### Statement of Deficiencies and Plan of Correction

- **Provider/Supplier/CLIA Identification Number:** 014024
- **Date Survey Completed:** 11/20/2017

#### Name of Provider or Supplier

**RABY HOME HEALTHCARE IN**

**8124 CALUMET AVE, REAR SUITE**

**MUNSTER, IN 46321**

#### Summary Statement of Deficiencies

- **N 000**
  - **Initial Comments**
    - This visit was for a Home Health Initial State licensure survey. On 11/20/17, per written agency request, the survey was ended.
    - Survey dates: 11/13/17 - 11/20/17
    - Facility #: 014024
    - Medicaid #: NA
    - Skilled Unduplicated Census: 8 patients
    - Active Census: 7 active patients
    - Discharged Census: 3 patients

- **N 400**
  - **410 IAC 17-10-1(a) Licensure**
    - Rule 10 Sec. 1(a) No home health agency shall:
      1. be opened;
      2. be operated;
      3. be managed;
      4. be maintained; or
      5. otherwise conduct business; without a license issued by the department.

    - This RULE is not met as evidenced by:

- **N 440**
  - **410 IAC 17-12-1(a) Home health agency administration/management**
    - Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be:
N 440 Continued From page 1

(1) clearly set forth in writing; and
(2) readily identifiable.

This RULE is not met as evidenced by:
Based on record review and interview, the agency failed to ensure 1 of 1 organizational chart was complete for 1 of 1 agency.

The findings include:

1. During the entrance conference on 11/13/17 at 11:15 AM, the organizational chart was requested to be presented within 1 hour.

2. On 11/14/17 at 11:40 AM, the organizational chart was requested. A copy was presented that was emailed to the agency at that time.

3. On 11/14/17 at 11:40 AM, the administrator indicated this organizational chart came from the nurse consultant.

4. A review of the organizational chart evidenced a chart with the following: a title of "Organizational Committee Chart." A flow chart began with "Board of Directors," to "Board of Directors," to "Administrator" to "Agency Supervisor." Under the box labeled "Agency Supervisor" was box with the following: "Physical Therapist," "Occupational Therapist," "Speech Therapist," and "Social Worker" and under this was a box with "Patient." Also under the box with Agency Supervisor was a box with "RN's," "LPNs" and HHAs" and under this box was "Patient." Off to the side under "Administrator" was a box with "Office Manager," "Biller," "Receptionist," and "Clerical Personnel." This was presented on 11/14/17 at 11:40 AM by the administrator.

5. A review of a second organizational chart
**Summary Statement of Deficiencies**

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<tr>
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<th>Provider’s Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Complete Date</th>
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<tr>
<td>N 440</td>
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<td></td>
<td>Continued From page 2 evidenced a chart with the following: a title of &quot;Raby Home Health Care.&quot; A flow chart began with &quot;Board of Directors,&quot; to &quot;Board of Directors,&quot; to &quot;Administrator&quot; to &quot;Agency Supervisor.&quot; Under the box labeled &quot;Agency Supervisor&quot; was box with the following: &quot;Physical Therapist&quot;, &quot;Occupational Therapist&quot;, &quot;Speech Therapist&quot;, and &quot;Social Worker&quot; and under this was a box with &quot;Patient.&quot; Also under the box with Agency Supervisor was a box with &quot;RN's,&quot; &quot;LPNs&quot; and &quot;HHAs&quot; and under this box was &quot;Patient.&quot; Off to the side under &quot;Administrator&quot; was a box with &quot;Office Manager,&quot; &quot;Biller,&quot; &quot;Receptionist,&quot; and &quot;Clerical Personnel.&quot; This was presented on 11/14/17 at 1:55 PM by the administrator.</td>
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<tr>
<td>N 444</td>
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<td>410 IAC 17-12-1(c)(1) Home health agency administration/management Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency’s ongoing functions.</td>
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This RULE is not met as evidenced by: Based on record review and interview, the administrator failed to ensure patients’ plans of care were signed in a timely manner by physicians and that the plans of care included the names and addresses of the patient's physicians for 10 of 10 records reviewed (#1 - 10).
The findings include:

1. A review of clinical record #1 evidenced failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 3/31/17 and certification period of 8/29/17 - 10/27/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one times a week for 9 weeks. Another similar plan of care for the certification period of 10/28/17 - 12/26/17 failed to evidence this second plan of care was signed by a physician.

2. A review of clinical record #2 failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 3/29/17 and certification period of 9/8/17 - 11/6/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one times a week for 9 weeks. Another similar plan of care for the certification period of 11/7/17 - 1/5/17 failed to evidence this second plan of care was signed by a physician.

3. A review of clinical record #3 failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 7/21/17 and certification period of 7/25/17 - 9/22/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one times a week for 9 weeks. Another similar plan of care for the certification period of 9/23/17 - 11/21/17 failed to evidence this second plan of care was signed by a physician.
4. A review of clinical record #4 failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 8/4/17 and certification period of 7/31/17 - 9/28/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one time a week for 9 weeks. Another similar plan of care for the certification period of 9/29/17 - 11/27/17 failed to evidence this second plan of care was signed by a physician.

During a phone interview on 11/17/17 at 3:20 PM, the office clerk of patient #4's physician indicated that a verbal order was found for August 2nd, 2017 and this was the last communication found in the physician's office records.

5. A review of clinical record #5 failed to evidence the plan of care was signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 10/9/17 and certification period of 10/9/17 - 12/7/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one time a week for 9 weeks.

6. A review of closed clinical record #6 evidenced a start of care date of 3/10/17. This plan of care for the certification period of 3/10/17 - 5/8/17 was not signed by a physician.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

014024

NAME OF PROVIDER OR SUPPLIER: RABY HOME HEALTHCARE INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 8124 CALUMET AVE, REAR SUITE, MUNSTER, IN 46321

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(N1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014024

(N2) MULTIPLE CONSTRUCTION

A. BUILDING: ____________________________

B. WING: ____________________________

(N3) DATE SURVEY COMPLETED:

11/20/2017

(N4) ID PREFIX TAG

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(N5) COMPLETE DATE

N 444 Continued From page 5

7. A review of closed clinical record #7 evidenced a start of care date of 3/10/17. The plan of care for the certification period of 3/10/17 - 5/8/17 was not signed by a physician.

During an interview on 11/17/17 at 3:05 PM, the office staff of patient #7's physician indicated there was no record of this home health agency's plan of care for patient #7 or other orders at this time.


9. A review of clinical record #9 evidenced a start of care date of 7/24/17 on the Home Health Certification and Plan of Care document for the certification period of 7/26/17 - 9/23/17. This plan of care document was not signed by the physician.

A. During an interview on 11/15/17 at 11:35 AM, the director of nursing did not respond to the question of why the physician name was not on the plan of care document.

B. During an interview on 11/20/17 at 11:38 AM, the writer asked the administrator / alternate director of nursing for the name of the physician for patient #9 and the administrator / alternate director of nursing indicated not knowing who the patient's physician was.

## N 444
Continued From page 6

Certification and Plan of Care document for the certification period of 3/16/17 - 5/14/17. This plan of care document was not signed by the physician and the name and address of the physician was not on this document.

11. The undated policy titled "Admission Criteria and Process" stated, "1. The patient must be under the care of a physician. The patient's physician [or other authorized licensed independent practitioner] must order and approve the provision of any service. A skilled service must be ordered ..." the clinical supervisor will assign clinical organization personnel to conduct initial assessments of eligibility for services within 48 hours of acceptance of referral information and / or discharge from referring facility. A. The initial assessment visit must be performed either 48 hours of the referral, within 48 hours of the patient's return home or on the start or care date ordered by the physician."

12. An undated policy titled "Computer Access to Information Policy No. 2 - 0.32.1" stated, "If the drug order is verbal or given by or through electronic transmission, it must be given only to a licensed nurse, nurse practitioner [where appropriate] pharmacist or physician. The individual receiving the order must record it, sign it immediately and have the prescribing person sign it in accordance with state and federal regulations. 4. Data will be protected by safeguards that prevent unauthorized access to information and / or modification of existing data ... Date and time of entries will be designated by the computer's internal clock. 7. Automated controls will be in place to prevent a change in entry.

13. During a phone interview on 11/17/17 at 4:20
PM, the office staff of the attending physician for
patient #2, #8, and closed record #10 indicated
that there were no communications from the
home health care agency in the office records
regarding these patients.

