STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157681	A. BUILDING 00 B. WING	10/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AGING & DISABLED HOME HEALTH CARE LLC	10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.22 for a Home Health Agency Federal and State recertification survey and investigation of 2 complaints. Dates of survey: 9/21/18, 9/24/18 - 9/28/18, 10/1/18-10/2/18 Facility # 013593 Federal# 157581 Medicaid #: 201284430 Complaints # IN 00243261: Substantiated with findings IN 00220561: Substantiated with findings 12 Month Unduplicated Census: 257 Home visits with record review: 3 Records reviewed without home visit : 4 Total records reviewed: 7 At this Emergency Preparedness survey, Aging and Disabled Home Health Care LLC was found to be in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E 0000		
G 0000				

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

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

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Bldg. 00	This visit was an Extended Federal recertification survey with investigation of 2 complaints. Dates of survey: 9/21/18, 9/24/18 - 9/28/18, 10/1/18-10/2/18 Facility # 013593 Federal # 157581 Medicaid #: 201284430 Complaints # IN 00243261: Substantiated with findings IN 00220561: Substantiated with findings 12 Month Unduplicated Census: 257 Home visits with record review: 3 Records reviewed without home visit : 4 Total records reviewed: 7 Aging and Disabled Home Health Care, LLC is precluded form doing it's own its own home health aide training and competency evaluation program for a period of 2 years beginning 10/02/2018 to 10/02/2020 for being out of compliance with the Conditions of Participation for 42 CFR 484.50 Patient Rights, 484.60 Care Planning, Coorination, Quality of Care, 484.80 Home Health Aide Service, and 484.105 Organization and Administration of Services.	G 0000		
G 0406 Bldg. 00				

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	Based on record review and interview, the agency failed to maintain compliance with the Condition of Participation of Patient Rights as evidenced by failure to provide documentation the patient or the patient's family had received written notice of patient's rights (See Tag G 422) , failure to ensure all services outlined in the POC (Plan Of Care) were provided (See Tag G 436), failure to inform the patient in writing the extent to which payment for HHA services may be expected from federally-funded programs (See Tag G 440), failure to investigate complaints of care that was needed and not provided as ordered on the plan of care (See Tag G 480), failure to document, investigate and resolve complaints (See Tag G 484). The cumulative effect of these systemic problems resulted in the home health agency's inability to provide quality health care in a safe environment for the Condition of Participation at 42 CFR 484.36, Patient Rights.	G 0406	G 406 The Administrator or designee will immediately review all active patient records for evidence that the patient and or legal representative received notice of their rights in a language and manner the individual understands during the initial evaluation, and if not obtained during this initial evaluation, will correct the deficiency by obtaining evidence that the deficiency has been corrected by obtaining a new Home Health Admission Service Agreement signed by patient and or legal representative. The agency will immediately do away with the practice of accepting referrals without approval of the DON. The administrator or designee will immediately review all active clinical records for evidence that all services in the POC are being provided. If there is evidence that the POC is not being followed the DON will call the PCP for a verbal order to update the plan of care and the POC will be updated in the clinical record and sent to the PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON will call the patient and offer to transfer them to an agency that can provide all services in the POC. If patient agrees to be transferred to another agency the DON will facilitate a transfer to an agency of the patients choice. The DON will	11/30/2018

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			review all new referrals to ensure that before acceptance of referral the agency can reasonably meet the needs of the patient before acceptance of such referral. The DON will sign off on all accepted referrals as evidence that she reviewed the referral. The administrator or designee will immediately review all active clinical records for evidence the patient or legal representative was informed of the extent of payment from federally funded programs. If no documentation exists in the patients clinical record the RN case manager will review this with the patient and obtain evidence by obtaining a new Home Health Admission Service Agreement as evidence that this was reviewed with the patient or the legal representative. The phone message system will be updated immediately to include the Administrators number in the event that a patient or family member wishes to file a complaint and all complaints will be forwarded to the Administrator or designee and will be documented, investigated, with resolution and logged in the complaint log book. The DON or designee will educate administration/management, all clinicians on agency policy "Plan of Care," "Client/family Complaint/grievance policy," " The Home Health Admission	

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			Service Agreement," " Patients' Rights" To prevent this deficiency in the future, the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed on 11/08/2018.	
G 0422 Bldg. 00	Based on record review and interview, the agency failed to provide documentation that the patient or the patient's family had received written notice of the patient's rights for 1 of 1 patient's (Patient' # 5) in a sample of 7 clinical records reviewed. Findings Include: An agency policy titled, "Home Care Bill of Rights" was reviewed and stated, "Clients will be informed of their rights as a consumers of home care services. This include the right to voice grievances and request changes without discrimination, reprisal or unreasonable interruption of services ...1. A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the	G 0422	G 422 The Administrator or designee will immediately review all active patient records for evidence that the patient and or legal representative received notice of their rights in a language and manner the individual understands during the initial evaluation, and if not obtained during this initial evaluation, will correct the deficiency by obtaining evidence that the deficiency has been corrected by obtaining a new Home Health Admission Service Agreement signed by patient and or legal representative and this documentation will be added to the patients clinical record.	11/30/2018

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	client or during the initial evaluation visit before treatment is initiated. In the event that the client is unable to make decision, the Home Care Bill of Rights shall be given to the client's legal guardian ...2. The client/caregiver shall be advised orally and in writing or their right to voice grievances ... Documentation of the receipt of the Home Care Bill of Rights will be maintained in the clinical record ...." The clinical record of Patient # 5 with a start of care date of 6/19/16 and a discharge date of 12/141/6. The clinical record failed to evidence a contain a copy of the patient's rights. The administrator was interviewed on 10/1/18 at 1:58 PM regarding the failure of the agency to produce copies of the patient's rights in the clinical record. The administrator was unable to produce any further documentation of the patient's rights in the clinical records.		The DON or designee will educate all clinicians on agency policy titled: Home Care Bill of Rights Home Health Admission Service Agreement **To prevent this deficiency in the future, the DON will review each new admission with the RN that performed the initial comprehensive assessment to ensure all documentation of patient rights was reviewed verbally with the patient or legal representative and written documentation of this was obtained during this assessment, the Administrator or designee will be responsible for all active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.** Education completed on 11/08/2018.	
G 0434 Bldg. 00	Based on record review and interview, the agency failed to inform the patient in writing the disciplines and the frequency of the services to be provided for 2 of 7 clincial record reviewed (Patient # 2 and 5) in a sample of 7.	G 0434	G 434 The Administrator or designee will immediately review all active clinical records for documentation of Patients' Rights to be informed of all services	11/30/2018

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	Findings Include: 1. An agency policy titled, "Home Care Bill of Rights" was reviewed and stated, "Clients will be informed of their rights as a consumers of home care services. This include the right to voice grievances and request changes without discrimination, reprisal or unreasonable interruption of services ...1. A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event that the client is unable to make decision, the Home Care Bill of Rights shall be given to the client's legal guardian ...2. The client/caregiver shall be advised orally and in writing or their right to voice grievances ... Documentation of the receipt of the Home Care Bill of Rights will be maintained in the clinical record ...." 2. The clinical record of Patient # 2 with a start of care date of 9/28/18 and a certification period of 7/14/18 to 9/11/18 was reviewed. The clinical record contained a document titled, Home Health Admission Service Agreement" dated 3/14/18. The section of the form to indicate services, frequency, and duration was blank and not completed. 3. The clinical record of Patient # 5 with a start of care date of 6/19/16 and a discharge date of 12/14/16. The clinical record failed to evidence a contain a copy of the patient's rights. 4. The administrator was interviewed on 9/26/18 at 4:00 PM regarding the incomplete service agreement that was in the clinical record of		including disciplines involved in care, frequency of visits, and duration of care. If documentation is not present in the clinical record, documentation of a new Home Health Admission Service Agreement acknowledging the patients' rights were given to the patient or legal representative will be obtained by the RN case manger to document correction of this deficiency. The DON will educate administration/management, all clinicians on agency policy: Home Care Bill of Rights Home Health Admission Service Agreement To prevent this deficiency in the future, the DON will review each new admission with the RN that performed the initial comprehensive assessment to ensure all documentation of patient rights was reviewed verbally with the patient or legal representative and written documentation of this was obtained during this assessment, the Administrator or designee will be responsible for all active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed 11/08/2018.	

