STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157180	A. BUILDING 00 B. WING	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	1400 MCGALLIARD RD MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000 Bldg. 00	This was a home health agency federal recertification survey. This was a partial extended survey. Survey Dates: May 11-14, 2015 Facility Number: IN005347 Medicaid Number: 100264810A Census Service Type: Skilled: 1104 Total: 1104 Sample: RR w/HV: 7 RR w/o HV: 10 Total: 17 QR: je 5/18/15	G 000		
G 158 Bldg. 00	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on clinical record and agency	G 158	**G158: 484.18 Acceptance of**	06/13/2015

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

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	policy review, the home health agency failed to ensure that care followed a written plan of care for visit frequency and labs or treatments for 5 of 17 records reviewed (#s 5, 8, 13, 14, 16). Findings: 1. Clinical record #5 contained a plan of care established by the patient's physician for the certification period 10/29/2104 through 12/27/2014 with orders for the nurse to see the patient 1 time weekly. There are no nursing notes in the clinical record to evidence a nurse saw the patient for the week of 12/23/2014 through 12/29/2014. 2. Clinical record #8 contained a comprehensive nursing assessment completed on the start of care date 3/19/2015. The assessment evidenced the patient had a stage one pressure ulcer to the buttocks measuring 20 cm by 15 cm. The plan of care established by the patient's physician for the certification period 3/19/2015 through 5/17/2015 included interventions to teach patient/caregiver pressure ulcer preventions measures. The nursing notes dated 3/23/2015 and 3/30/2015 failed to evidence that employee H, a licensed practical nurse (LPN), assessed the patient's wound or provided teaching to		**Patients, POC, Med Super** Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicineCorrective Action to be accomplished for those patients cited in the statement of deficiency. Completion date: 5/31/15:1. Patient #5 is no longer active with the agency. 2. Patient #8 is no longer active with the agency. 3. Patient #13: POC signed 5/18/15 states, “Pt refused OT at this time. Physician is aware”4. Patient #14 is no longer active with the agency5. Patient #16: pt was hospitalized 4/1/15 through 4/25/15; late entry missed visit note entered on 5/31/15 for wk of 4/26-5/2/15 Administrator or designee will provide 1:1 education to all clinicians involved in providing the care to Patient #5, #8, #13, #14 and #16. Completion Date: 6/3/15Education: Administrator or designee provided education to clinical associates on care following the physician ordered plan of care beginning on May 20, 2015 and continuing until all clinical associates have been educated. Completion Date: 6/13/15Monitoring: Administrator or designee will monitor through focused record review of 10 charts per week x 3 weeks for evidence of care following physician ordered plan of care until compliance reaches 90% or	

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	the patient or caregiver regarding pressure ulcer prevention measures. 3. Clinical record #13 contained a plan of care established by the patient's physician for the certification period 5/1/2015 through 6/29/2015 with orders for the occupational therapist to see the patient during the week of 5/4/2015 for an evaluation. The record failed to evidence that an occupational therapy evaluation was completed. 4. Clinical record #14 contained plan of care for the certification period 2/4/15-4/4/14 with a physician order to draw lab specimens for a HgA1C, tsh, uric acid and lipid panel no later than 2/23/2015. The lab result report dated 2/28/2015 evidenced the specimen was collected on 2/27/2015. The record failed to evidence any earlier collection or lab results. 5. Clinical record #16 contained a plan of care established by the patient's physician for the certification period 3/24/2015 through 5/19/2015 with orders for the nurse to see the patient twice weekly and the physical therapist twice weekly. A. The clinical notes evidenced only visit during the weeks of 3/29 through		greater. Once compliance of 90% or greater is reached, monitoring will continue through quarterly clinical record review. Completion Date: 6/13/15	

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	4/4/ 2015 and 4/26 through 5/2/ 2015. B. No nursing visit clinical notes were evidenced in the record during the week of 4/5 through 4/ 11/ 2015. C. The clinical notes evidenced that only one physical therapy visit was made to the patient during the week of 3/29 through 4/4/2105. 6. An agency policy titled 03-11 Care Planning dated 10/23/2013 states, "The total number of visits will be appropriate to the care required/ordered. Patients will receive the number of visits needed/ordered."			
G 170 Bldg. 00	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. Based on clinical record and agency policy review, the home health agency failed to ensure that care followed a written plan of care for visit frequency	G 170	**G170 484.30 SKILLED NURSING SERVICES** The HHA furnishes skilled nursing services in accordance with the plan of care. Corrective Action to be	06/13/2015