Rule 12 Sec. 1(e) The administrator shall be
responsible for an ongoing quality assurance
program designed to do the following:
(1) Objectively and systematically monitor and
evaluate the quality and appropriateness of
patient care.
(2) Resolve identified problems.
(3) Improve patient care.

This RULE is not met as evidenced by:
Based on record review and interview, the agency
failed to ensure the ongoing quality assurance
program was designed to objectively evaluate the
quality and appropriateness of patient care,
resolve identified problems, and improve patient
care for 1 of 1 agency.

Findings

1. During an interview on 11/16/17 at 3:40 PM,
the director of nursing indicated the quality
assurance program was not in effect yet.
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>N 472</td>
<td>Continued From page 8</td>
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<td>the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure the ongoing quality assurance program was designed to objectively evaluate the quality and appropriateness of patient care, resolve identified problems, and improve patient care for 1 of 1 agency. Findings 1. During an interview on 11/16/17 at 3:40 PM, the director of nursing indicated the quality assurance program was not in effect yet.</td>
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<tr>
<td>N 488</td>
<td>410 IAC 17-12-2(i) and (j) Q A and performance improvement</td>
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<td>Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the</td>
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Indiana State Department of Health

STATE FORM

QB7S11

If continuation sheet 9 of 56
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| continued From page 9 |

| home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. |
| (2) The patient refuses the home health agency's services. |
| (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or |
| (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. |

This RULE is not met as evidenced by:

Based on record review and interview, the agency failed to develop and implement a policy / procedure requiring a notice of discharge of service at least fifteen calendar days before the services are stopped for 1 of 1 agency.

The findings include:

1. The undated agency policy titled "Discharge Criteria and Process" stated, "The organization will verbally notify the patient of the decision to terminate or reduce services within one visit prior to discharge."
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** RABY HOME HEALTHCARE IN

**Address:** 8124 CALUMET AVE, REAR SUITE

**City, State, Zip Code:** MUNSTER, IN 46321

**Provider's Plan of Correction**

Each corrective action should be cross-referenced to the appropriate deficiency.

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<td>N 488</td>
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<tr>
<td>N 494</td>
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<td>410 IAC 17-12-3(a)(1)&amp;(2) Patient Rights</td>
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**Rule 12 Sec. 3(a)**
The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following:

1. Provide the patient with a written notice of the patient's right:
   - A) in advance of furnishing care to the patient; or
   - B) during the initial evaluation visit before the initiation of treatment.
2. Maintain documentation showing that it has complied with the requirements of this section.

This RULE is not met as evidenced by:

Based on record review, and interview, the agency failed to ensure patients had been informed of the patient rights in 10 of 10 records reviewed (#1 - 10).

The findings include:

1. A review of 10 clinical records evidenced the lack of patient's either receiving complete patient rights or patient rights. The records did not evidence identical patient rights documents. This is evidenced as follows:

   A. A review of the undated Patient Information handbook evidenced a document titled "Client Rights and Responsibilities." This document failed to evidence all of the patient rights including the right to be free of verbal, physical, and psychological abuse and the right to...
**NAME OF PROVIDER OR SUPPLIER**
RABY HOME HEALTHCARE IN

**STREET ADDRESS, CITY, STATE, ZIP CODE**
8124 CALUMET AVE, REAR SUITE
MUNSTER, IN 46321

**STATE FORM**
STATE FORM QB7S11

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 014024 |
| (X2) MULTIPLE CONSTRUCTION | A. BUILDING: ____________________________ |
|  | B. WING ____________________________ |
| (X3) DATE SURVEY COMPLETED | 11/20/2017 |

**NAME OF PROVIDER OR SUPPLIER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**STATE FORM**
STATE FORM QB7S11

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| (X4) ID | PREFIX | TAG |
| (X5) COMPLETE DATE |

**SUMMARY STATEMENT OF DEFICIENCIES**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

- **N 494** Continued From page 11
  - be informed of the state complaint number.

  **B.** During an interview on 11/16/17 at 4:16 PM, the director of nursing indicated the complete rights were not given to the patients.

  **C.** A review of clinical records #1 evidenced the patients and/or powers of attorney for the patients signed the "Patient Acknowledges Receipt of Patient Information Handbook. This was signed on 9/13/17 by the patient and director of nursing. This document showed the patient had received the Patient Rights and Responsibilities. This document failed to evidence all of the patient rights including the right to be free of verbal, physical, and psychological abuse and the right to be informed of the state complaint number.

  **D.** A review of clinical record #2 evidenced the patient received a document titled "Rights and Responsibilities" which failed to evidence the Indiana State Department of Health's Complaint Hotline number or the patient's right to be free of verbal, physical, and psychological abuse.

  **E.** A review of clinical record #3 evidenced the patient received the patient rights' agency document titled "Clients Rights and Responsibilities." This document was signed by the patient on 8/2/17. This document failed to evidence all of the patient rights including the right to be free of verbal, physical, and psychological abuse and the right to be informed of the state complaint number.

  **F.** A review of clinical record #4 evidenced the patient was instructed on the patient rights on the OASIS - C2 Start of Care document. This
# Summary Statement of Deficiencies

## Document Failed to Evidence All of the Patient Rights

A review of clinical record #5 evidenced the patient signed the "Patient Acknowledges Receipt of Patient Information Handbook". This was signed by the patient and director of nursing. This document showed the patient had received the Patient Rights and Responsibilities. This document was not dated. This document failed to evidence all of the patient rights including the right to be free of verbal, physical, and psychological abuse and the right to be informed of the state complaint number.

## Document Failed to Evidence All of the Patient Rights

A review of closed clinical record #6 evidenced the patient received a page of patient rights with no title. This was signed by the patient and/or patient representative on 3/3/17. This document failed to evidence all of the patient rights including the right to be free of verbal, physical, and psychological abuse and the right to be informed of the state complaint number.

## Document Failed to Evidence All of the Patient Rights

A review of clinical record #7 evidenced the patient was instructed on the patient rights on the OASIS - C2 Start of Care document. This document failed to evidence all of the patient rights including the right to be free of verbal, physical, and psychological abuse and the right to be informed of the state complaint number.

## Document Failed to Evidence All of the Patient Rights

A review of clinical record #8 evidenced the patient received a page of patient rights with no title. This was signed by the patient on 7/31/17. This document failed to evidence all of the patient rights including the right to be free of verbal, physical, and psychological abuse and the right to be informed of the state complaint number.
**Standards of Designation and Plan of Correction**

**Provider/Supplier/CLIA Identification Number:**

- **STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**
- **MULTIPLE CONSTRUCTION**
- **DATE SURVEY COMPLETED**

<table>
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<th>A. BUILDING:</th>
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**MULTIPLE CONSTRUCTION**

- **WING:**

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**Form Approved:** 01/19/2018

**Summary Statement of Deficiencies**

- **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)**
  - **COMPLETE DATE**

<table>
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<th>N 494</th>
<th>Continued From page 13 right to be informed of the state complaint number.</th>
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**K.** A review of clinical record #9 failed to evidence the patient received any patient rights documentation. This document failed to evidence all of the patient rights including the right to be free of verbal, physical, and psychological abuse and the right to be informed of the state complaint number.

**L.** A review of clinical record #10 evidenced the patient received a page of patient rights with no title. This was signed by the patient on 3/29/17. This document failed to evidence all of the patient rights including the right to be free of verbal, physical, and psychological abuse and the right to be informed of the state complaint number.

2. During an interview on 11/16/17 at 4:10 PM, the director of nursing indicated that the rights were not complete.

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<th>N 502</th>
<th>410 IAC 17-12-3(b)(2)(C) Patient Rights</th>
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**Rule 12 (b)** The patient has the right to exercise his or her rights as a patient of the home health agency as follows:

1. The patient has the right to the following:
2. Place a complaint with the department regarding treatment or care furnished by a home health agency.

This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure patients were provided the telephone number of the home health hotline established by the Indiana State Department of Health.
The findings include:

1. A review of clinical record #1 - #10 failed to evidence the patient received the telephone number and hours of operation of the home health hotline established by the Indiana State Department of Health. This is evidenced by the following:
   
   A. A review of the undated admission handbook evidenced a document titled "Client Rights and Responsibilities."

   B. A review of an undated document titled "Client Rights and Responsibilities" stated, "Clients have the right to ... be advised of the Illinois state Medicare Hotline phone number which receives complaints or questions about home care agencies - the number is 800 - 252 - 4343 which is accessible 24 hours a day, 7 days a week."