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	Patient's # 2 . The administrator stated, "I see what's wrong. I yelled at them about this." 5. The administrator was interviewed on 10/1/18 at 1:58 PM regarding the failure of the agency to produce copies of the patient's rights in the clinical record for Patient # 5. The administrator was unable to produce any further documentation of the patient's rights in the clinical records.			
G 0436 Bldg. 00	Based on record review and interviews, the agency failed to ensure all services outlined in the POC (Plan Of Care) was provided in 1 out of 4 (Patient #1) record reviewed of patients receiving SN (Skilled Nurse) and 4 of 4 patient (Patients # 1, 2, 4 and 5) record reviewed of patients receiving HHA (Home Health Aide) in a sample of 7 patients. Findings Include: 1. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ... The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. Medications, treatments, and procedures ... p. Treatment goals... At the time of certification and recertification, a	G 0436	G 436 The administrator or designee will immediately review all active clinical records for evidence that all services in the POC are being provided. If there is evidence that the POC is not being provided as per POC, the DON will call the PCP for a verbal order to update the plan of care and the POC will be updated in the clinical record and sent to the PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON will call the patient and offer to transfer them to an agency that can provide all services in the POC. If patient agrees to be transferred to another agency the DON will facilitate a transfer to an agency of the patients choice. The DON will make a communication note in the clinical record of this conversation as evidence that the patient was informed of their right to transfer to another agency if A and D is unable to provide the services the	11/30/2018

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	written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16 included orders for skilled nurse 5 times a week for G-Tube (a tube in the stomach where liquid nutrition is provided) feedings while the parent was at work and HHA services 6 times a week. The SN failed to provide services until 8/9/16 (21 days) after the SOC. The HHA provided services 5 times a week 1- 2 and 3 times week 6 of the certification period and failed to conduct visits as ordered. The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while the parent was at work and HHA services 6 times a week for assistance with IADL's and ADL's. SN services were provided 4 times during week 6, 3 times during week 7, 0 times during week 8, and 2 times during week 9 of the certification period and failed to be provided as ordered. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist the family in finding a nursing care via another agency at this time family has declined this offer. Currently, mother is		patient needs. The DON or designee will educate administration/management, all clinicians on policy: Plan of Care To prevent this deficiency in the future, the DON will review all new referrals to ensure that before acceptance of referral the agency can reasonably meet the needs of the patient before acceptance of such referral. The DON will sign off on all accepted referrals as evidence that she reviewed the referral. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education on Plan of Care was completed on 11/08/2018.	

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coming home at noon to feed daughter via G-Tube until nursing staff available." The HHA services were provided 3 times during week 5 of the certification period and failed to be conducted as ordered.

The POC for the certification period of 11/15/16 to 1/13/17 included orders for SN 5 times a week for G-Tube feedings and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 4 of the 45 visits ordered on the POC for the certification period and failed to provide visits as ordered.

The POC for the certification period of 1/14/17 to 3/14/17 included orders for SN 1 time a week for G-tube feedings each visit and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 5 visits in the certification period and failed to provide visit as ordered. There were no orders to change the POC.

A SN note 3/14/17 stated, "Informed the cg (caregiver) of SN visits weekly for skilled intervention, but that daily is not achievable and not necessary when available CG competent in administration of feedings. Encourage to call agency office prn (as needed)."

The POC for the certification period of 3/15/17 to 5/13/17 included orders for SN 1 time a week for assessment and instruction to caregivers and HHA 6 times a week for assistance with IADL'S and ADL's. The SN failed to provide 1 visit weekly for the weeks 1-3 of the certification period. The clinical record failed to evidence documentation of any HHA visits for weeks 4-9 of the certification period.

The POC for the certification period of 5/14/17 to

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	7/12/17 included orders for SN 1 time a week for assessment and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The POC failed to include the duration of the SN and HHA services. The clinical record failed to evidence documentation of HHA visits for week 1 and 2. The HHA conducted 6 visits week 4-8 and 4 visits during week 9 of the certification period. The POC for the certification period of 7/13/17 to 9/101/7 included orders for SN 5 times a week for G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during weeks 2-3 and 5-9 of the certification period and failed to provide 5 visits per week as ordered. The HHA conducted 3 visits during week 1 and 6 visits during week 2-9 of the certification period and failed to provide visits 5 times weekly as ordered. The POC for the certification period of 9/11/17 to 11/9/17 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 2 visits during weeks 1 and 4-8, 0 visits during week 2 and 1 visit during week 9 of the certification period. The SN failed to provide as ordered. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during week 8 and 9 of the certification period. The HHA failed to provided visits as ordered. A SN note dated 9/11/17 stated, "continues to request daily SN to cover G-Tube feedings while mother is at work. Will discuss with leadership. Parent states at this time his/her family has been able to cover the other days of the week there has not been a daily RN." The POC for the certification period of 11/10/17 to			

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	1/8/18 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. There were orders present to change the SN frequency to 1 visit during week 7 and 9 of the certification period. The SN failed to follow the POC and provided visits 2 times during weeks 2-6. No SN visits were conducted during week 1 and 8. The HHA provided 1 visit week 1 of the certification period on 11/10/17, 6 visits during weekly from 12/3/17 to 1/6/18. The HHA failed to provide visits as ordered. The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week for tube G-tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided visits 1 time during week 1 and 2 times during week 2-9 of the certification period. The SN failed to provide visits as ordered. The HHA provided visits 4 times a week from 1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and 1/11/18. The HHA provided visits 5 times a week from 1/15/18 to 1/19/18 with 14-hour visits on 1/16/18 and 1/18/18. The HHA provided visits 6 times a week from 1/21/18 to 3/9/18. The HHA failed to provide visits as ordered. The POC for the certification period of 3/10/18 to 5/8/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1, 2, 3, 4, 6, 8, and 3 visits during week 9. The HHA failed to provide visits as ordered.			