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	and labs or treatments for 3 of 17 records reviewed (#s 5, 8, and 16). Findings: 1. Clinical record #5 contained a plan of care established by the patient's physician for the certification period 10/29/2104 through 12/27/2014 with orders for the nurse to see the patient 1 time weekly. There are no nursing notes in the clinical record to evidence a nurse saw the patient for the week of 12/23/2014 through 12/29/2014. 2. Clinical record #8 contained a comprehensive nursing assessment completed on the start of care date 3/19/2015. The assessment evidenced the patient had a stage one pressure ulcer to the buttocks measuring 20 cm by 15 cm. The plan of care established by the patient's physician for the certification period 3/19/2015 through 5/17/2015 included interventions to teach patient/caregiver pressure ulcer preventions measures. The nursing notes dated 3/23/2015 and 3/30/2015 failed to evidence that employee H, a licensed practical nurse (LPN), assessed the patient's wound or provided teaching to the patient or caregiver regarding pressure ulcer prevention measures.		accomplished for those patients cited in the statement of deficiency. Completion Date: 5/31/15:a. Patient #5 is no longer active with the agency.b. Patient #8 is no longer active with the agency.c. Patient #16: pt was hospitalized 4/1/15 through 4/25/15; late entry missed visit note entered on 5/31/15 for wk of 4/26-5/2/15 Administrator or designee will provide 1:1 education to all clinicians involved in providing the care to Patient #5, #8, and #16. Completion Date: 6/3/15Education: Administrator or designee will provide education to all nursing staff on ensuring that nursing care follows a written Plan of Care and following physician ordered frequency of visits. Completion Date: 6/13/15Monitoring: Administrator or designee will monitor through a focused record review of 10 records per week for 3 weeks for evidence of nursing care following physician ordered plan of care including frequency, until 90% compliance is reached. Once the 90% threshold is reached, monitoring will continue through quarterly clinical record review. Completion Date: 6/13/15	

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	3. Clinical record #16 contained a plan of care established by the patient's physician for the certification period 3/24/2015 through 5/19/2015 with orders for the nurse to see the patient twice weekly. A. The clinical notes evidenced the patient was visited only once by the nurse during the weeks of 3/29 through 4/ 4/ 2015 and 4/26 through 5/2/2015. B. No nursing visit clinical notes were evidenced in the record for the week of 4/5 through 4/ 11/ 2015. 4. An agency policy titled 03-11 Care Planning dated 10/23/2013 states, "The total number of visits will be appropriate to the care required/ordered. Patients will receive the number of visits needed/ordered."			
G 179 Bldg. 00	484.30(b) DUTIES OF THE LICENSED PRACTICAL NURSE The licensed practical nurse furnishes			

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	services in accordance with agency policy. Based on clinical record and agency policy review, The licensed practical nurse (LPN) failed to assess the patient's skin and provide teaching as ordered in the plan of care and in accordance with the agency's assessment policy for one of seventeen records reviewed (# eight). Findings 1) Clinical record #8 contained a comprehensive nursing assessment completed on the start of care date 3/19/2015. The assessment evidenced the patient had a stage one pressure ulcer to the buttocks measuring 20 cm by 15 cm. The plan of care established by the patient's physician for the certification period 3/19/2015 through 5/17/2015 included interventions to teach patient/caregiver pressure ulcer preventions measures. 2) The nursing notes dated 3/23/2015 and 3/30/2015 failed to evidence employee H, a LPN, assessed the patient's wound or provided teaching to the patient or caregiver regarding pressure ulcer prevention measures. The LPN documented in the skin assessment section of the nursing notes on the dates listed above "Skin intact, no problems."	G 179	**G179: 484.30(b) Duties of the Licensed Practical Nurse** The licensed Practical nurse furnishes services in accordance with agency policyCorrective Action to be accomplished for the patient cited in the statement of deficiency:1. Patient #8 – is no longer active with the agency.Administrator or designee will provide 1:1 education to all clinicians involved in providing the care to Patient #8. Completion Date: 5/28/15Education: Administrator or designee provided education to all nursing staff on the duties of the Licensed Practical Nurse. All nursing staff will be provided with Policy 03-05 Assessment. Completion Date: 6/13/15Monitoring: Administrator or designee will monitor through a focused record review of 10 records per week for 3 weeks for evidence of LPN furnishing services in accordance policy 03-05 Assessment, until 90% compliance is achieved. Once the 90% threshold is reached, monitoring will continue through quarterly clinical record review. Completion Date: 6/13/15	06/13/2015