   C. During an interview on 11/16/17 at 4:05 PM, the director of nursing indicated the phone number in finding #B above was the Illinois Hotline number and not the Indiana Hotline number.

2. A review of clinical records #1 - #8 and #10 evidenced the patients / powers of attorney received the patient rights at the start of care.

3. A review of clinical record #9 failed to evidence the patient received the patient rights.
### Summary Statement of Deficiencies

This RULE is not met as evidenced by:

Based on record review and interview, the agency failed to ensure the patient was informed in advance about the care to be furnished by the home health agency for 1 of 3 closed records reviewed (#9).

The findings include:

1. A review of clinical record #9 failed to evidence the patient had received a written notice of the patient's rights in advance of care furnished to patient #9 about the care to be furnished. The patient started care on 8/9/17. This lack of information in an advance about the care to be furnished is evidenced by the following:

   A. A review of a clinical record document titled "OASIS C2 Start of Care" signed by the director of nursing on 8/9/17 evidenced the patient was seen for a start of care skilled nursing visit on this date.

   B. During an interview on 11/15/17 at 11:10 AM, the director of nursing indicated the rights...
2. A review of an undated document titled "Client Rights and Responsibilities" identified as the agency rights on 11/16/17 stated, "Clients have a right to be notified in writing of their rights and responsibilities before treatment begins and to exercise those rights ... Clients have the right to be notified in advance about the care that is to be furnished, the caregiver who will furnish the care, and the frequency of the visits, to be advised of any change in the plan of care, to participate in the planning changes in the care and to be advised that they have the right to do so, right to have family / cg [caregiver] coached on providing client care independently."

410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights

Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows:

(2) The patient has the right to the following:

(D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows:

(ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following:

(AA) The care or treatment.

(BB) Changes in the care or treatment.

This RULE is not met as evidenced by:

Based on record review and interview, the agency failed to ensure the patient was informed in advance about the care to be furnished by the
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<td>N 505</td>
<td>Continued From page 17</td>
<td>home health agency for 1 of 3 closed records reviewed (#9).</td>
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- The findings include:
  - A review of clinical record #9 failed to evidence the patient had received a written notice of the patient's rights in advance of care furnished to patient #9 about the care to be furnished. The patient started care on 8/9/17. This lack of information in an advance about the care to be furnished is evidenced by the following:
  - A review of a clinical record document titled "OASIS C2 Start of Care" signed by the director of nursing on 8/9/17 evidenced the patient was seen for a start of care skilled nursing visit on this date.
  - During an interview on 11/15/17 at 11:10 AM, the director of nursing indicated the rights had been signed but were not found in the record. She indicated the secretary had moved and now there are documents missing.
- A review of an undated document titled "Client Rights and Responsibilities" identified as the agency rights on 11/16/17 stated, "Clients have a right to be notified in writing of their rights and responsibilities before treatment begins and to exercise those rights ... Clients have the right to be notified in advance about the care that is to be furnished, the caregiver who will furnish the care, and the frequency of the visits, to be advised of any change in the plan of care, to participate in the planning changes in the care and to be advised that they have the right to do so, right to have family / cg [caregiver] coached on providing client care independently."
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#### 410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights

Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows:

- (2) The patient has the right to the following:
- (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows:
  - (iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice.

This RULE is not met as evidenced by:

Based on record review and interview, the agency failed to ensure the patient was informed in advance about the care to be furnished by the home health agency for 1 of 3 closed records reviewed (#9).

The findings include:

1. A review of clinical record #9 failed to evidence the patient had received a written notice of the patient's rights in advance of care furnished to patient #9 about the care to be furnished. The patient started care on 8/9/17. This lack of information in an advance about the care to be furnished is evidenced by the following:
   
   A. A review of a clinical record document titled "OASIS C2 Start of Care" signed by the director of nursing on 8/9/17 evidenced the patient was seen for a start of care skilled nursing visit on this date.

   B. During an interview on 11/15/17 at 11:10 AM, the director of nursing indicated the rights
Continued From page 19

had been signed but were not found in the record. She indicated the secretary had moved and now there are documents missing.

2. A review of an undated document titled "Client Rights and Responsibilities" identified as the agency rights on 11/16/17 stated, "Clients have a right to be notified in writing of their rights and responsibilities before treatment begins and to exercise those rights ... Clients have the right to be notified in advance about the care that is to be furnished, the caregiver who will furnish the care, and the frequency of the visits, to be advised of any change in the plan of care, to participate in the planning changes in the care and to be advised that they have the right to do so, right to have family / cg [caregiver] coached on providing client care independently."

410 IAC 17-12-3(e) Patient Rights

Rule 12 Sec. 3(e)

(e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

This RULE is not met as evidenced by:

Based on record review and interview, the agency failed to ensure patients had been provided with the most current description of Indiana state law regarding advance directives in 1 of 3 records reviewed (#9).

The findings include:
## Statement of Deficiencies and Plan of Correction

A. BUILDING: ____________________________________________  
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 014024  
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  
DATE SURVEY COMPLETED: ____________________________  
MULTIPLE CONSTRUCTION B. WING _____________________________  
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  
DATE SURVEY COMPLETED: ____________________________

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<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>N 518</td>
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### 1. A review of Clinical record #9 evidenced a start of care on 8/9/17 and failed to evidence the most current version of the description of Indiana state law regarding advance directives, "Your Right To Decide", dated July 2013, had been provided to the patients at the start of care. The patient's record failed to evidence the patient had signed the document titled "Client Rights and Responsibilities." This is further evidenced by the following:

### 2. A review of the undated "Client Rights and Responsibilities" stated, "Clients have the right to have health care providers comply with advanced directives in accordance with clients choices and in accordance with state law requirements."

### 3. During an interview on 11/15/17 at 11:10 AM, the director of nursing indicated the rights had been signed but were not found in the record. She indicated the secretary had moved and now there are documents missing.

### 410 IAC 17-13-1(a) Patient Care

Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.

This RULE is not met as evidenced by: Based on record review and interview, the agency failed to meet the patient's needs in the patient's residence for 1 of 2 patients referred to physical therapy for evaluation and treatment (#2).

The findings include:
### SECTION 1: SUMMARY STATEMENT OF DEFICIENCIES

1. A review of a communication note dated 11/3/17 evidenced patient #2 had been referred to physical therapy for evaluation and treatment. There was no evidence in the record that this physical therapy visit had been completed by 11/20/17.

2. A review of an incident / accident log dated 11/6/17 stated, "Patient / caregiver reported falls in resident home. Patient stated [he / she] was walking in kitchen and slipped ... hit [his / her] face on the wall and a little cut noted. Paramedics called and patient refused to go with them. MD [physician] notified of the falls."

3. A review of a skilled nurse visit dated 11/6/17 completed by the director of nursing evidenced the patient was instructed on strategies that can significantly help decrease the risk of a fall such as skid proof mats. There was no communication note about physical therapy and a need for physical therapy.

4. A review of a skilled nurse visit dated 11/13/17 completed by the director of nursing evidenced the patient was instructed on strategies that can significantly help decrease the risk of a fall such as skid proof mats. There was nothing on this note about physical therapy being ordered.

### SECTION 2: PROVIDER'S PLAN OF CORRECTION

#### Rule 13 Sec. 1(a) Patient Care

Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:
This RULE is not met as evidenced by:
Based on home visit observation, record review and interview, the agency failed to ensure care followed the plan of care for 3 of 5 records reviewed (#1, #3, #5) at home visit observations.

The findings include:

1. A review of clinical record #1 evidenced a plan of care for the certification period of 10/28/17 - 12/26/17 not signed by the physician. This plan of care evidenced the skilled nurse was to visit once a week for 9 weeks. At the visits, the skilled nurse was to assess patient filling medication box to determine if patient is preparing correctly. Skilled nurse was to complete a neurological examination at each visit. This lack of care following the plan of care is evidenced by the following:

   During a home visit observation on 11/13/17 at 12:45 PM, the director of nursing was observed to care for patient #1. The nurse was not observed to complete a neurological examination on this patient. The nurse was not observed to assess patient filling medication boxes.