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	The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. A 14-hour visit on 5/9/18 and a 10-hour visit 5/12/18. The HHA provided 4 visits a week from 5/13/18 to 5/16/18 and 6 visits weekly from 5/17/18 to 7/7/18, when the clinical record evidenced that the patient was in the hospital from 5/17/18 to 6/1/18. The POC for the certification period of 7/8/18 to 9/5/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1-8 and 3 visits during week 9 of the verification period. The HHA provided 14-hour visits on 7/8/18, 7/10/18, 7/12/18. The HHA failed to provide visits as ordered. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 1 of the certification period and failed to provide visits as ordered. The HHA provided 3 visits during week 1 and 6 visits during weeks 2 and 3 of the certification period. The HHA provided 14-hour visits on 9/6/18, 9/11/8.9/13/18, 9/18/18, and 9/20/18 and 16-hour visits on 9/9/18 and 9/16/18. The HHA failed to provide services as ordered. A PA (prior authorization) was requested for patient # 1. The administrator provided a PA for the period of 8/8/18 to 2/6/19. The administrator			

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	was unable to present any other PAs for clinical record #1. The current PA established the SN services were requested for 2 times weekly and not 5 times weekly. An interview was conducted with the Parent of Patient # 1 on 9/24/18 at 10: 00 AM. The Parent reported that he/she worked 5-6 days a week. The patient's full-time HHA for the agency, the patient's sibling can not administer tube feedings in the role of a HHA. Without a nurse to come to the home daily the parent had to change the patient bolus G-tube feeding schedule. The parent reported when the patient had been admitted on (7/18/16) the feedings had been given in mid day by a nurse of the agency. The parent reported the full-time nurse left the agency around November of 2016 and soon after the agency stopped sending a nurse 5 days a week. The parent reported he/she was told that the agency was working on getting a replacement nurse. The parent reported he/she had reported to the patient's nurses and to the agency that he/she needed a nurse 5 days a week, but the staffing concern had not been addressed or resolved. The parent reported a nurse had told him/her that a nurse was not necessary and another nurse told him/her that Medicaid had denied the prior authorization for a nurse 5 times a week. An interview was conducted with Patient # 1's sibling and full-time HHA on 9/25/18 at 1:50 PM. The sibling reported the parent administered the G-Tube feedings for Patient #1 before he/she left for work. The tube feeding schedule had been changed to late afternoon when the parent came home and then at bedtime. The sibling reported since he/she was working as a HHA it was not within his/her scope of practice to give the tube feedings. He/she reported they have not had a			

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nurse for 2/1/2 years and have been told the agency would get a nurse for the feedings 5 days a week. The sibling reported she/he had been told the PA visits for 5 times a week had been denied.

An interview was conducted with the administrator on 9/24/18 at 2:35 PM. The administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided.

3. The clinical record of Patient # 2 with a SOC date of 9/28/15 and a certification period of 7/14/18 to 9/11/18, with services to include HHA 8 hours a day 5 days a week for assistance with IADL's and ADL's was reviewed with the following findings:

The HHA provided visits 6 days in week 4 of the certification period ranging from 3 to 11 hours a day for a weekly total of 46 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 4 days in week 5 of the certification period ranging from 8-9 hours a day for a weekly total of 33 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 4 days in week 7 of the certification period ranging from 7-8 hours a day for a weekly total of 31 hours. The HHA failed to perform the visits as ordered.

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The HHA provided visits 6 days in week 8 of the certification period ranging for 7 hours daily for a weekly total of 42 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 3 days in week 9 of the certification period ranging from 4 to 11 hours for a weekly total of 22 hours. The HHA failed to perform the visits as ordered.

An interview was conducted with the administrator on 9/26/18 at 2:45 PM regarding the failure to provide HHA visits 8 hours/ 5 days a week as ordered. The administrator reported, " All I can say the changes and hours are an error ... It doesn't look like the aide reported changes in schedule." The administrator had no further documentation to be provided.

4. The clinical record of Patient # 4 with a SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed with the following findings:

The SN failed to conduct a supervisory visit in the month of August 2018. This exceeded the Agency policy by 2 days.

For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during week 5, 6, 7 and 2 visits during week 8.

For the certification period of 9/9/18 to 11/17/18,

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	the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3. An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind." An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided. 5. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week for assistance with IADL's and ADL's was reviewed with the following findings: During the certification period of 6/19/16 to 8/17/16, the HHA failed to provide 2 hours of care during weeks 3 and 4, 10 hours of care during week 6, and 4 hours of care during weeks 8 and 9. During the certification period of 8/18/16 to 10/16/16, there were no HHA visit notes for weeks 1,2, 3, 4, 5, 6, week. Week 7, 8, and 9 all were missing with the exception of 2-hour notes on 9/29/16, 9/30/16, 10/3/16 and 10/13/16. During the certification period of 10/17/16 to 12/14/16 the HHA failed to provide 10 hours during week 1, 18 hours during week 2, 18 hours during week 3 and with the exception of a 2-hour visit on 12/6/18. There were no further HHA notes for the certification period.			

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	An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes and if there were any orders to change the POC. The Administrator reported he/she was not working at the agency during that time period. He/she reported there was no additional information to be provided.			
G 0440 Bldg. 00	Based on record review and interview, the agency failed to inform the patient in writing the extent to which payment for HHA services may be expected from federally-funded programs for 2 of 7 clincial record reviewed (Patient # 2 and 5) in a sample of 7. Findings Include: 1. An agency policy titled, "Home Care Bill of Rights" was reviewed and stated, "Clients will be informed of their rights as a consumers of home care services. This include the right to voice grievances and request changes without discrimination, reprisal or unreasonable interruption of services ...1. A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event that the client is unable to make decision, the Home Care Bill of Rights shall be given to the client's legal guardian ...2. The client/caregiver shall be advised orally and in writing or their right to voice grievances ... Documentation of the receipt of the Home Care Bill of Rights will be maintained in the clinical	G 0440	G 440 The Administrator or designee will immediately review all active clinical records for evidence that the Patients' Rights including the disciplines to be provided, frequency, duration of services and the expected payment from federal-funded programs. If documentation is not present in the clinical record, documentation will be obtained to document correction of this deficiency. The DON or designee will educate administration/management, all clinicians on policy: Home Care Bill of Rights Home Health Admission Service Agreement To prevent this deficiency in the future, the DON will review each new admission with the RN that performed the initial comprehensive assessment to ensure all documentation of patient rights was reviewed verbally with the patient or legal representative and written	11/30/2018

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	record ...." 2. The clinical record of Patient # 2 with a start of care date of 9/28/18 and a certification period of 7/14/18 to 9/11/18 was reviewed. The clinical record contained a document titled, "Home Health Admission Service Agreement" dated 3/14/18. The "rates for services" section of the form to indicate payment expectation from the patient/ federally funded programs, services, frequency, and duration was blank and not completed. 3. The clinical record of Patient # 5 with a start of care date of 6/19/16 and a discharge date of 12/14/16 was reviewed and failed to evidence a contain a copy of the patient's rights. The administrator was interviewed on 9/26/18 at 4:00 PM regarding the incomplete service agreement that was in the clinical record of Patient's # 2 . The administrator stated, "I see what's wrong. I yelled at them about this." 4. The administrator was interviewed on 10/1/18 at 1:58 PM regarding the failure of the agency to produce copies of the patient's rights in the clinical record for Patient # 5. The administrator was unable to produce any further documentation of the patient's rights in the clinical records.		documentation of this was obtained during this assessment, the Administrator or designee will be responsible for all active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed on 11/08/2018.	
G 0480 Bldg. 00	Based on record review and interview, the agency failed to investigate complaints that were made in regards to lack of care being provided by the agency for 3 of 7 clinical records reviewed. (Patients # 1, 4 and 5)	G 0480	G 480 The phone message system will be updated immediately to include the Administrators number in the event that a patient or family member wishes to file a complaint or grievance and all complaints	11/30/2018