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	3) An agency policy, dated 10/23/2013, titled 03-05 Assessment states, "The LPN will execute interventions in accordance to the Plan of Care, collect data on wound status, document in the patient record, and contribute to the evaluation of the individualized interventions related to the Plan of Care."			
G 229 Bldg. 00	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on clinical record and agency policy review, the agency failed to ensure the registered nurse (RN) made an on-site supervisory visits for the home health aide at least every two weeks for 1 of 3 clinical records reviewed of patients receiving skilled and home health aide services (#16). Findings: 1. Clinical record number sixteen, start of care date,3/21/2105 contained a plan of care established by the patient's physician for the certification period 3/21/15-5/19/2015 with orders for the home health aide to visit twice weekly for	G 229	**G229: 484.36(d)(2) Supervision** The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks.Corrective Action to be accomplished for the patient cited in the statement of deficiency:1. Patient #16 – Supervisory visit was completed on 5/15/2015Administrator or designee will provide 1:1 education to all clinicians involved in providing the care to Patient #16. Completion Date: 6/3/15Education: Administrator or designee provided education to professional staff on supervision of home health aide. All professional staff reviewed policy	06/13/2015

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	eight weeks. The skilled nursing notes failed to evidence that the RN made supervisory visits for the home health aide. 2) An agency policy titled 9-9 Supervisory Visits, dated 12/4/13 states, "Supervisory visits by the RN are required every two weeks or less on al skilled cases receiving home health aide services." 3) In an interview with employee A, the agency's administrator, on May 14, 2015, at 11:30 AM, the employee was unable to provide additional documentation to support compliance with RN supervisory visits for clinical record number 16.		9-9 Supervisory visits. Completion Date: 6/13/15Monitoring: Administrator or designee will audit 100% of all current patients with home health aide will for evidence of supervisory visits. Administrator or designee will monitor for evidence of timely home health aide supervisory visits through a focused record review of 10 records per week for 3 until 90% compliance is achieved. Once the 90% threshold is reached, monitoring will continue through quarterly clinical record review. Completion Date: 6/13/15	
G 321 Bldg. 00	484.20(a) ENCODING OASIS DATA The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data set. Based on agency document and policy review and interview, the home health agency failed to ensure OASIS data was submitted within 30 days of the OASIS M0900 date for 28 of 83 records submitted during the month of April 2015.	G 321	**G321 484.20(a) ENCODING OASIS DATA** The HHA must encode and be capable of transmitting OASIS data for each agency patient within 30 days of completing an OASIS data setEducation: Administrator or designee will in-service the MCP (Managers of	06/13/2015

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	Findings: 1. An agency document titled OASIS Final Validation report dated 4/13/2015 evidenced that 14 of 38 records had OASIS data submitted greater than 30 days past the M0900 date. 2. An agency document titled OASIS Final Validation report dated 4/20/2015 evidenced that 14 of 45 records had OASIS data submitted greater than 30 days past the M0900 date. 3. An agency policy titled 03-05 Assessment dated 10/23/2013 states, "The OASIS data items from the assessment of adult, non maternity Medicare and Medicaid patients receiving skilled care (including those under managed care and Medicaid waiver programs) will be encoded and transmitted within 30 calendar days of the completion of the OASIS assessment." 4. In an interview with employee A, the agency's administrator, on May 24, at 11:30 AM, the administrator acknowledged the agency's OASIS data submission reports showed that data was submitted later than 30 days past the M0900 date for 28 of 83 patient's during		Clinical Practice) regarding Gentiva policy and process for timely completion of Oasis assessments. Completion Date: 5/28/15Monitoring: Administrator or designee will review all Oasis transmissions for 3 weeks for evidence of timely transmission. Once 95% compliance reached, monitoring will continue through quarterly clinical record review. Completion Date: 6/13/15	

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	the month of April.			
G 337 Bldg. 00	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on clinical record and agency policy review and interview, the home health agency failed to ensure the comprehensive assessment included a review of all medications the patient is currently using to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy for 5 of 17 clinical records reviewed (clinical records 1, 2, 9, 15 and 17). Findings: 1. Clinical record number 1, start of care date 1/6/2015, failed to evidence completion of the agency's drug regimen review form with the initial comprehensive assessment at start of care	G 337	**G337 484.55(c) DRUG REGIMEN REVIEW** The comprehensive assessment must include a review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Corrective Action to be accomplished for those patients cited in the statement of deficiency. Completion Date: 5/31/15a. Record #1: Medication reconciliation, review and medication profile update was completed on 5/5/15b. Record #2: Medication reconciliation, review and medication profile update was completed on 5/14/15c. Record #9: Medication reconciliation, review and medication profile update was	06/13/2015

