinate services. The personal care agency updated the home care agency on medication changes but, the registered nurse failed to obtain an updated medication list from the dialysis agency. B. The nurse failed to coordinate with the dialysis dietician to include the following renal diet: 1800 AK/cal,	N 0545	**N545** - The Administrator has inserviced the Clinical Manager on the Coordination of Care requirements. The Administrator & Clinical Manager will be responsible for ensuring that all care is coordinated between Best Home Care Services and any other agencies providing services to our clients. The agency must include all medications & renal diet orders that the client receives during dialysis, on the medication record & plan of treatment. The Clinical Manager has established coordination of care with the personal care services agency & the dialysis center. The Clinical Manager & nursing staff have compiled an information binder and placed in home of Client #5, that includes the HHA care plan & all instructions related to infection control, renal diet, fluid restrictions, intake/output measuring, suprapubic catheter care, dialysis shunt & AV fistula care. The nursing staff has been inserviced on the requirement to obtain signed orders whenever a verbal order has been received and the plan of treatment & medication record must be updated to reflect the most recent changes. The Clinical Manager will be responsible for ensuring the home health aide care plan identifies specific type of diet, fluid restrictions & permission &	11/17/2017

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	Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The plan of care for 8-18-17 to 10-16-17 had the following incorrect diet listed : NAS (no added salt) 1500 cal, soft cut up food, renal diet. C. The nurse failed to coordinate with the dialysis agency and include the following dialysis medications and an allergy on the plan of care: Heparin 3,000 unit bolus IV at the start of dialysis treatment and 3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and 2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain, Hepatitis B vaccine, and an allergy to "Gadolinium." 4. The home health aide care plan, last updated 8-14-17 by Employee F, a registered nurse, had assigned the following: "nutrition 'per request', offer fluids, cut up food." The care plan failed to specify any type of diet or fluid restrictions. An interview was conducted with the Employee P, a home health aide		instructions for emptying and handling of the urinary drainage bag. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency will not recur. Completion Date: 11/17/2017	

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	regarding their knowledge of the patients care needs on 9-20-17 at 12:50 PM. Employee P, reported the following: " I know he/she can't have sodium, I think they [personal care agency] monitor her liquid intake, I have not seen an I&0 (intake and output) sheet, I feed him/her eggs and 8 ounces of water for breakfast." The home health aide denied knowledge of Nephro or a fluid restriction. The home health aide, in regards to care of the patient's right arm AV fistula, reported, "I have been told not to put tight things on his/her arm." The nurse failed to coordinate with the dialysis unit and to update the home health aide care plan to include the patients accurate diet, fluid restrictions and how to report and record accurate intake and output. 5. A policy titled, "Coordination of Patient Services" was reviewed and stated the following: "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the plan of care ...after the initial assessment the admitting registered nurse/therapist shall discuss the findings of the initial visit with the clinical manager to ensure ... coordination with other agencies and institutions...."			

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N 0547 Bldg. 00	410 IAC 17-14-1(a)(1)(H) Scope of Services Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written).			
	Based on record review and interview the agency failed to date the verbal orders for start of care for 9 of 10 records reviewed. (Patients # 1,2,3,4,5,6,8,9 and 10) Findings include: 1. The plan of treatment dated 8-30-17 to 10-28-17 for Patient # 1 was reviewed on 9-19-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 2. The plan of treatment dated 7-9-24 to 9-24-17 for Patient # 2 was reviewed on 9-19-17. The verbal start of care section, signed by Employee F, failed to evidence documentation of a time and date the order was received.	N 0547	**N547** - The Clinical Manager has been inserviced on the requirement that all verbal orders must have a signature, date & time the order was received. The Clinical Manager will be responsible for ensuring that all verbal orders obtained by Registered Nurses have a signature, date & time the order was received. All Registered Nurses have received education regarding the need for date, time as well as signature for verbal orders obtained. Quarterly chart audits will be performed to ensure that all verbal orders have date, time & signature. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	11/17/2017

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	3. The plan of treatment dated 1-9-14 to 3-9-14 for Patient #3 was reviewed on 9-19-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 4. The plan of treatment dated 12-21-16 to 2-18-17 for Patient # 5 was reviewed on 9-20-17. The verbal start of care section, signed by Employee HH, failed to evidence documentation of a time and date the order was received. 5. The plan of treatment dated 2-22-17 to 4-22-17 for Patient # 6 was reviewed on 9-21-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 6. The plan of treatment dated 8-9-17 to 10-7-17 for Patient #8 was reviewed on 9-21-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received 7. The plan of treatment dated 4-3-17 to 6-1-17 for Patient #9 was reviewed on 9-22-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the			

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order was received.

8. The plan of treatment dated 2-2-1 to 4-2-17 for Patient # 10 was reviewed on 9-22-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received.