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	Findings Include: 1. An agency policy titled, "Client/Family Complaint /Grievance Policy" was reviewed and stated, " Definitions: Client Complaint: A complaint is defined as "any expression of dissatisfaction by a client/family regarding care or services that can be addressed at the time of complaint by staff present" ... Grievance: A grievance is any formal or informal written expression of dissatisfaction with care or services that is expressed by the client/family that is not solved at that time by staff present ... Any complaint that fits the grievance definition will require a written response to the person complaining ... Special Instructions ... 2. Client complaints will be documented on a client complaint form and filed with the complaint log in an administrative file. 3. The grievance as defined above include treatment, services ... will be documented on the grievance form by the person receiving the complain/grievances e and forwarded as soon as possible to the appropriate director ... for investigation action and trending. 4. Grievance will be addressed by the department director or his/her designee and response made to the complainant within 7 calendar days ... and the responsible person will report back within 30 calendar days with a resolution of the grievance. All persons with a grievance will receive a written notice of the investigators review...7. Grievances are considered completed when an approved response has been mailed to the client/complainant ...the originally along with the letters sent ... are returned to the administrator or Quality Designee for tabulation and trending of data ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with		/grievances will be forwarded to the Administrator or designee and will be documented, investigated, with resolution and logged in the complaint log book, complaint / grievances will be processed according to agency policy. The Administrator will review the Client/Family complaint/grievance policy. The Administrator or designee will educate administration/management, all clinicians on policy: Client/Family complaint/grievance policy To prevent this deficiency in the future, all complaints/grievances will be reviewed with the QAPI committee and Governing Body quarterly for trending of complaints / grievances. Any trends will be investigated and QAPI committee will address any trends identified. Education on Client/Family complaint / grievance policy completed 11/08/2018.	

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	the following findings: The POC for the certification period of 7/18/16 to 9/15/16 included orders for skilled nurse 5 times a week for G-Tube (a tube in the stomach where liquid nutrition is provided) feedings while the parent was at work and HHA services 6 times a week. The SN failed to provide services until 8/9/16 (21 days) after the SOC. The HHA provided services 5 times a week 1- 2 and 3 times week 6 of the certification period and failed to conduct visits as ordered. The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while the parent was at work and HHA services 6 times a week for assistance with IADL's and ADL's. SN services were provided 4 times during week 6, 3 times during week 7, 0 times during week 8, and 2 times during week 9 of the certification period and failed to be provided as ordered. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist the family in finding a nursing care via another agency at this time family has declined this offer. Currently, mother is coming home at noon to feed daughter via G-Tube until nursing staff available." The HHA services were provided 3 times during week 5 of the certification period and failed to be conducted as ordered. The POC for the certification period of 11/15/16 to 1/13/17 included orders for SN 5 times a week for G-Tube feedings and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 4 of the 45 visits ordered on the POC for the certification period and failed to			

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	provide visits as ordered. The POC for the certification period of 1/14/17 to 3/14/17 included orders for SN 1 time a week for G-tube feedings each visit and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 5 visits in the certification period and failed to provide visit as ordered. There were no orders to change the POC. A SN note 3/14/17 stated, "Informed the cg (caregiver) of SN visits weekly for skilled intervention, but that daily is not achievable and not necessary when available CG competent in administration of feedings. Encourage to call agency office prn (as needed)." The POC for the certification period of 3/15/17 to 5/13/17 included orders for SN 1 time a week for assessment and instruction to caregivers and HHA 6 times a week for assistance with IADL'S and ADL's. The SN failed to provide 1 visit weekly for the weeks 1-3 of the certification period. The clinical record failed to evidence documentation of any HHA visits for weeks 4-9 of the certification period. The POC for the certification period of 5/14/17 to 7/12/17 included orders for SN 1 time a week for assessment and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The POC failed to include the duration of the SN and HHA services. The clinical record failed to evidence documentation of HHA visits for week 1 and 2. The HHA conducted 6 visits week 4-8 and 4 visits during week 9 of the certification period. The POC for the certification period of 7/13/17 to 9/101/7 included orders for SN 5 times a week for G-tube feedings and HHA 9 hours a day for 5			

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days a week for assistance with IADL's and ADL's. The SN provided 1 visit during weeks 2-3 and 5-9 of the certification period and failed to provide 5 visits per week as ordered. The HHA conducted 3 visits during week 1 and 6 visits during week 2-9 of the certification period and failed to provide visits 5 times weekly as ordered.

The POC for the certification period of 9/11/17 to 11/9/17 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 2 visits during weeks 1 and 4-8, 0 visits during week 2 and 1 visit during week 9 of the certification period. The SN failed to provide as ordered. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during week 8 and 9 of the certification period. The HHA failed to provided visits as ordered.

A SN note dated 9/11/17 stated, "continues to request daily SN to cover G-Tube feedings while mother is at work. Will discuss with leadership. Parent states at this time his/her family has been able to cover the other days of the week there has not been a daily RN."

The POC for the certification period of 11/10/17 to 1/8/18 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. There were orders present to change the SN frequency to 1 visit during week 7 and 9 of the certification period. The SN failed to follow the POC and provided visits 2 times during weeks 2-6. No SN visits were conducted during week 1 and 8. The HHA provided 1 visit week 1 of the certification period on 11/10/17, 6 visits during weekly from 12/3/17 to 1/6/18. The HHA failed to provide visits as ordered.

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The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week for tube G-tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided visits 1 time during week 1 and 2 times during week 2-9 of the certification period. The SN failed to provide visits as ordered. The HHA provided visits 4 times a week from 1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and 1/11/18. The HHA provided visits 5 times a week from 1/15/18 to 1/19/18 with 14-hour visits on 1/16/18 and 1/18/18. The HHA provided visits 6 times a week from 1/21/18 to 3/9/18. The HHA failed to provide visits as ordered.

The POC for the certification period of 3/10/18 to 5/8/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1, 2, 3, 4, 6, 8, and 3 visits during week 9. The HHA failed to provide visits as ordered.

The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. A 14-hour visit on 5/9/18 and a 10-hour visit 5/12/18. The HHA provided 4 visits a week from 5/13/18 to 5/16/18 and 6 visits weekly from 5/17/18 to 7/7/18, when the clinical record evidenced that the patient was in the hospital from 5/17/18 to 6/1/18.