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	and with the recertification comprehensive assessment on 3/4/2015. 2. Clinical record number 2, start of care date 3/11/2015, failed to evidence completion of the agency's drug regimen review form with the recertification comprehensive assessment on 5/7/2015. 3. Clinical record number 9, start of care date 2/9/2015, failed to evidence completion of the agency's drug regimen review form with the initial comprehensive assessment. 4. Clinical record number 15, start of care date 2/16/2015, failed to evidence completion of the agency's drug regimen review form with the recertification comprehensive assessment dated 4/16/2015. 5. Clinical record number 17, start of care date 12/22/2014, failed to evidence completion of the agency's drug regimen review form with the initial comprehensive assessment at start of care. 6. An agency policy titled 03-05 Assessment dated 10/23/2013 states, "A review of each patient's medications will be conducted as a part of each comprehensive assessment and whenever		completed on 5/18/15d. Record #15: Medication reconciliation, review, and medication profile update was completed immediately on 5/31/15 e. Record #1 7: Medication reconciliation, review, and medication profile update was completed immediately on 5/20/15 Administrator or designee will provide 1:1 education to all staff involved in providing care to those patient cited in Record #1, 2, 9, 15, and 17. Education: Administrator or designee will provide education to all professional staff on performing a comprehensive review of all medications the patient is currently using to identify adverse effects, drug reactions, ineffective drug therapy and non compliance with drug therapy. Completion Date: 6/3/15Monitoring: Administrator or designee will monitor through focused record review of all start of cares and recertifications for the next 3 weeks until 90% compliance is reached. Once 90% or greater is reached, monitoring will continue through quarterly clinical record review. Completion Date: 6/13/15	

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	a new medication is added. The review will be documented on the Medication Profile form. These reviews include an evaluation of all medications the patient is taking for possible adverse reactions, allergies, duplication of medication therapy, contraindications and significant side effects and non-compliance with drug therapy." 7. In an interview on 5/14/2015 at 11:30 AM with employee A, the agency's administrator, the administrator was unable to provide additional documentation to evidence compliance with this standard and agreed that the missing medication assessments were contrary to agency policy.			
N 000 Bldg. 00	This was a home health agency state relicensure survey. Survey Dates: May 11-14, 2015 Facility Number: IN005347 Medicaid Number: 100264810A	N 000		

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	Census Service Type: Skilled: 1104 Total: 1104 Sample: RR w/HV: 7 RR w/o HV: 10 Total: 17 QR: je 5/18/15			
N 522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on clinical record and agency policy review, the home health agency failed to ensure that care followed a written plan of care for visit frequency and labs or treatments for 5 of 17 records reviewed (#s 5, 8, 13, 14, 16). Findings: 1. Clinical record #5 contained a plan of care established by the patient's physician for the certification period 10/29/2104 through 12/27/2014 with orders for the nurse to see the patient 1 time weekly. There are no nursing notes in the clinical record to evidence a nurse saw the patient	N 522	**N522: 410 IAC 17-13-1(a) patient Care** Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist.Corrective Action to be accomplished for those patients cited in the statement of deficiency. Completion Date: 5/31/15:1. Patient #5 is no longer active with the agency2. Patient #8 is no longer active with the agency3. Patient #13: POC signed 5/18/15 states, “Pt refused OT at this time. Physician is aware”4. Patient #14 is no longer active with the agency5. Patient #16: is currently active. Late	06/13/2015

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	157180	A. BUILDING 00 B. WING	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTIVA HEALTH SERVICES	1400 MCGALLIARD RD MUNCIE, IN 47303