9. An agency policy titled, "Physician Orders C-635", stated the following: ... "When the nurse or therapist 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 ...."

10. An interview was conducted with the nursing manager on 9-18-17 at 1:30 PM. The nursing manager reported he/she was not aware the date and time were missing on the verbal start of care order on the plan of treatment.

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N 0550 Bldg. 00	410 IAC 17-14-1(a)(1)(K) Scope of Services Rule 14 Sec. 1(a) (1)(K) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (K) Delegate duties and tasks to licensed practical nurses and other individuals as appropriate. Based on observation, interview and record review the registered nurse failed to prepare complete and accurate home health aide patient care instructions for 1 of 10 records reviewed. (Patient # 5) Findings include: 1. A home visit was conducted on 9-20-17 at 8:00 AM for Patient # 5. The patients diagnosis included, end stage renal disease with dialysis 3 times weekly and a recent hospitalization from 6-26-17 to 7-4-17 for Urosepsis. Employee P, a home health aide was observed to place a urine filled suprapubic catheter drainage bag in the arms of the patient, above the level of the bladder during a hoyer lift transfer to the patients wheelchair. A. An interview was conducted with the home health aide on 9-20-17 at 12:50PM. Employee P, reported he/she does not empty the catheter bag and the [other personal care agency] takes care of the intake and output from the catheter.	N 0550	**N550** - The Administrator has inserviced the Clinical Manager & nursing staff on the requirements that the home health aide plan of care must be updated with all changes regularly and includes all services to be performed. The home health aide must follow the plan of care. The HHAs are only allowed to provide services that are listed on the care plan and they must document all services performed. The Clinical Manager & nursing staff have compiled an information binder and placed in the home of Client #5, that will include the HHA care plan & all instructions related to infection control, renal diet, fluid restrictions, intake/output measuring, suprapubic catheter care, dialysis shunt & AV fistula . The Clinical Manager will be responsible for ensuring the home health aide care plan identifies specific type of diet, fluid restrictions & permission & instructions for emptying and handling of the urinary drainage bag & is updated with all new orders. The Clinical Manager has implemented an intake	11/17/2017

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	B. The clinical supervisor was interviewed on 9-20-17 at 8:37 AM and validated that the home care aide should have emptied the urine from the catheter bag before transferring the patient and kept the bag below the bladder level to prevent urinary tract infections. C. The aide care plan listed the following instructions for elimination: "suprapubic catheter care daily and incontinence care daily". The nurse failed to include instructions to empty the catheter drainage bag or measure intake and output. 2. . The home health aide care plan, last updated 8-14-17 by Employee F, a registered nurse, had assigned the following for nutrition: "nutrition 'per request', offer fluids, cut up food." The care plan failed to specify any type of diet or fluid restrictions. The dialysis dietician was interviewed 9-20-17 at 9:40 AM. He/She reported the patient's current diet orders as follows: 1800 K/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The plan of care for 8-18-17 to 10-16-17 had the following		& output sheet in the client's home. The Clinical Manager has inserviced all HHAs on documenting the intake & output for the period of time that our agency is in the home. The Clinical Manager has inserviced all home health aides in the home on catheter care, emptying & handling of the urinary drainage bag. Nursing Supervisors will continue to observe personal care given during reassessment & supervisory visits to ensure HHAs are following proper infection control techniques with catheter care & handling of the urinary drainage bag & correct intake & output measuring. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	

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	diet listed : NAS (no added salt) 1500 cal, soft cut up food, renal diet. The nurse failed to coordinate with the dialysis agency to update the home health aide plan of care with the accurate renal diet. A. An interview was conducted with the Employee P, a home health aide regarding their knowledge of the patients dietary needs on 9-20-17 at 12:50 PM. Employee P, reported the following: " I know he/she can't have sodium, I think they [personal care agency] monitor her liquid intake, I have not seen an I&0 (intake and output) sheet, I feed him/her eggs and 8 ounces of water for breakfast." He/she denied writing down the amount the patient drinks or communication with the personal care agency regarding intake or output. The home health aide denied knowledge of Nephro or a fluid restriction. 3. The patient had a left subclavin dialysis catheter and an immature right arm AV fistula. Employee P reported on 9-2017 at 12:50 PM, "I have been told not to put tight things on his/her arm" and denied any instructions regarding the dialysis catheter. The nurse failed to include instructions on the home health aide care plan on safety and precautions for the right arm fistula or the dialysis catheter.			