2. A review of clinical record #3 evidenced a plan of care for the certification period of 9/23/17 - 11/21/17 not signed by the physician. This plan of care evidenced the skilled nurse was to visit once a week. At the visits, the skilled nurse was assess the effectiveness of pain medications. The skilled nurse was to instruct on bladder regimen. The skilled nurse was to complete a neurological assessment at each visit. The skilled nurse is to assess the caregiver filling medication box to determine if caregiver is preparing correctly. This is evidenced further by
**NAME OF PROVIDER OR SUPPLIER**
RABY HOME HEALTHCARE INC

**ADDRESS**
8124 CALUMET AVE, REAR SUITE
MUNSTER, IN 46321

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<td>N 522</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

- **A.** During a home visit observation on 11/13/17 at 3 PM, the director of nursing was observed to care for patient #3. The nurse was not observed to complete a neurological examination on this patient. The nurse was not observed to assess any caregiver filling medication boxes. The nurse was not observed to instruct the patient on a bladder regimen or Kegel exercises.

- **B.** During an interview on 11/17/17 at 11:31 AM, the director of nursing indicated completing a Neuro exam with this patient as well as instructing on Kegel exercise.

- **C.** During an interview on 11/17/17 at 11:40 AM, the director of nursing indicated the patient had patient caregivers available to assist the patient if needed.

- **3.** A review of clinical record #5 evidenced a plan of care for the certification period of 10/9/17 - 12/7/17 not signed by the physician. This plan of care evidenced the skilled nurse was to visit once a week. At the visits, the skilled nurse was to visit one times a week for 9 weeks. Skilled nurse was to instruct on bladder regimen. Skilled nurse to assess caregiver filling the medication box to determine if caregiver is filling correctly. Skilled nurse to complete a neurological examination. Physical therapist to evaluate and submit plan of treatment. The plan of care was not followed as evidenced below:

  - **A.** During a home visit observation on 11/13/17 at 4 PM, the skilled nurse was not observed to instruct the patient on bladder regimen, complete a neurological examination, or...
B. A review of record #5 failed to evidence a physical therapist had completed an evaluation or submitted a plan of treatment.

C. During an interview on 11/15/17 at 3 PM, the director of nursing indicated the patient had not wanted therapy. She indicated completing the neurological examination.

4. An undated policy titled "Neuro Assessment" stated, "Check sensory function a. have the client close his / her eyes b. Ask the client to voice when dull or sharp sensation is felt by alternate applications of the pointed and blunt ends of a pin to skin. 9. Assess motor function by observing gait, equality of hand grasps, and equality of leg / foot resistance. 10. Assess pupillary reaction: a. Dim room lights b. have the client look straight ahead. c. move the penlight from the side of the client's face and direct the light on the pupil. d. observe pupillary response of both eyes and measure the size in millimeters e. Inspect the eyelids for drooping. f. Assess facial symmetry."

5. An undated policy titled "Contents of Clinical Record" stated, "The following information will be available in the clinical record for patients receiving skilled care ... legible, complete and individualized diagnostic and therapeutic orders authenticated within the time frame defined by the organization or according to law and regulation."

N 524

410 IAC 17-13-1(a)(1) Patient Care

Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:
B. WING _____________________________

NAME OF PROVIDER OR SUPPLIER
RABY HOME HEALTHCARE IN
8124 CALUMET AVE, REAR SUITE
MUNSTER, IN 46321

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<th>TAG</th>
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<td>(A)</td>
<td>Be developed in consultation with the home health agency staff.</td>
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<td>(B)</td>
<td>Include all services to be provided if a skilled service is being provided.</td>
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<td>(B)</td>
<td>Cover all pertinent diagnoses.</td>
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<td>Include the following:</td>
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<td>Mental status.</td>
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<td>Types of services and equipment required.</td>
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<td>(iii)</td>
<td>Frequency and duration of visits.</td>
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<td>Prognosis.</td>
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<td>Rehabilitation potential.</td>
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<td>Functional limitations.</td>
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<td>Activities permitted.</td>
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<td>Nutritional requirements.</td>
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<td>Medications and treatments.</td>
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<td>Any safety measures to protect against injury.</td>
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<td>(xi)</td>
<td>Instructions for timely discharge or referral.</td>
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<td>(xii)</td>
<td>Therapy modalities specifying length of treatment.</td>
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This RULE is not met as evidenced by:
Based on home visit observation, record review and interview, the agency failed to ensure the plans of care were in place, complete, and accurate for 10 of 10 records reviewed (#1 - #10).

The findings include:

1. A review of clinical record #1 included a Home Health Certification and Plan of care document for the certification period of 10/28/17 - 12/26/17. This plan of care included a start of care date of 3/31/17 which was not accurate. The patient was visited on 9/13/17 by the director of nursing for a start of care assessment visit. The plan of care failed to include the physician's
name and address. This plan of care had not been signed or dated by the physician.

2. A review of clinical record #2 included Home Health Certification and Plans of Care documents for the certification periods of 7/10/17 - 9/7/17, 9/8/17 - 11/6/17, and 11/7/17 - 1/5/17. These plans of care failed to have the attending physician's signature and date signed, and the physician's name and address.

3. A review of clinical record #3 included Home Health Certifications and Plans of Care documents for the certification periods of 7/25/17 - 9/22/17, 9/23/17 - 2/17. These plans of care failed to have the attending physician's signature and date signed, and the physician's name and address.


   During a phone interview on 11/17/17 at 3:20 PM, the office clerk of patient #4's physician indicated that a verbal order was found for August 2nd, 2017 and this was the last communication found in the physician's office records.

5. A review of clinical record #5 evidenced a start of care date of 10/9/17 which was not an accurate date for a start of care. The patient's OASIS - C2 Start of Care document which showed the day care was initiated was completed on 10/30/17. This record included a Home Health Certification and Plan of Care document for the certification
Continued From page 27

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<td>N 524</td>
<td>Period of 10/9/17 - 12/7/17. This plan of care failed to have the attending physician's signature and date signed and the physician's name and address. This plan of care failed to evidence a left leg immobilizer and support brace the patient wears daily. An observation below evidenced this failure to document the left leg immobilizer on the plan of care: During a home visit observation on 11/13/17 at 4 PM, it was observed that patient #5 had a rollator and a left leg immobilizer with a brace to support the patient's left leg.</td>
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6. A review of closed clinical record #6 evidenced a start of care date of 3/10/17. This Home Health Certification and Plan of Care document for the certification period of 3/10/17 - 5/8/17 failed to evidence the attending physician's signature or date or the name and address of the physician.

7. A review of clinical record #7 evidenced a start of care date of 8/29/17. This plan of care for the certification period of 10/30/17 - 12/28/17 was not signed by the physician. The physician's name and address was not noted on the plan of care.

8. A review of clinical record #8 evidenced a start of care date of 7/28/17 on the Home Health Certification and Plan of care document with a certification period of 7/13/17 - 9/28/17 and another Home Health Certification and Plan of Care with a certification period of 9/29/17 - 11/27/17. These plans of care were not signed by the physician and did not include the physician's name or address. These plans of care evidenced the patient's address was in Gary, IN.

A partial Home Health Certification and Plan of Care document with the certification period of...
### Statement of Deficiencies and Plan of Correction

#### (X1) Provider/Supplier/CLIA Identification Number:

014024

#### (X2) Multiple Construction

A. Building: ______________________

B. Wing: ______________________

#### (X3) Date Survey Completed

11/20/2017

#### Name of Provider or Supplier

RABY HOME HEALTHCARE IN

8124 CALUMET AVE, REAR SUITE

MUNSTER, IN 46321

#### (X4) ID Prefix Tag

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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
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<td>9/29/17 - 11/27/17 evidenced the patient's address was in Nashville, IN.</td>
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<td>9.</td>
<td>A review of clinical record #9 evidenced a start of care date of 7/24/17 on the Home Health Certification and Plan of Care document for the certification period of 7/26/17 - 9/23/17. This plan of care document was not signed by the physician and the name and address of the physician was not on this document.</td>
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<td>A. During an interview on 11/15/17 at 11:35 AM, the director of nursing did not respond to the question of why the physician name was not on the plan of care document.</td>
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<td>B. During an interview on 11/20/17 at 11:38 AM, the writer asked the administrator / alternate director of nursing for the name of the physician for patient #9 and the administrator / alternate director of nursing indicated not knowing who the patient's physician was.</td>
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<td>10.</td>
<td>A review of clinical record #10 evidenced a start of care date of 3/29/17 on the Home Health Certification and Plan of Care document for the certification period of 3/16/17 - 5/14/17. This plan of care document was not signed by the physician and the name and address of the physician was not on this document.</td>
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<td>11.</td>
<td>The undated policy titled &quot;Admission Criteria and Process&quot; stated, &quot;1. The patient must be under the care of a physician. The patient's physician [or other authorized licensed independent practitioner] must order and approve the provision of any service. A skilled service must be ordered .... the clinical supervisor will assign clinical organization personnel to conduct...&quot;</td>
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The undated policy titled "Admission Criteria and Process" stated, "1. The patient must be under the care of a physician. The patient's physician [or other authorized licensed independent practitioner] must order and approve the provision of any service. A skilled service must be ordered .... the clinical supervisor will assign clinical organization personnel to conduct..."
### Summary of Deficiencies

#### N 524

Continued from page 29

- **Initial Assessments of Eligibility:**
  - Initial assessments of eligibility for services within 48 hours of acceptance of referral information and/or discharge from referring facility. A. The initial assessment visit must be performed either within 48 hours of the referral, within 48 hours of the patient's return home, or on the start or care date ordered by the physician.