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	for the week of 12/23/2014 through 12/29/2014. 2. Clinical record #8 contained a comprehensive nursing assessment completed on the start of care date 3/19/2015. The assessment evidenced the patient had a stage one pressure ulcer to the buttocks measuring 20 cm by 15 cm. The plan of care established by the patient's physician for the certification period 3/19/2015 through 5/17/2015 included interventions to teach patient/caregiver pressure ulcer preventions measures. The nursing notes dated 3/23/2015 and 3/30/2015 failed to evidence that employee H, a licensed practical nurse (LPN), assessed the patient's wound or provided teaching to the patient or caregiver regarding pressure ulcer prevention measures. 3. Clinical record #13 contained a plan of care established by the patient's physician for the certification period 5/1/2015 through 6/29/2015 with orders for the occupational therapist to see the patient during the week of 5/4/2015 for an evaluation. The record failed to evidence that an occupational therapy evaluation was completed. 4. Clinical record #14 contained plan of care for the certification period		entry missed visit notes added to chart on 5/31/2015 along with evidence of physician contactAdministrator or designee will provide 1:1 education to all clinicians involved in providing the care to Patient #5, #8, #13, #14 and #16. Completion Date: 6/3/15Education: Administrator or designee provided education to clinical associates on care following the physician ordered plan of care beginning on May 20, 2015 and continuing until all staff have been educated. Completion Date: 6/13/15Monitoring: Administrator or designee will monitor through focused record review of 10 charts per week x 3 weeks for evidence of care following physician ordered plan of care until compliance reaches 90% or greater. Once compliance of 90% or greater is reached, monitoring will continue through quarterly clinical record review. Completion Date: 6/13/15	

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	2/4/15-4/4/14 with a physician order to draw lab specimens for a HgA1C, tsh, uric acid and lipid panel no later than 2/23/2015. The lab result report dated 2/28/2015 evidenced the specimen was collected on 2/27/2015. The record failed to evidence any earlier collection or lab results. 5. Clinical record #16 contained a plan of care established by the patient's physician for the certification period 3/24/2015 through 5/19/2015 with orders for the nurse to see the patient twice weekly and the physical therapist twice weekly. A. The clinical notes evidenced only visit during the weeks of 3/29 through 4/4/ 2015 and 4/26 through 5/2/ 2015. B. No nursing visit clinical notes were evidenced in the record during the week of 4/5 through 4/ 11/ 2015. C. The clinical notes evidenced that only one physical therapy visit was made to the patient during the week of 3/29 through 4/4/2105. 6. An agency policy titled 03-11 Care Planning dated 10/23/2013 states, "The total number of visits will be appropriate to the care required/ordered. Patients			

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	will receive the number of visits needed/ordered."			
N 537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on clinical record and agency policy review, the home health agency failed to ensure that care followed a written plan of care for visit frequency and labs or treatments for 3 of 17 records reviewed (#s 5, 8, and 16). Findings: 1. Clinical record #5 contained a plan of care established by the patient's physician for the certification period 10/29/2104 through 12/27/2014 with orders for the nurse to see the patient 1 time weekly. There are no nursing notes in the clinical record to evidence a nurse saw the patient for the week of 12/23/2014 through 12/29/2014. 2. Clinical record #8 contained a comprehensive nursing assessment completed on the start of care date 3/19/2015. The assessment evidenced the patient had a stage one pressure ulcer to the buttocks measuring 20 cm by 15	N 537	**N537: 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 careCorrective Action to be accomplished for those patients cited in the statement of deficiency. Completion Date: 5/31/15:a. Patient #5 is no longer active with the agencyb. Patient #8 is no longer active with the agency.c. Patient #16: pt was hospitalized 4/1/15 through 4/25/15; late entry missed visit note entered on 5/31/15 for wk of 4/26-5/2/15Administrator or designee will provide 1:1 education to all clinicians involved in providing the care to Patient #5, #8, and #16. Completion Date: 6/3/15Education: Administrator or designee will provide education to all nursing staff on ensuring that nursing care follows a written Plan of Care and following physician ordered frequency of visits. Completion Date:	06/13/2015

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	cm. The plan of care established by the patient's physician for the certification period 3/19/2015 through 5/17/2015 included interventions to teach patient/caregiver pressure ulcer preventions measures. The nursing notes dated 3/23/2015 and 3/30/2015 failed to evidence that employee H, a licensed practical nurse (LPN), assessed the patient's wound or provided teaching to the patient or caregiver regarding pressure ulcer prevention measures. 3. Clinical record #16 contained a plan of care established by the patient's physician for the certification period 3/24/2015 through 5/19/2015 with orders for the nurse to see the patient twice weekly. A. The clinical notes evidenced the patient was visited only once by the nurse during the weeks of 3/29 through 4/ 4/ 2015 and 4/26 through 5/2/2015. B. No nursing visit clinical notes were evidenced in the record for the week of 4/5 through 4/ 11/ 2015. 4. An agency policy titled 03-11 Care Planning dated 10/23/2013 states, "The total number of visits will be appropriate to the care required/ordered. Patients will receive the number of visits		6/13/15Monitoring: Administrator or designee will monitor through a focused record review of 10 records per week for 3 weeks for evidence of nursing care following physician ordered plan of care including frequency, until 90% compliance is reached. Once the 90% threshold is reached, monitoring will continue through quarterly clinical record review. Completion Date: 6/13/15	