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	4. A policy titled, " Home Health Aide Supervision" was reviewed and stated: " Agency shall provide home health aide services under the direction and supervision of a registered professional nurse/therapist when personal care services are indicated and ordered by a physician ... the registered nurse will give the home health aide direction for patient care by way of the home health aide care plan .... a copy of this written plan is to be left in the patient's home and revised ... if the care plan is complex ... the registered nurse will personally supervise and instruct the home health aide on the first day of the assignment and from then on, as often as necessary ... the aide visit record is reviewed by the supervising nurse to assure services are being provided according to the care plan. "			
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, observation and interview the LPN (Licensed Practical Nurse) failed to accurately document gastric tube feedings in the clinical notes for 1 of 10 patient records reviewed. (Patient # 1)	N 0554	**N554 -** The Clinical Manager has inserviced the LPNs on accurately documenting gastric tube feedings & flush amounts and documenting it in the clinical record. Nursing Supervisors will continue to observe tube feedings & flushes during	11/17/2017

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	Findings include: 1. The medical record for Patient # 1 was reviewed on 9-18-17 and 9-18-17. A. A document titled "Plan of Treatment", dated 8-30-17, and signed by the physician on 9-7-17, had the following order: "Pediasure 240 cc+8 H2O, GT(gastric tube) 1 can formula +80 ml's H2O flush AM, 11 AM, and 5 PM." B. A clinical nursing note for 9-7-17 at 8:30 AM and signed by the Employee I, LPN (Licensed Practical Nurse) stated the following: "250 cc bolus fdg [feeding] of Pediasure given via GT -along c[with] approx 70 cc H2O flush." A clinical nursing note for 11 AM, signed by Employee I, stated the following: "250 cc's of Pediasure given via GT-followed c 70 cc H2O flush." C. A clinical nursing note for 9-8-17 at 8:05 AM, signed by the Employee I, stated the following: "250 cc of Pediasure given via GT, following with 70 cc H2O." A clinical nursing note for 11 AM, signed by Employee I, stated the following: "250 cc's of Pediasure given via GT-followed c 70 cc H2O flush." D. During a home visits on 9-18-17 at		reassessment & supervisory visits to ensure that there is no variance between the amounts being administered and the plan of treatment, the medical records, and the clinical documentation. Quarterly chart audits will ensure that gastric tube feedings are accurately recorded. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	

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	15K011	A. BUILDING 00 B. WING	09/22/2017

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	12:27 PM and on 9-19-17 at 10:45 AM, Employee I was observed to administer Pedisure by gravity into the gastric tube of Patient # 1. The label of the Pediasure was examined and the content amount was listed as 237 ml. E. An interview was conducted with Employee I, on 9-19-17 at 10:35 AM. Employee I reported he/she had given 1 can of Pedisure (237 ml) and had incorrectly documented 240 ml in the clinical notes and gave 80 ml of water after the Pedisure and had incorrectly documented 70 ml in the clinical notes. F. An interview with Employee B, the clinical manager was conducted on 9-18-17 at 1:30 PM. The clinical manager validated the tube feeding amount on the plan of treatment orders and the nurses documentation should have been 237 ml of Pedisure and 80 ml of water.			
N 0610	410 IAC 17-15-1(a)(7)			

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Bldg. 00	Clinical Records Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview the agency failed to complete the clinical record to include dates and signatures for all verbal order and discharge summaries, updated and current drug profile and dietary orders in 9 of 10 records reviewed. (Patient # 1, 2, 3, 5, 6, 7, 8, 9,10) Findings include: 1. The plan of treatment dated 8-30-17 to 10-28-17 for Patient # 1 was reviewed on 9-19-17. The verbal start of care section, signed by Employee B, failed to have documentation of a time and date the order was received. A. The nutritional orders were as follows: "Pediasure 240 cc+8 H2O, GT(gastric tube) 1 can formula +80 ml's H2O flush AM, 11 AM, and 5 PM." On 9-18-17 during a home visit the correct amount of 237 ml was observed on the Pediasure label. B. An interview with Employee B, the clinical manager was conducted on 9-18-17 at 1:30 PM. The clinical manager	N 0610	**N610 –** The Clinical Manager and nursing staff have been inserviced on the requirement that all verbal orders & discharge summaries must have a signature, date & time that the order was received or the summary was written. The Clinical Manager & nursing staff have been inserviced on accurately documenting gastric tube feedings & flushes in the clinical record. The Clinical Manager and nursing staff have been inserviced on the requirement that all updated & current medications, OTC medications, allergies, dietary orders, fluid restrictions, will be included on the plan of treatment & medication record. Quarterly chart & documentation audits will ensure that all the above measures are included on the plan of treatment and medication record. The Clinical Manager will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	11/17/2017

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validated the tube feeding amount on the plan of treatment orders should have been 237 ml of Pedisure.

2. The plan of treatment dated 7-9-24 to 9-24-17 for Patient # 2 was reviewed on 9-19-17. The verbal start of care section, signed by Employee F, failed to evidence documentation of a time and date the order was received.