- **Care Planning Process:**
  - A written plan of care will be initiated within five days of start of care and updated at least every 60 days or as patient's condition warrants. The patient plan of care will be developed or revised within 5 working days of initiation of each service or reassessment of the patient.

- **Physician Participation in Plan of Care:**
  - A physician will direct the care of every home health care patient admitted for service... the attending physician will participate in the care planning process by initiating, reviewing, and revising therapeutic and diagnostic orders... the attending physician will sign the plan of care/treatment within 30 days of the start of care... the attending physician recertification will be obtained in intervals of at least every 60 days when the patient's plan of care is reviewed, the patient recertified, and more often, if warranted.

- **Verification of Physician Orders:**
  - A qualified individual will review each order or prescription before care is provided... signed orders will be in the clinical record within 30 days of initiation of care or interim order, unless otherwise specified by applicable state law or regulation.

- **During a phone interview on 11/17/17 at 4:20**

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**Indiana State Department of Health**

**STATE FORM**

**If continuation sheet 30 of 56**

**QB7S11**
## Statement of Deficiencies and Plan of Correction

**A. Building:**

**Provider/Supplier/CLIA Identification Number:** 014024

**State:**

**Statement of Deficiencies and Plan of Correction**

**B. Wing:**

**Date Survey Completed:** 11/20/2017

### Name of Provider or Supplier

RABY HOME HEALTHCARE IN

8124 CALUMET AVE, REAR SUITE

MUNSTER, IN 46321

### Provider's Plan of Correction

*Each corrective action should be cross-referenced to the appropriate deficiency*

<table>
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<tr>
<th>ID</th>
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<th>Summary Statement of Deficiencies</th>
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| N 524 |  |  | Continued From page 30  
PM, the office staff of the attending physician for patient #2, #8, and closed record #10 indicated that there were no communications from the home health care agency in the office records regarding these patients. |  |
| N 529 |  |  | 410 IAC 17-13-1(a)(2) Patient Care  
Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the:  
(A) physician;  
(B) dentist;  
(C) chiropractor;  
(D) optometrist or  
(E) podiatrist;  
at least every two (2) months.  
This RULE is not met as evidenced by:  
Based on record review and interview, the agency failed to ensure written summary reports were completed and sent to the physician at least every 60 days for 1 of 10 records reviewed (#3).  
The findings include:  
1. A review of Clinical Record #3 evidenced a start of care 7/21/17. This record failed to evidence a 60 day summary had been completed within 60 days and sent to the physician summarizing the care the patient had received and the patient's condition for the certification period of 7/25/17 - 9/22/17. The patient received a OASIS C2 Recertification and continued care in the next certification period dated 9/23/17 - 11/21/17. The 60 day summary was dated 9/18/17 but was not created until 10/16/17 and not completed until 10/21/17. This is evidenced by the following: |  |
A. A review of a 60 day summary / Case Conference dated 9/18/17 and signed by the director of nursing evidenced this document had been created on 10/16/17 and completed on 10/21/17.

2. During an interview on 11/17/17 at 11:50 AM, the director of nursing indicated the summary was not completed timely.

N 537
410 IAC 17-14-1(a) Scope of Services

Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows:

This RULE is not met as evidenced by:
Based on home visit observation, record review and interview, the agency failed to ensure the registered nurse (the director of nursing) followed the plan of care for 3 of 5 records reviewed (#1, #3, #5) at home visit observations.

The findings include:

1. A review of clinical record #1 evidenced a plan of care for the certification period of 10/28/17 - 12/26/17 not signed by the physician. This plan of care evidenced the skilled nurse was to visit once a week for 9 weeks. At the visits, the skilled nurse was to assess patient filling medication box to determine if patient is preparing correctly. Skilled nurse was to complete a neurological examination at each visit. This lack of care following the plan of care is evidenced by the following:
### A. BUILDING: ________________

#### PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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#### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 014024

**A. BUILDING:** ________________  **B. WING** ________________

**DATE SURVEY COMPLETED:** 11/20/2017

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**NAME OF PROVIDER OR SUPPLIER:** RABY HOME HEALTHCARE IN

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

8124 CALUMET AVE, REAR SUITE

MUNSTER, IN 46321

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**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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<tbody>
<tr>
<td></td>
<td><strong>During a home visit observation on 11/13/17 at 12:45 PM, the director of nursing was observed to care for patient #1. The nurse was not observed to complete a neurological examination on this patient. The nurse was not observed to assess patient filling medication boxes.</strong></td>
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2. A review of clinical record #3 evidenced a plan of care for the certification period of 9/23/17 - 11/21/17 not signed by the physician. This plan of care evidenced the skilled nurse was to visit once a week. At the visits, the skilled nurse was to assess the effectiveness of pain medications. The skilled nurse was to instruct on bladder regimen. The skilled nurse was to complete a neurological assessment at each visit. The skilled nurse is to assess the caregiver filling medication box to determine if caregiver is preparing correctly. This is evidenced further by the following:

A. **During a home visit observation on 11/13/17 at 3 PM, the director of nursing was observed to care for patient #3. The nurse was not observed to complete a neurological examination on this patient. The nurse was not observed to assess any caregiver filling medication boxes. The nurse was not observed to instruct the patient on a bladder regimen or Kegel exercises.**

B. **During an interview on 11/17/17 at 11:31 AM, the director of nursing indicated completing a neuro exam with this patient as well as instructing on Kegel exercise.**

C. **During an interview on 11/17/17 at 11:40 AM, the director of nursing indicated the patient had patient caregivers available to assist the patient if needed.**
### Summary Statement of Deficiencies

#### N 537

Continued From page 33

3. A review of clinical record #5 evidenced a plan of care for the certification period of 10/9/17 - 12/7/17 not signed by the physician. This plan of care evidenced the skilled nurse was to visit once a week. At the visits, the skilled nurse was to visit one time a week for 9 weeks. Skilled nurse was to instruct on bladder regimen. Skilled nurse to assess caregiver filling the medication box to determine if caregiver is filling correctly. Skilled nurse to complete a neurological examination. Physical therapist to evaluate and submit plan of treatment. The plan of care was not followed as evidenced below:

   A. During a home visit observation on 11/13/17 at 4 PM, the skilled nurse was not observed to instruct the patient on bladder regimen, complete a neurological examination, or assess if caregiver filling the medication box to determine if caregiver is filling correctly.

   B. A review of record #5 failed to evidence a physical therapist had completed an evaluation or submitted a plan of treatment.

   C. During an interview on 11/15/17 at 3 PM, the director of nursing indicated the patient had not wanted therapy. She indicated completing the neurological examination.

4. An undated policy titled "Neuro Assessment" stated, "Check sensory function a. have the client close his / her eyes b. Ask the client to voice when dull or sharp sensation is felt by alternate applications of the pointed and blunt ends of a pin to skin. 9. Assess motor function by observing gait, equality of hand grasps, and equality of leg / foot resistance. 10. Assess pupillary reaction: a. Dim room lights b. have the client look straight
N 537 Continued From page 34

a. move the penlight from the side of the client's face and direct the light on the pupil. d. observe pupillary response of both eyes and measure the size in millimeters e. Inspect the eyelids for drooping. f. Assess facial symmetry."

5. An undated policy titled "Contents of Clinical Record" stated, "The following information will be available in the clinical record for patients receiving skilled care ... legible, complete and individualized diagnostic and therapeutic orders authenticated within the time frame defined by the organization or according to law and regulation."

N 540 410 IAC 17-14-1(a)(1)(A) Scope of Services

Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:
(A) Make the initial evaluation visit.