The POC for the certification period of 7/8/18 to

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AGING & DISABLED HOME HEALTH CARE LLC	10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256

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	9/5/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1-8 and 3 visits during week 9 of the verification period. The HHA provided 14-hour visits on 7/8/18, 7/10/18, 7/12/18. The HHA failed to provide visits as ordered. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 1 of the certification period and failed to provide visits as ordered. The HHA provided 3 visits during week 1 and 6 visits during weeks 2 and 3 of the certification period. The HHA provided 14-hour visits on 9/6/18, 9/11/8.9/13/18, 9/18/18, and 9/20/18 and 16-hour visits on 9/9/18 and 9/16/18. The HHA failed to provide services as ordered. A PA (prior authorization) was requested for patient # 1. The administrator provided a PA for the period of 8/8/18 to 2/6/19. The administrator was unable to present any other PAs for clinical record #1. The current PA established the SN services were requested for 2 times weekly and not 5 times weekly. An interview was conducted with the Parent of Patient # 1 on 9/24/18 at 10: 00 AM. The Parent reported that he/she worked 5-6 days a week. The patient's full-time HHA for the agency, the patient's sibling can not administer tube feedings in the role of a HHA. Without a nurse to come to the home daily the parent had to change the			

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	patient bolus G-tube feeding schedule. The parent reported when the patient had been admitted on (7/18/16) the feedings had been given in mid day by a nurse of the agency. The parent reported the full-time nurse left the agency around November of 2016 and soon after the agency stopped sending a nurse 5 days a week. The parent reported he/she was told that the agency was working on getting a replacement nurse. The parent reported he/she had reported to the patient's nurses and to the agency that he/she needed a nurse 5 days a week, but the staffing concern had not been addressed or resolved. The parent reported a nurse had told him/her that a nurse was not necessary and another nurse told him/her that Medicaid had denied the prior authorization for a nurse 5 times a week. An interview was conducted with Patient # 1's sibling and full-time HHA on 9/25/18 at 1:50 PM. The sibling reported the parent administered the G-Tube feedings for Patient #1 before he/she left for work. The tube feeding schedule had been changed to late afternoon when the parent came home and then at bedtime. The sibling reported since he/she was working as a HHA it was not within his/her scope of practice to give the tube feedings. He/she reported they have not had a nurse for 2/1/2 years and have been told the agency would get a nurse for the feedings 5 days a week. The sibling reported she/he had been told the PA visits for 5 times a week had been denied. An interview was conducted with the administrator on 9/24/18 at 2:35 PM. The administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in			

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	the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided. 3. The clinical record of Patient # 4 with an original SOC of 7/29/16, a recent readmission SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed with the following findings: The SN failed to conduct a supervisory visit in the month of August, 2018. This exceeded the Agency policy by 2 days. For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during weeks 5, 6, 7 and 2 visits during week 8. For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3. An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind."			

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An interview was conducted with the administrator on 10/1/18 at 4:30 PM regarding the missed visits for Patient #4. The complaint log failed to include any complaints regarding missed services for Patient # 4. The administrator reported he/she was not made aware of the missed visits or the complaints expressed to the staff by Patient # 4. The administrator reported there was no further documentation to be provided.

4. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week for assistance with IADL's and ADL's was reviewed with the following findings:

A SN note for a HHA supervisory visit 9/23/16 was reviewed and stated, "Past Tuesday had no night time coverage. CG (caregiver) stated office knew about client not being covered. CG and patient highly satisfied with aides, C/O (complained of) poor office communication."

The agency complaint log was reviewed on 10/1/18 and failed to include any documentation of a complaint from the family of Patient # 5 regarding missed visits and poor office communication.

An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes, orders to change the plan of care, patient rights and admission agreement. The administrator reported he/she could not locate the missing documents. In addition the Administrator was asked about the failure of the agency to document the complaint from the family of Patient # 5. The Administrator reported he/she was not working at the agency during 2016 and

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	did not know why the complaint was not documented or investigated.			
G 0484 Bldg. 00	Based on record review and interview, the agency failed to document and resolve complaints for 3 of 7 patients record reviews. (Patients # 1, 4 and 5) in a sample of 7. Findings Include: 1. An agency policy titled, "Client/Family Complaint /Grievance Policy" was reviewed and stated, "Definitions: Client Complaint: A complaint is defined as "any expression of dissatisfaction by a client/family regarding care or services that can be addressed at the time of complaint by staff present" ... Grievance: A grievance is any formal or informal written expression of dissatisfaction with care or services that is expressed by the client/family that is not solved at that time by staff present ... Any complaint that fits the grievance definition will require a written response to the person complaining ... Special Instructions ... 2. Client complaints will be documented on a client complaint form and filed with the complaint log in an administrative file. 3. The grievance as defined above include treatment, services ... will be documented on the grievance form by the person receiving the complain/grievances e and forwarded as soon as possible to the appropriate director ... for investigation action and trending. 4. Grievance will be addressed by the department director or his/her designee and response made to the complainant within 7 calendar days ... and the responsible person will report back within 30	G 0484	N 484 The Administrator or designee will immediately review all clinical records for coordination of care between SN/HHA. Immediately all RN case managers will be required to conference with the HHA weekly for patients they case manage, and document this coordination of care through a communication note in the clinical record. The DON or designee will educate administration/management, all clinicians on policy: Coordination of Client Services Home Health Aide Supervision Care Planning/ Coordination of Care Home health aides will be educated on: "What to Report to RN, Case Manager" Home Health Aide Documentation To prevent this deficiency in the future, the RN case managers will be required to review all HHA documentation and perform weekly conference with HHA's for	11/30/2018

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	calendar days with a resolution of the grievance. All persons with a grievance will receive a written notice of the investigators review...7. Grievances are considered completed when an approved response has been mailed to the client/complainant ...the originally along with the letters sent ... are returned to the administrator or Quality Designee for tabulation and trending of data ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: An interview was conducted with the Parent of Patient # 1 on 9/24/18 at 10: 00 AM. The Parent reported that he/she worked 5-6 days a week. The patient's full time HHA for the agency, the patient's sibling can not administer tube feedings in the role of a HHA. Without a nurse to come to the home daily the parent had to change the patient bolus G-tube feeding schedule. The parent reported when the patient had been admitted on (7/18/16) the feedings had been given in mid day by a nurse of the agency. The parent reported the full time nurse left the agency around November of 2016 and soon after the agency stopped sending a nurse 5 days a week. The parent reported he/she was told that the agency was working on getting a replacement nurse. The parent reported he/she had reported to the patient's nurses and to the agency that he/she needed a nurse 5 days a week, but the staffing concern had not been addressed or resolved. The parent reported a nurse had told him/her that a nurse was not necessary and another nurse told him/her that medicaid had denied the prior authorization for a nurse 5 times a week. An interview was conducted with Patient # 1's		all the patients they case manage. RN case manager will also review the aide care plan with the assigned home health aide prior to the home health aide providing services to the patient and review the home health aide care plan with the home health aide at least every 60 days or when there is a change in the patients' condition. the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	

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	sibling and full time HHA on 9/25/18 at 1:50 PM. The sibling reported the parent administered the G-Tube feedings for Patient #1 before he/she left for work. The tube feeding schedule had been changed to late afternoon when the parent came home and then at bedtime. The sibling reported since he/she was working as a HHA it was not within his/her scope of practice to give the tube feedings. He/she reported they have not had a nurse for 2/1/2 years and have been told the agency would get a nurse for the feedings 5 days a week. The sibling reported she/he had been told the PA visits for 5 times a week had been denied. An interview was conducted with the administrator on 9/24/18 at 2:35 PM. The administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided. 3. The clinical record of Patient # 4 with an original SOC of 7/29/16, a recent readmission SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed with the following findings: An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had			

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been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind."

An interview was conducted with the administrator on 10/1/18 at 4:30 PM regarding the missed visits for Patient #4. The complaint log failed to include any complaints regarding missed services for Patient # 4. The administrator reported he/she was not made aware of the missed visits or the complaints expressed to the staff by Patient # 4. The administrator reported there was no further documentation to be provided.

4. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week for assistance with IADL's and ADL's was reviewed with the following findings:

A SN note for a HHA supervisory visit 9/23/16 was reviewed and stated, "Past Tuesday had no night time coverage. CG (caregiver) stated office knew about client not being covered. CG and patient highly satisfied with aides, C/O (complained of) poor office communication."