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	needed/ordered."			
N 553 Bldg. 00	410 IAC 17-14-1(a)(2)(A) Scope of Services Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies. Based on clinical record and agency policy review, The licensed practical nurse (LPN) failed to assess the patient's skin and provide teaching as ordered in the plan of care and in accordance with the agency's assessment policy for one of seventeen records reviewed (# eight). Findings 1) Clinical record #8 contained a comprehensive nursing assessment completed on the start of care date 3/19/2015. The assessment evidenced the patient had a stage one pressure ulcer to the buttocks measuring 20 cm by 15 cm. The plan of care established by the patient's physician for the certification period 3/19/2015 through 5/17/2015 included interventions to teach patient/caregiver pressure ulcer preventions measures. 2) The nursing notes dated 3/23/2015	N 553	**N553: 410 IAC 17-14-1(a)(2)(A) Scope of Services** Rule 14 Sec. 1(a) (2) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (A) Provide services in accordance with agency policies.Corrective Action to be accomplished for the patient cited in the statement of deficiency:1. Patient #8 – is no longer active with the agency.Administrator or designee will provide 1:1 education to all clinicians involved in providing the care to Patient #8 Completion Date: 5/28/15Education: Administrator or designee provided education to all nursing staff on the duties of the Licensed Practical Nurse. All nursing staff will be provided with Policy 03-05 Assessment. Completion Date: 6/13/15Monitoring: Administrator or designee will monitor through a focused record review of 10 records per week for 3 weeks for evidence of LPN furnishing services in accordance policy 03-05 Assessment, until 90%	06/13/2015

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	and 3/30/2015 failed to evidence employee H, a LPN, assessed the patient's wound or provided teaching to the patient or caregiver regarding pressure ulcer prevention measures. The LPN documented in the skin assessment section of the nursing notes on the dates listed above "Skin intact, no problems." 3) An agency policy, dated 10/23/2013, titled 03-05 Assessment states, "The LPN will execute interventions in accordance to the Plan of Care, collect data on wound status, document in the patient record, and contribute to the evaluation of the individualized interventions related to the Plan of Care."		compliance is achieved. Once the 90% threshold is reached, monitoring will continue through quarterly clinical record review. Completion Date: 6/13/15	
N 606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on clinical record and agency policy review, the agency failed to ensure the registered nurse (RN) made an on-site supervisory visits for the home health aide at least every two weeks as required	N 606	**N606: 410 IAC 17-14-1(n) Scope of Services** Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a	06/13/2015

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	by agency policy for 1 of 3 clinical records reviewed of patients receiving skilled and home health aide services (#16). Findings: 1. Clinical record number sixteen, start of care date,3/21/2105 contained a plan of care established by the patient's physician for the certification period 3/21/15-5/19/2015 with orders for the home health aide to visit twice weekly for eight weeks. The skilled nursing notes failed to evidence that the RN made supervisory visits for the home health aide. 2) An agency policy titled 9-9 Supervisory Visits, dated 12/4/13 states, "Supervisory visits by the RN are required every two weeks or less on al skilled cases receiving home health aide services." 3) In an interview with employee A, the agency's administrator, on May 14, 2015, at 11:30 AM, the employee was unable to provide additional documentation to support compliance with RN supervisory visits for clinical record number 16.		supervisory visit at least every thirty (30) days, either when the home health aide present or absent, to observe the care, to assess relationships, and to determine whether goals are being met.Corrective Action to be accomplished for the patient cited in the statement of deficiency:1. Patient #16 – Supervisory visit was completed on 5/15/2015Administrator or designee will provide 1:1 education to all clinicians involved in providing the care to Patient #16. Completion Date: 6/3/15Education: Administrator or designee provided education to professional staff on supervision of home health aide. All professional staff reviewed policy 9-9 Supervisory visits. Completion Date: 6/13/15Monitoring: Administrator or designee will audit 100% of all current patients with home health aide will for evidence of supervisory visits. Administrator or designee will monitor for evidence of timely home health aide supervisory visits through a focused record review of 10 records per week for 3 until 90% compliance is achieved. Once the 90% threshold is reached, monitoring will continue through quarterly clinical record review. Completion Date: 6/13/15	