This RULE is not met as evidenced by:
Based on record review and interview, the agency failed to ensure the registered nurse completed an initial assessment for 10 of 10 clinical records reviewed (#1 - #10).

The findings include:

1. A review of record #1 evidenced a OASIS [outcome and assessment information set]- C2 Start of Care visit assessment document dated 9/13/17 completed by the director of nursing. The comprehensive assessment was the first visit documented and included OASIS data elements. A review of this record failed to evidence a
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2. A review of record #2 failed to evidence an initial assessment had been completed.

3. A review of record #3 evidenced an OASIS - C2 Start of Care visit assessment document completed by the director of nursing. This document evidenced a comprehensive assessment with OASIS data elements. A review of this record failed to evidence a separate initial assessment had been completed before the start of care of 8/3/17.

4. A review of record #4 evidenced an OASIS - C2 Start of Care visit assessment document completed by the director of nursing. This document evidenced a comprehensive assessment with OASIS data elements. A review of this record failed to evidence a separate initial assessment had been completed before the start of care of 8/4/17.

5. A review of record #5 evidenced an OASIS - C2 Start of Care visit assessment document completed by the director of nursing. This document evidenced a comprehensive assessment with OASIS data elements. A review of this record failed to evidence a separate initial assessment had been completed before the start of care of 10/30/17.

6. A review of record #6 evidenced an OASIS - C2 Start of Care visit assessment document completed by the director of nursing. This document evidenced a comprehensive assessment with OASIS data elements. A review of this record failed to evidence a separate initial assessment had been completed before the start of care of 8/3/17.
7. A review of record #7 evidenced an OASIS - C2 Start of Care Visit assessment completed by the director of nursing. The initial and comprehensive assessment were combined in one visit with OASIS data elements. A review of this record failed to evidence a separate initial assessment had been completed before the start of care of 11/2/17.

During an interview on 11/16/17 at 11:40 AM, the director of nursing indicated the initial assessment was not in the record. The initial assessments had been completed but had not been documented in the clinical record.

8. A review of record #8 evidenced an OASIS - C2 Start of Care visit assessment completed by the director of nursing. The comprehensive assessment was the first visit documented and included OASIS data elements. A review of this record failed to evidence a separate initial assessment had been completed before the start of care of 7/13/17.

9. A review of record #9 evidenced an OASIS - C2 Start of Care visit assessment completed by the director of nursing. The comprehensive assessment was the first visit documented and included OASIS data elements. A review of this record failed to evidence a separate initial assessment had been completed before the start of care of 8/9/17.

10. A review of record #10 evidenced an OASIS - C2 Start of Care Visit assessment completed by the director of nursing. The comprehensive assessment was the first visit and included OASIS data elements. A review of this record...
**Summary Statement of Deficiencies**

**N 540** Continued From page 37

Failed to evidence a separate initial assessment had been completed before the start of care on 3/29/17.

11. The undated policy titled "Admission Criteria and Process" stated, "1. The patient must be under the care of a physician. The patient's physician [or other authorized licensed independent practitioner] must order and approve the provision of any service. A skilled service must be ordered .... the clinical supervisor will assign clinical organization personnel to conduct initial assessments of eligibility for services within 48 hours of acceptance of referral information and / or discharge from referring facility. A. The initial assessment visit must be performed either 48 hours of the referral, within 48 hours of the patient's return home or on the start or care date ordered by the physician."

**N 544** 410 IAC 17-14-1(a)(1)(E) Scope of Services

Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:

(E) Prepare clinical notes.

This RULE is not met as evidenced by:

Based on record review and interview, the agency failed to ensure the registered nurse (director of nursing) prepared clinical visit notes accurately for 4 of 7 active charts reviewed with skilled nursing (#1 - 3 and #7).

The findings include:

1. A review of a skilled nurse visit with patient #1 dated 11/13/17 with patient #1 and signed by the
**Summary Statement of Deficiencies**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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The director of nursing failed to evidence an accurate and complete clinical note and completion of orders for discipline and treatments on the plan of care. This note evidenced the nurse visited from 12 - 1 PM. The visit began approximately at 12:40 PM and was over at 1:10 PM. During the visit, patient complained of pain in the abdomen. This abdominal pain was not mentioned on the visit note. The pain profile evidenced the patient experienced pain in the low back and was aching. During the visit, patient #1 complained of stomach pain with a frequency of every morning until the patient ate breakfast. The nurse was not observed to complete a neurological exam on this patient or observed to assess the patient filling medication boxes. This is evidenced by the following observation and treatment interventions to be completed at a skilled nurse home visit:

A. A review of clinical record #1 included a plan of care for the certification period of 11/7/17 - 1/5/17 with orders for discipline and treatments. The skilled nurse was to complete one visit every week for 9 weeks. This plan of care evidenced the skilled nurse was to assess patient filling medication box to determine if patient is preparing correctly. Skilled nurse was to complete a neurological examination at each visit. The skilled nurse was to assess and instruct on pain management.

B. During a home visit observation on 11/13/17 at 12:40 PM, the director of nursing was observed to enter the home of patient #1 for a skilled nurse visit. During the visit, patient complained of stomach pain that was relieved upon eating breakfast. The patient indicated this stomach pain occurred daily. The nurse was not observed to complete a neurological examination on this patient. The nurse was not observed to...
### N 544

Continued From page 39

assess patient filling medication boxes. The skilled nurse visit was complete at 1:10 PM.

2. A review of a skilled nurse visit with patient #2 dated 11/13/17 with patient #2 and signed by the director of nursing failed to evidence an accurate and complete clinical note and completion of orders for discipline and treatments on the plan of care. This note evidenced the nurse visited from 1 - 2 PM. The visit began approximately at 1:55 PM and was completed at 2:25 PM. This is evidenced by the following:

   A. A review of clinical record #2 included a plan of care for the certification period of 11/7/17 - 1/5/18 with orders for discipline and treatments. The skilled nurse was to complete one visit every week for 9 weeks. Skilled nurse was to complete a neurological examination at each visit. The skilled nurse was to assess the effectiveness of pain medications.

   B. During a home visit observation on 11/13/17 at 1:55 PM, the director of nursing was observed to enter the home of patient #2 for a skilled nurse visit. The nurse was not observed to complete a neurological examination on this patient. The skilled nurse visit was complete at 2:30 PM.

3. A review of a skilled nurse visit with patient #3 dated 11/13/17 with patient #3 and signed by the director of nursing failed to evidence an accurate and complete clinical note and completion of orders for discipline and treatments on the plan of care. This note evidenced the nurse visited from 3 - 4 PM. The visit began approximately at 3 PM and was completed by 3:25 PM. This is evidenced by the following:
A. A review of clinical record #3 included a plan of care for the certification period of 9/23/17 - 11/21/17 with orders for discipline and treatments. The skilled nurse was to complete one visit every week for 9 weeks. Skilled nurse was to complete a neurological examination at each visit. The skilled nurse was to assess the effectiveness of pain medications.

B. During a home visit observation on 11/13/17 at 3 PM, the director of nursing was observed to enter the home of patient #3 for a skilled nurse visit. The nurse was not observed to complete a neurological examination on this patient. The skilled nurse visit was complete at 3:25 PM.

4. A review of clinical record #7 evidenced a start of care date of 8/29/17. The record evidenced an OASIS C2 Start of Care Assessment completed by the director of nursing on 11/2/17. There had been a delay in the start of care and evaluation for PT / OT and this was explained by the director of nursing. A referral evidenced PT / OT were needed. The plan of care evidenced the nurse was to assess the pain level and effectiveness of pain medications and current pain management therapy every visit. The plan of care and the medication profile documents did not evidence any pain medication on these documents. This is evidenced by the following:

   A. A review of a referral / response letter dated 10/30/17 and signed by the physician stated, "Per [physician] evaluation and treat for PT / OT and Nursing services."

   B. A review of a "Home Health Certification and Plan of Care" document for the certification period of 10/30/17 - 12/28/17 evidenced no
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Tylenol or other pain medications listed under the patient's medications. The skilled nurse was to visit one time a week for 9 weeks. The orders included the skilled nurse was to assess pain level and effectiveness of pain medications and current pain management therapy every visit. Skilled nurse was to instruct patient to take pain medication before pain becomes severe to achieve better pain control.

C. A review of an OASIS C-2 Start of care document dated 11/2/17 signed by the director of nursing evidenced the pain had a pain level of a "6" on a 10 point scale with "0" being no pain and "10" being the most severe pain. A question on the document asked, "What makes the pain better?" The answer was rest, relaxation and medication.