The agency complaint log was reviewed on 10/1/18 and failed to include any documentation of a complaint from the family of Patient # 5 regarding missed visits and poor office communication.

An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes, orders to change the plan of care, patient rights and admission agreement. The administrator reported he/she could not

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	locate the missing documents. In addition the Administrator was asked about the failure of the agency to document the complaint from the family of Patient # 5. The Administrator reported he/she was not working at the agency during 2016 and did not know why the complaint was not documented or investigated.			
G 0546 Bldg. 00	Based on record review and interview the agency failed to complete the comprehensive assessment the last 5 days of every 60 days for 1 of 7 (Patient #1) clinical records reviewed. Findings Include: An agency policy titled, "Client Reassessment/Update of Comprehensive Assessment" was reviewed and stated, "The Comprehensive Assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status. Assessment will include OASIS data collection for all Medicare and Medicaid skilled clients ... Reassessments must be done at least: 1. Every second calendar month beginning with start of care within the last five (5) days of the episode, including day sixty (60) ...." The clincial record of Patient #1 with a SOC (start of care) date of 7/18/16 was reviewed. During the certification period of 11/15/16 to 1/13/17, the clinical record evidenced an OASIS recertification reassessment that was completed on 1/18/17. The OASIS recertification reassessment failed to be completed within the last 5 days of the certification period (between 1/9/17 to 1/13/17).	G 0546	N 546 The Administrator or designee will immediately review all clinical records for coordination of care with any patient receiving dialysis, wound care. If coordination of care has not been established the DON or RN case manager will establish this coordination of care by calling the dialysis center or wound care center and request weekly updates on patients care. The DON or designee will educate administration/management, all clinicians on policy: Coordination of Client Services To prevent this deficiency in the future, the DON will audit these clinical records weekly to ensure updates from these providers are present in the clinical record, if not present the DON will call the provider for an update and notify the RN case Manager of the update so the RN can update the POC if needed.	11/30/2018

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	The administrator was interviewed on 9/27/18 at 2:50 PM regarding the failure of the nurse to complete the OASIS assessment timely. The administrator reported he/she did not know why the assessment had been conducted late and there was no further documentation to be provided.		The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency does nor reoccur. Education completed on 11/11/2018.	
G 0570 Bldg. 00	Based on record review and interview, the agency failed to ensure they accepted patients with an expectation that the agency would meet their needs for 1 out of 4 patients receiving SN (Skilled Nurse) and 4 of 4 patient's receiving HHA services (Patients #1, 2, 4, 5) (See G 570), failed to ensure all services outlined in the POC (Plan Of Care) was provided (See Tag G 572), failed to accurately complete the plan of care to include the frequency and duration of visits to be conducted, the nutritional requirements, all medications and treatments and measurable goals (See Tag G 574), failed to ensure communication occurred with the nephrologist caring for 1 ESRD (End State Renal Dialysis) patient receiving hemodialysis (See Tag G 602), and failed to ensure the clinical record included documentation of coordination between the SN (skilled nurse) and the HHA (home health aide) regarding a change in the patient's skin condition that progressed from irritation to a stage 3 pressure ulcer (See Tag G 606) The cumulative effect of these systemic problems resulted in the home health agency's inability to	G 0570	G 570 The agency will immediately do away with the practice of accepting referrals without approval of the DON. The administrator or designee will immediately review all active clinical records for evidence that all services in the POC are being provided. If there is evidence that the POC is not being followed the DON will call the PCP for a verbal order to update the plan of care and the POC will be updated in the clinical record and sent to the PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON will call the patient and offer to transfer them to an agency that can provide all services in the POC. If patient agrees to be transferred to another agency the DON will facilitate a transfer to an agency of the patients choice. The Administrator or designee will	11/30/2018

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	provide quality health care in a safe environment for the Condition of Participation at 42 CFR 484.60: Coordination of Care. In regards to G570, findings include: 1. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ... The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. Medications, treatments, and procedures ... p. Treatment goals... At the time of certification and recertification, a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed. The agency failed to meet the patient's needs as evidenced by the following findings: The POC for the certification period of 7/18/16 to 9/15/16 included orders for skilled nurse 5 times a week for G-Tube (a tube in the stomach where liquid nutrition is provided) feedings while the		educate administration/management, all clinicians on policy: Admission Policy Client Admission Process Comprehensive Client Assessment Plan of Care Coordination of Client Care Service Agreement Skilled Nursing Services Client/Caregiver Education Client Discharge Policy Therapy Services To prevent this deficiency in the future, the DON will review all new referrals to ensure that before acceptance of referral the agency can reasonably meet the needs of the patient before acceptance of such referral. The DON will sign off on all accepted referrals as evidence that she reviewed the referral. The Administrator or designee will review all referrals weekly with the DON.	

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	parent was at work and HHA services 6 times a week. The SN failed to provide services until 8/9/16 (21 days) after the SOC. The HHA provided services 5 times a week 1- 2 and 3 times week 6 of the certification period and failed to conduct visits as ordered. The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while the parent was at work and HHA services 6 times a week for assistance with IADL's and ADL's. SN services were provided 4 times during week 6, 3 times during week 7, 0 times during week 8, and 2 times during week 9 of the certification period and failed to be provided as ordered. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist the family in finding a nursing care via another agency at this time family has declined this offer. Currently, mother is coming home at noon to feed daughter via G-Tube until nursing staff available." The HHA services were provided 3 times during week 5 of the certification period and failed to be conducted as ordered. The POC for the certification period of 11/15/16 to 1/13/17 included orders for SN 5 times a week for G-Tube feedings and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 4 of the 45 visits ordered on the POC for the certification period and failed to provide visits as ordered. The POC for the certification period of 1/14/17 to 3/14/17 included orders for SN 1 time a week for G-tube feedings each visit and HHA 6 times a week for assistance with IADL's and ADL's. The			

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	SN conducted a total of 5 visits in the certification period and failed to provide visit as ordered. There were no orders to change the POC. A SN note 3/14/17 stated, "Informed the cg (caregiver) of SN visits weekly for skilled intervention, but that daily is not achievable and not necessary when available CG competent in administration of feedings. Encourage to call agency office prn (as needed)." The POC for the certification period of 3/15/17 to 5/13/17 included orders for SN 1 time a week for assessment and instruction to caregivers and HHA 6 times a week for assistance with IADL'S and ADL's. The SN failed to provide 1 visit weekly for the weeks 1-3 of the certification period. The clinical record failed to evidence documentation of any HHA visits for weeks 4-9 of the certification period. The POC for the certification period of 5/14/17 to 7/12/17 included orders for SN 1 time a week for assessment and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The POC failed to include the duration of the SN and HHA services. The clinical record failed to evidence documentation of HHA visits for week 1 and 2. The HHA conducted 6 visits week 4-8 and 4 visits during week 9 of the certification period. The POC for the certification period of 7/13/17 to 9/101/7 included orders for SN 5 times a week for G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during weeks 2-3 and 5-9 of the certification period and failed to provide 5 visits per week as ordered. The HHA conducted 3 visits during week 1 and 6 visits during week 2-9 of the certification period and			