3. The plan of treatment dated 1-9-14 to 3-9-14 for Patient #3 was reviewed on 9-19-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the was received.

4. The plan of treatment dated 12-21-17 to 2-18-17 for Patient # 5 was reviewed on 9-20-17.

A. The verbal start of care section, signed by Employee HHA, failed to evidence documentation of a time and date the order was received.. The medication profile and plan of care failed to include the following medications and allergy the dialysis agency reported: Heparin 3,000 unit bolus IV at the start of dialysis treatment and 3,000 additional units IV during dialysis treatment, the subclavin dialysis catheter had Heparin dwell 2,200 units in the arterial port and

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	2,300 units in the venous port, Venofer 50 mg/kg IV(intravenous) weekly, Epogen 6,800 mcg every 3 weeks IV, Tylenol 650 mg 1 tablet orally every 4-6 hours as needed for headache or pain. The Hepatitis B vaccination series was being given, # 2 due 10-11-17. The dialysis center has "Gadolinium" listed as an allergy. The home health agency has listed no known drug allergies. B. The dialysis dietician explained patient's current daily diet orders as follows: 1800 AK/cal, Protein 100 grams, 1500 ml (milliliter) fluid restriction , 2 gram sodium, 3 gram potassium and 1200 milligram phosphorous. Nephro (renal supplement) 2 cans on non-dialysis days and 1 can on dialysis days. The plan of care for 8-18-17 to 10-16-17 had the following diet listed : NAS (no added salt) 1500 cal, soft cut up food, renal diet. The agency failed to revise the patients diet to reflect current dialysis orders. 5. The plan of treatment dated 2-22-17 to 4-22-17 for Patient # 6 was revived on 9-21-17. The verbal start of care section , signed by Employee B, failed to evidence documentation of a time and date the order was received. The discharge summary failed to have a signature, date or time when the summary was completed.			

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	6. The clinical record for Patient #7 was reviewed on 9-21-17. The medication profile last updated 12-27-16 and the plan of care dated 12-28-16 to 2-25-17 had the following documentation : "Warfarin 1 mg as directed po ." The entry is incomplete with frequency for medication. A fax from the patients physician, dated 1-5-17 had the following order: "Warfarin 1 mg on Monday and 2 mg all other days. We will have mobile lab retest in 10 days." The agency failed to update the medication record with changes in Warfarin. The discharge summary for Patient # 7 failed to have a signature, date and time when the summary was completed. 7. The plan of treatment dated 8-9-17 to 10-7-17 for Patient #8 was reviewed on 9-21-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 8. The plan of treatment dated 4-3-17 to 6-1-17 for Patient #9 was reviewed on 9-22-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 9. The plan of treatment dated 2-2-17 to			

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	3-1-17 for Patient #10 was reviewed on 9-22-17. The verbal start of care section, signed by Employee B, failed to evidence documentation of a time and date the order was received. 10. An agency policy titled, "Plan of Care C-580" was reviewed. The policy stated, "Home care services are furnished under the supervision and direction of the patient's physician ... The Plan of Care shall be completed in full to include: ... type, frequency and duration of all visits/services, medications, treatments and procedures, other appropriate items ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ... Verbal/telephone orders shall be obtained from the patient's physician for changes in the Plan of Care .... "			

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N 0614 Bldg. 00	410 IAC 17-15-1(c) Clinical Records Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service.			
	Based on observation, interview and record review, the agency failed to safeguard records stored in an outside building from loss in 1 of 1 agency. Findings include: 1. An observation of the agency medical records storage was conducted on 9-22-17 at 2:54 PM. The small wood constructed building is behind the agency with a lock on the double door. The west side of the building had loosened boards and nails around the base of the frame. Patient medical records area were stored in multiple plastic containers on the	N 0614	**N614**- The storage unit has been secured against any rain or snow leakage. Animals have never been able to get into our storage unit. Shelves have been built to get storage totes off the floor of the shed. Damaged storage totes are being replaced. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. Completion Date: 11/17/2017	11/17/2017

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	floor. Several of the containers and lids were broken or warped, which prevented them being sealed against water, dirt and animals. The inside west ceiling of the building had deteriorated wood eroding away. There were weeds around the north side of the building and several large spiders and spider webs were noted. 2. On 9-22-17 at 3:20 PM, Employee E reported there had been cats inside the records storage building. 3. The clinical nurse supervisor was present at the time of the observation 9-22-17 at 2:54 PM. He/She validated the containers were not sealed and needed to be replaced to secure the records. 4. An agency policy titled, "Clinical Records/Medical Record Retention C-870" was reviewed on 9-22-17. The policy states, "The clinical record information shall be safeguarded against loss ...stored in a secure area .... "			

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