D. A review of a medication profile document dated 11/2/17 signed by the director of nursing failed to evidence the patient had any pain medications ordered.

E. During an interview on 11/15/17 at 3:25 PM, the director of nursing indicated the physical therapy and occupational therapy evaluations were discussed with the patient representative. The director of nursing stated, "I don't know if I put in the notes. The [patient representative] has been calling since August and did not receive the orders at the home office."

5. The undated policy "Pain Assessment" stated, "When the patient or the clinician identifies pain, the following in-depth pain assessment information should be obtained whenever possible: A. Pain intensity using a rating scale [on a scale of 0 - 10: 0 = no pain; 10 = unbearable pain] Pain intensity should include current pain,
## Statement of Deficiencies and Plan of Correction

### Building:
- PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
  - (X1) 014024
- MULTIPLE CONSTRUCTION B. WING
  - (X2) 11/20/2017

### Name of Provider or Supplier
- RABY HOME HEALTHCARE IN
- 8124 CALUMET AVE, REAR SUITE
- MUNSTER, IN 46321

### Summary Statement of Deficiencies

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<td>N 547</td>
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- ...worst pain, and least pain using the scale. A separate, age appropriate, pain scale may be used for children. B. Pain location C. Pain quality, patterns of radiation, and character ... D. Pain onset, duration, variations, and patterns #. Alleviating and aggravating factors. F. Present pain management regimen and effectiveness. G. Pain management history ... H. Effects of pain - these include impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration ... I. The patient's pain goal including pain intensity and goals related to function, activities, and quality of life j. Physical examination of the site of pain K. Secondary symptoms related to pain such as nausea, vomiting, respiratory distress or nutritional symptoms.

#### N 547 410 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).

  This RULE is not met as evidenced by:

  Based on record review and interview, the agency failed to ensure the physicians' verbal, telephone, and plan of care orders were signed and dated by the physician and that all physician orders placed in the clinical record for 10 of 10 records reviewed were completed, sent to the physician, and signed by the physician in a timely manner (#1-#10).

  The findings include:
**NAME OF PROVIDER OR SUPPLIER:** RABY HOME HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 8124 CALUMET AVE, REAR SUITE MUNSTER, IN 46321

<table>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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1. A review of clinical record #1 evidenced failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 3/31/17 and certification period of 8/29/17 - 10/27/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one times a week for 9 weeks. Another similar plan of care for the certification period of 10/28/17 - 12/26/17 failed to evidence this second plan of care was signed by a physician.

2. A review of clinical record #2 failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 3/29/17 and certification period of 9/8/17 - 11/6/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one times a week for 9 weeks. Another similar plan of care for the certification period of 11/7/17 - 1/5/17 failed to evidence this second plan of care was signed by a physician.

3. A review of clinical record #3 failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 7/21/17 and certification period of 7/25/17 - 9/22/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one times a week for 9 weeks. Another similar plan of care for the certification period of 9/23/17 - 11/21/17 failed to evidence this second plan of care was signed by a physician.
During an interview on 11/17/17 at 2:10 PM, the office clerk for the physician of patient #3 indicated there had been a referral to Raby Home Health on 7/14/17.

4. A review of clinical record #4 failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 8/4/17 and certification period of 7/31/17 - 9/28/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one time a week for 9 weeks. Another similar plan of care for the certification period of 9/29/17 - 11/27/17 failed to evidence this second plan of care was signed by a physician.

During a phone interview on 11/17/17 at 3:20 PM, the office clerk of patient #4's physician indicated that a verbal order was found for August 2nd, 2017 and this was the last communication found in the physician's office records.

5. A review of clinical record #5 failed to evidence the plan of care was signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 10/9/17 and certification period of 10/9/17 - 12/7/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one time a week for 9 weeks.

6. A review of closed clinical record #6 evidenced a start of care date of 3/10/17. This plan of care for the certification period of 3/10/17 - 5/8/17 was not signed by a physician.

7. A review of closed clinical record #7 evidenced...
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<td>a start of care date of 3/10/17. The plan of care for the certification period of 3/10/17 - 5/8/17 was not signed by a physician.</td>
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<tr>
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<td>During an interview on 11/17/17 at 3:05 PM, the office staff of patient #7's physician indicated there was no record of this home health agency's plan of care for patient #7 or other orders at this time.</td>
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9. A review of clinical record #9 evidenced a start of care date of 7/24/17 on the Home Health Certification and Plan of Care document for the certification period of 7/26/17 - 9/23/17. This plan of care document was not signed by the physician.

A. During an interview on 11/15/17 at 11:35 AM, the director of nursing did not respond to the question of why the physician name was not on the plan of care document.

B. During an interview on 11/20/17 at 11:38 AM, the writer asked the administrator / alternate director of nursing for the name of the physician for patient #9 and the administrator / alternate director of nursing indicated not knowing who the patient's physician was.

10. A review of clinical record #10 evidenced a start of care date of 3/29/17 on the Home Health Certification and Plan of Care document for the certification period of 3/16/17 - 5/14/17. This plan...
of care document was not signed by the physician and the name and address of the physician was not on this document.

11. The undated policy titled "Admission Criteria and Process" stated, "1. The patient must be under the care of a physician. The patient's physician [or other authorized licensed independent practitioner] must order and approve the provision of any service. A skilled service must be ordered .... the clinical supervisor will assign clinical organization personnel to conduct initial assessments of eligibility for services within 48 hours of acceptance of referral information and / or discharge from referring facility. A. The initial assessment visit must be performed either 48 hours of the referral, within 48 hours of the patient's return home or on the start or care date ordered by the physician."

12. The undated policy titled "Care Planning Process" stated, "A written plan of care will be initiated within five days of start of care and updated at least every 60 days or as patient's condition warrants. The patient plan of care will be developed or revised within 5 working days of initiation of each service or of the reassessment of the patient."

13. The undated policy titled "Physician Participation in Plan of Care" stated, "A physician will direct the care of every home health care patient admitted for service ... the attending physician will participate in the care planning process by initiating, reviewing and revising therapeutic and diagnostic orders ... the attending physician will sign the plan of care / treatment within 30 days of the start of care ... the attending physician recertification will be obtained in intervals of at least every 60 days when the
### Statement of Deficiencies and Plan of Correction

#### Indiana State Department of Health

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#### Name of Provider or Supplier

**RABY HOME HEALTHCARE IN**

8124 CALUMET AVE, REAR SUITE

MUNSTER, IN 46321

#### Name of Provider or Supplier

**RABY HOME HEALTHCARE IN**

8124 CALUMET AVE, REAR SUITE

MUNSTER, IN 46321

#### Summary Statement of Deficiencies

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<td>N 608</td>
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Patient's plan of care is reviewed, the patient recertified, and more often, if warranted.

14. The undated policy titled "Verification of Physician Orders" stated, "A qualified individual will review each order or prescription before care is provided ... signed orders will be in the clinical record within 30 days of initiation of care or interim order, unless otherwise specified by applicable state law or regulation."

**410 IAC 17-15-1(a)(1-6) Clinical Records**

Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows:

1. The medical plan of care and appropriate identifying information.
2. Name of the physician, dentist, chiropractor, podiatrist, or optometrist.
3. Drug, dietary, treatment, and activity orders.
4. Signed and dated clinical notes contributed by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days.
5. Copies of summary reports sent to the person responsible for the medical component of the patient's care.
6. A discharge summary.

This RULE is not met as evidenced by:

Based on record review and interview, the agency failed to ensure clinical records were maintained in accordance with professional standards and were complete and accurate for 10 of 10 records reviewed (#1 - 10).

The findings include:
### N 608

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Regarding clinical records which showed work log notes completed or created during the survey dates and without late entry dates and times

1. A review of Clinical Record #2 and a communication note dated 8/2/17 with no clinician signature evidenced a note was completed months after the note’s date. The initial note stated, "Patient states to skilled nurse that physical therapy will not be needed because [he/she] goes to swimming pool for exercises." This note’s creation occurred on 11/15/17. This is evidenced by the following:

   A. A review of the work log dated 11/15/17 and accessed on 11/17/17 from the electronic medical record evidenced this note had been created on 11/15/17 by the director of nursing.

   B. During an interview on 11/15/17 at 1:20 PM, the director of nursing indicated refreshing the work that she had completed.