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	failed to provide visits 5 times weekly as ordered. The POC for the certification period of 9/11/17 to 11/9/17 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 2 visits during weeks 1 and 4-8, 0 visits during week 2 and 1 visit during week 9 of the certification period. The SN failed to provide as ordered. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during week 8 and 9 of the certification period. The HHA failed to provided visits as ordered. A SN note dated 9/11/17 stated, "continues to request daily SN to cover G-Tube feedings while mother is at work. Will discuss with leadership. Parent states at this time his/her family has been able to cover the other days of the week there has not been a daily RN." The POC for the certification period of 11/10/17 to 1/8/18 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. There were orders present to change the SN frequency to 1 visit during week 7 and 9 of the certification period. The SN failed to follow the POC and provided visits 2 times during weeks 2-6. No SN visits were conducted during week 1 and 8. The HHA provided 1 visit week 1 of the certification period on 11/10/17, 6 visits during weekly from 12/3/17 to 1/6/18. The HHA failed to provide visits as ordered. The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week for tube G-tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN			

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	provided visits 1 time during week 1 and 2 times during week 2-9 of the certification period. The SN failed to provide visits as ordered. The HHA provided visits 4 times a week from 1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and 1/11/18. The HHA provided visits 5 times a week from 1/15/18 to 1/19/18 with 14-hour visits on 1/16/18 and 1/18/18. The HHA provided visits 6 times a week from 1/21/18 to 3/9/18. The HHA failed to provide visits as ordered. The POC for the certification period of 3/10/18 to 5/8/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1, 2, 3, 4, 6, 8, and 3 visits during week 9. The HHA failed to provide visits as ordered. The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. A 14-hour visit on 5/9/18 and a 10-hour visit 5/12/18. The HHA provided 4 visits a week from 5/13/18 to 5/16/18 and 6 visits weekly from 5/17/18 to 7/7/18, when the clinical record evidenced that the patient was in the hospital from 5/17/18 to 6/1/18. The POC for the certification period of 7/8/18 to 9/5/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6			

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	visits during weeks 1-8 and 3 visits during week 9 of the verification period. The HHA provided 14-hour visits on 7/8/18, 7/10/18, 7/12/18. The HHA failed to provide visits as ordered. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 1 of the certification period and failed to provide visits as ordered. The HHA provided 3 visits during week 1 and 6 visits during weeks 2 and 3 of the certification period. The HHA provided 14-hour visits on 9/6/18, 9/11/8.9/13/18, 9/18/18, and 9/20/18 and 16-hour visits on 9/9/18 and 9/16/18. The HHA failed to provide services as ordered. A PA (prior authorization) was requested for patient # 1. The administrator provided a PA for the period of 8/8/18 to 2/6/19. The administrator was unable to present any other PAs for clinical record #1. The current PA established the SN services were requested for 2 times weekly and not 5 times weekly. An interview was conducted with the Parent of Patient # 1 on 9/24/18 at 10: 00 AM. The Parent reported that he/she worked 5-6 days a week. The patient's full-time HHA for the agency, the patient's sibling can not administer tube feedings in the role of a HHA. Without a nurse to come to the home daily the parent had to change the patient bolus G-tube feeding schedule. The parent reported when the patient had been admitted on (7/18/16) the feedings had been given in mid day by a nurse of the agency. The parent reported the full-time nurse left the agency around November of 2016 and soon after the agency stopped			

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	sending a nurse 5 days a week. The parent reported he/she was told that the agency was working on getting a replacement nurse. The parent reported he/she had reported to the patient's nurses and to the agency that he/she needed a nurse 5 days a week, but the staffing concern had not been addressed or resolved. The parent reported a nurse had told him/her that a nurse was not necessary and another nurse told him/her that Medicaid had denied the prior authorization for a nurse 5 times a week. An interview was conducted with Patient # 1's sibling and full-time HHA on 9/25/18 at 1:50 PM. The sibling reported the parent administered the G-Tube feedings for Patient #1 before he/she left for work. The tube feeding schedule had been changed to late afternoon when the parent came home and then at bedtime. The sibling reported since he/she was working as a HHA it was not within his/her scope of practice to give the tube feedings. He/she reported they have not had a nurse for 2/1/2 years and have been told the agency would get a nurse for the feedings 5 days a week. The sibling reported she/he had been told the PA visits for 5 times a week had been denied. An interview was conducted with the administrator on 9/24/18 at 2:35 PM. The administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be			

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provided.

3. The clinical record of Patient # 2 with a SOC date of 9/28/15 and a certification period of 7/14/18 to 9/11/18, with services to include HHA 8 hours a day 5 days a week for assistance with IADL's and ADL's was reviewed. The agency failed to meet the patient's needs as evidenced by the following findings:

The HHA provided visits 6 days in week 4 of the certification period ranging from 3 to 11 hours a day for a weekly total of 46 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 4 days in week 5 of the certification period ranging from 8-9 hours a day for a weekly total of 33 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 4 days in week 7 of the certification period ranging from 7-8 hours a day for a weekly total of 31 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 6 days in week 8 of the certification period ranging for 7 hours daily for a weekly total of 42 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 3 days in week 9 of the certification period ranging from 4 to 11 hours for a weekly total of 22 hours. The HHA failed to perform the visits as ordered.

An interview was conducted with the administrator on 9/26/18 at 2:45 PM regarding the failure to provide HHA visits 8 hours/ 5 days a week as ordered. The administrator reported, " All I can say the changes and hours are an error ... It

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doesn't look like the aide reported changes in schedule." The administrator had no further documentation to be provided.

4. The clinical record of Patient # 4 with a SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed. The agency failed to meet the patient's needs as evidenced by the following findings:

The SN failed to conduct a supervisory visit in the month of August 2018. This exceeded the Agency policy by 2 days.

For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during week 5, 6, 7 and 2 visits during week 8.

For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3.

An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind."

An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be

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	provided. 5. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week for assistance with IADL's and ADL's was reviewed. The agency failed to meet the patient's needs as evidenced by the following findings: During the certification period of 6/19/16 to 8/17/16, the HHA failed to provide 2 hours of care during weeks 3 and 4, 10 hours of care during week 6, and 4 hours of care during weeks 8 and 9. During the certification period of 8/18/16 to 10/16/16, there were no HHA visit notes for weeks 1,2, 3, 4, 5, 6, week. Week 7, 8, and 9 all were missing with the exception of 2-hour notes on 9/29/16, 9/30/16, 10/3/16 and 10/13/16. During the certification period of 10/17/16 to 12/14/16, the HHA failed to provide 10 hours during week 1, 18 hours during week 2, 18 hours during week 3 and with the exception of a 2-hour visit on 12/6/18. There were no further HHA notes for the certification period. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes and if there were any orders to change the POC. The Administrator reported he/she was not working at the agency during that time period. He/she reported there was no additional information to be provided.			
G 0572 Bldg. 00	Based on record review and interviews, the agency failed to ensure all services outlined in the	G 0572	G 572 The Administrator or designee will immediately review	11/30/2018