2. A review of Clinical Record #3 evidenced a start of care 7/21/17. This record failed to evidence a 60 day summary had been completed within 60 days and sent to the physician summarizing the care the patient had received and the patient’s condition for the certification period of 7/25/17 - 9/22/17. The patient received a OASIS C2 Recertification and continued care in the next certification period dated 9/23/17 - 11/21/17. The 60 day summary was dated 9/18/17 but was not created until 10/16/17 and not completed until 10/21/17. This is evidenced by the following:

   A. A review of a 60 day summary / Case Conference dated 9/18/17 and signed by the
N 608 Continued From page 49

director of nursing evidenced this document had been created on 10/16/17 and completed on 10/21/17.

B. During an interview on 11/17/17 at 11:50 AM, the director of nursing indicated the summary was not completed timely.

3. A review of Clinical Record #6 evidenced a communication note dated 4/25/17 and signed by the director of nursing. The communication note stated, "Patient / caregiver going to outpatient rehab for physical. MD office made aware and they confirmed okay to discharge patient to outpatient therapy." The work log evidenced this note was created on 11/15/17 at 12:18 PM by the director of nursing.

   During an interview on 11/16/17 at 11:42 AM, the director of nursing indicated the work log showed the creation of the above note on 11/15/17.

4. A review of Clinical Record #7 evidenced the plan of care listed the start of care date as 8/29/17 and the certification date on the plan of care as 10/30/17 - 12/28/17. The record evidenced a start of care as 11/2/17. This is evidenced as follows:

   A. A review of a document titled "Home Health Certification and Plan of Care" with a start of date of 8/29/17 and certification period of 10/30/17 - 12/26/17. This plan of care did not list the physician’s name or address. This plan of care was signed by the director of nursing on 11/2/17.

   B. A review of a document titled "OASIS C 2 Start of Care" dated 11/2/17 and signed by the
Continued From page 50

director of nursing on this date evidenced a first start of care visit from the director of nursing for a skilled nursing assessment with OASIS data elements.

C. During an interview on 11/15/17 at 3:25 PM, the director of nursing indicated the patient caregiver had been calling to get on service since August. The physician office had not given the order until late October and this is in the referral log. [The referral log could not be found].

5. A review of Clinical Record #8 evidenced Home Health Certification and plan of care document listed the start of care date as 7/28/17. These plans of care with certification periods of 7/31/17 - 9/28/17 and 9/29/17 - 11/27/17 did not list the physician's name or address. Dates in the record did not correspond with the timeline seen in these documents. This is evidenced by the following:

Regarding verbal orders / plans of care not signed by physicians

6. A review of clinical record #1 evidenced failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 3/31/17 and certification period of 8/29/17 - 10/27/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one times a week for 9 weeks. Another similar plan of care for the certification period of 10/28/17 - 12/26/17 failed to evidence this second plan of care was signed by a physician.

7. A review of clinical record #2 failed to evidence two plans of care were signed by the
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physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 3/29/17 and certification period of 9/8/17 - 11/6/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one times a week for 9 weeks. Another similar plan of care for the certification period of 11/7/17 - 1/5/17 failed to evidence this second plan of care was signed by a physician.

8. A review of clinical record #3 failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 7/21/17 and certification period of 7/25/17 - 9/22/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one times a week for 9 weeks. Another similar plan of care for the certification period of 9/23/17 - 11/21/17 failed to evidence this second plan of care was signed by a physician.

During an interview on 11/17/17 at 2:10 PM, the office clerk for the physician of patient #3 indicated there had been a referral to Raby Home Health on 7/14/17.

9. A review of clinical record #4 failed to evidence two plans of care were signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 8/4/17 and certification period of 7/31/17 - 9/28/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one times a week for 9 weeks. Another similar plan of care for the certification period of 9/29/17 - 11/27/17 failed to evidence this second plan of care was signed by a physician.
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signed by a physician.

   During a phone interview on 11/17/17 at 3:20 PM, the office clerk of patient #4's physician indicated that a verbal order was found for August 2nd, 2017 and this was the last communication found in the physician's office records.

10. A review of clinical record #5 failed to evidence the plan of care was signed by the physician. A review of a document titled "Home Health Certification and Plan of Care" with a start of care date of 10/9/17 and certification period of 10/9/17 - 12/7/17 failed to evidence a physician's signature on the plan of care which included orders for the skilled nurse to visit one time a week for 9 weeks.

11. A review of closed clinical record #6 evidenced a start of care date of 3/10/17. This plan of care for the certification period of 3/10/17 - 5/8/17 was not signed by a physician.


   During an interview on 11/17/17 at 3:05 PM, the office staff of patient #7's physician indicated there was no record of this home health agency's plan of care for patient #7 or other orders at this time.

### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**A. BUILDING:**

**PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 014024

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DATE SURVEY COMPLETED:** 11/20/2017

**NAME OF PROVIDER OR SUPPLIER:** RABY HOME HEALTHCARE IN

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 8124 CALUMET AVE, REAR SUITE, MUNSTER, IN 46321

**DATE PRINTED:** 01/19/2018

**FORM APPROVED:**

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14. A review of clinical record #9 evidenced a start of care date of 7/24/17 on the Home Health Certification and Plan of Care document for the certification period of 7/26/17 - 9/23/17. This plan of care document was not signed by the physician.

   A. During an interview on 11/15/17 at 11:35 AM, the director of nursing did not respond to the question of why the physician name was not on the plan of care document.

   B. During an interview on 11/20/17 at 11:38 AM, the writer asked the administrator / alternate director of nursing for the name of the physician for patient #9 and the administrator / alternate director of nursing indicated not knowing who the patient's physician was.

15. A review of clinical record #10 evidenced a start of care date of 3/29/17 on the Home Health Certification and Plan of Care document for the certification period of 3/16/17 - 5/14/17. This plan of care document was not signed by the physician and the name and address of the physician was not on this document.

16. An undated policy titled "Computer Access to Information Policy No. 2 - 0.32.1" stated, "If the drug order is verbal or given by or through electronic transmission, it must be given only to a licensed nurse, nurse practitioner [where appropriate] pharmacist or physician. The individual receiving the order must record it, sign it immediately and have the prescribing person sign it in accordance with state and federal regulations. 4. Data will be protected by safeguards that prevent unauthorized access to information and / or modification of existing data information."

**STATE FORM**

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### SUMMARY STATEMENT OF DEFICIENCIES

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... Date and time of entries will be designated by the computer's internal clock. 7. Automated controls will be in place to prevent a change in entry.

17. The undated policy titled "Admission Criteria and Process" stated, "1. The patient must be under the care of a physician. The patient's physician [or other authorized licensed independent practitioner] must order and approve the provision of any service. A skilled service must be ordered … the clinical supervisor will assign clinical organization personnel to conduct initial assessments of eligibility for services within 48 hours of acceptance of referral information and / or discharge from referring facility. A. The initial assessment visit must be performed either 48 hours of the referral, within 48 hours of the patient's return home or on the start or care date ordered by the physician."

18. The undated policy titled "Care Planning Process" stated, "A written plan of care will be initiated within five days of start of care and updated at least every 60 days or as patient's condition warrants. The patient plan of care will be developed or revised within 5 working days of initiation of each service or of the reassessment of the patient."

19. The undated policy titled "Physician Participation in Plan of Care" stated, "A physician will direct the care of every home health care patient admitted for service ... the attending physician will participate in the care planning process by initiating, reviewing and revising therapeutic and diagnostic orders ... the attending physician will sign the plan of care / treatment within 30 days of the start of care ... the attending physician recertification will be obtained in
Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

014024

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: ______________________

B. WING _________________________

(X3) DATE SURVEY COMPLETED

11/20/2017

NAME OF PROVIDER OR SUPPLIER

RABY HOME HEALTHCARE IN

STREET ADDRESS, CITY, STATE, ZIP CODE

8124 CALUMET AVE, REAR SUITE

MUNSTER, IN  46321

(ID) 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) COMPLETE DATE

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intervals of at least every 60 days when the patient's plan of care is reviewed, the patient recertified, and more often, if warranted."

20. The undated policy titled "Verification of Physician Orders" stated, "A qualified individual will review each order or prescription before care is provided ... signed orders will be in the clinical record within 30 days of initiation of care or interim order, unless otherwise specified by applicable state law or regulation."

21. During a phone interview on 11/17/17 at 4:20 PM, the office staff of the attending physician for patient #2, #8, and closed record #10 indicated that there were no communications from the home health care agency in the office records regarding these patients.

Indiana State Department of Health

STATE FORM

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