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	POC (Plan Of Care) was provided in 1 out of 4 (Patient #1) record reviewed of patients receiving SN (Skilled Nurse) and 4 of 4 patient (Patients # 1, 2, 4 and 5) record reviewed of patients receiving HHA (Home Health Aide) in a sample of 7 patients. Findings Include: 1. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ... The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. Medications, treatments, and procedures ... p. Treatment goals... At the time of certification and recertification, a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to		all clinical records with SN/ HHA services are being provided. If there is evidence that the POC is not being followed the DON will call the PCP for a verbal order to update the plan of care and the POC will be updated in the clinical record and sent to the PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON will call the patient and offer to transfer them to an agency that can provide all services in the POC. If patient agrees to be transferred to another agency the DON will facilitate a transfer to an agency of the patients choice and documentation of conversation with patient will be recorded in the patients clinical record. The Administrator or designee will educate administration/management, all clinicians/home health aides on policy: Plan of Care To prevent this deficiency in the future, the DON will monitor the services of all clients weekly through audits of services provided and any trends will be addressed weekly with the administrator. The Administrator or designee will also do clinical records audits until 100% compliance is met, then 10% of clinical records thereafter	

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	9/15/16 included orders for skilled nurse 5 times a week for G-Tube (a tube in the stomach where liquid nutrition is provided) feedings while the parent was at work and HHA services 6 times a week. The SN failed to provide services until 8/9/16 (21 days) after the SOC. The HHA provided services 5 times a week 1- 2 and 3 times week 6 of the certification period and failed to conduct visits as ordered. The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while the parent was at work and HHA services 6 times a week for assistance with IADL's and ADL's. SN services were provided 4 times during week 6, 3 times during week 7, 0 times during week 8, and 2 times during week 9 of the certification period and failed to be provided as ordered. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist the family in finding a nursing care via another agency at this time family has declined this offer. Currently, mother is coming home at noon to feed daughter via G-Tube until nursing staff available." The HHA services were provided 3 times during week 5 of the certification period and failed to be conducted as ordered. The POC for the certification period of 11/15/16 to 1/13/17 included orders for SN 5 times a week for G-Tube feedings and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 4 of the 45 visits ordered on the POC for the certification period and failed to provide visits as ordered. The POC for the certification period of 1/14/17 to		quarterly to ensure deficiency does not reoccur. Education on Plan of Care was completed 11/08/2018.	

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	3/14/17 included orders for SN 1 time a week for G-tube feedings each visit and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 5 visits in the certification period and failed to provide visit as ordered. There were no orders to change the POC. A SN note 3/14/17 stated, "Informed the cg (caregiver) of SN visits weekly for skilled intervention, but that daily is not achievable and not necessary when available CG competent in administration of feedings. Encourage to call agency office prn (as needed)." The POC for the certification period of 3/15/17 to 5/13/17 included orders for SN 1 time a week for assessment and instruction to caregivers and HHA 6 times a week for assistance with IADL'S and ADL's. The SN failed to provide 1 visit weekly for the weeks 1-3 of the certification period. The clinical record failed to evidence documentation of any HHA visits for weeks 4-9 of the certification period. The POC for the certification period of 5/14/17 to 7/12/17 included orders for SN 1 time a week for assessment and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The POC failed to include the duration of the SN and HHA services. The clinical record failed to evidence documentation of HHA visits for week 1 and 2. The HHA conducted 6 visits week 4-8 and 4 visits during week 9 of the certification period. The POC for the certification period of 7/13/17 to 9/101/7 included orders for SN 5 times a week for G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during weeks 2-3 and 5-9 of the certification period and failed to			

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	provide 5 visits per week as ordered. The HHA conducted 3 visits during week 1 and 6 visits during week 2-9 of the certification period and failed to provide visits 5 times weekly as ordered. The POC for the certification period of 9/11/17 to 11/9/17 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 2 visits during weeks 1 and 4-8, 0 visits during week 2 and 1 visit during week 9 of the certification period. The SN failed to provide as ordered. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during week 8 and 9 of the certification period. The HHA failed to provided visits as ordered. A SN note dated 9/11/17 stated, "continues to request daily SN to cover G-Tube feedings while mother is at work. Will discuss with leadership. Parent states at this time his/her family has been able to cover the other days of the week there has not been a daily RN." The POC for the certification period of 11/10/17 to 1/8/18 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. There were orders present to change the SN frequency to 1 visit during week 7 and 9 of the certification period. The SN failed to follow the POC and provided visits 2 times during weeks 2-6. No SN visits were conducted during week 1 and 8. The HHA provided 1 visit week 1 of the certification period on 11/10/17, 6 visits during weekly from 12/3/17 to 1/6/18. The HHA failed to provide visits as ordered. The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week for			

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	tube G-tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided visits 1 time during week 1 and 2 times during week 2-9 of the certification period. The SN failed to provide visits as ordered. The HHA provided visits 4 times a week from 1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and 1/11/18. The HHA provided visits 5 times a week from 1/15/18 to 1/19/18 with 14-hour visits on 1/16/18 and 1/18/18. The HHA provided visits 6 times a week from 1/21/18 to 3/9/18. The HHA failed to provide visits as ordered. The POC for the certification period of 3/10/18 to 5/8/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1, 2, 3, 4, 6, 8, and 3 visits during week 9. The HHA failed to provide visits as ordered. The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. A 14-hour visit on 5/9/18 and a 10-hour visit 5/12/18. The HHA provided 4 visits a week from 5/13/18 to 5/16/18 and 6 visits weekly from 5/17/18 to 7/7/18, when the clinical record evidenced that the patient was in the hospital from 5/17/18 to 6/1/18. The POC for the certification period of 7/8/18 to 9/5/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with			

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	IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1-8 and 3 visits during week 9 of the verification period. The HHA provided 14-hour visits on 7/8/18, 7/10/18, 7/12/18. The HHA failed to provide visits as ordered. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 1 of the certification period and failed to provide visits as ordered. The HHA provided 3 visits during week 1 and 6 visits during weeks 2 and 3 of the certification period. The HHA provided 14-hour visits on 9/6/18, 9/11/8.9/13/18, 9/18/18, and 9/20/18 and 16-hour visits on 9/9/18 and 9/16/18. The HHA failed to provide services as ordered. A PA (prior authorization) was requested for patient # 1. The administrator provided a PA for the period of 8/8/18 to 2/6/19. The administrator was unable to present any other PAs for clinical record #1. The current PA established the SN services were requested for 2 times weekly and not 5 times weekly. An interview was conducted with the Parent of Patient # 1 on 9/24/18 at 10: 00 AM. The Parent reported that he/she worked 5-6 days a week. The patient's full-time HHA for the agency, the patient's sibling can not administer tube feedings in the role of a HHA. Without a nurse to come to the home daily the parent had to change the patient bolus G-tube feeding schedule. The parent reported when the patient had been admitted on (7/18/16) the feedings had been given in mid day			

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	by a nurse of the agency. The parent reported the full-time nurse left the agency around November of 2016 and soon after the agency stopped sending a nurse 5 days a week. The parent reported he/she was told that the agency was working on getting a replacement nurse. The parent reported he/she had reported to the patient's nurses and to the agency that he/she needed a nurse 5 days a week, but the staffing concern had not been addressed or resolved. The parent reported a nurse had told him/her that a nurse was not necessary and another nurse told him/her that Medicaid had denied the prior authorization for a nurse 5 times a week. An interview was conducted with Patient # 1's sibling and full-time HHA on 9/25/18 at 1:50 PM. The sibling reported the parent administered the G-Tube feedings for Patient #1 before he/she left for work. The tube feeding schedule had been changed to late afternoon when the parent came home and then at bedtime. The sibling reported since he/she was working as a HHA it was not within his/her scope of practice to give the tube feedings. He/she reported they have not had a nurse for 2/1/2 years and have been told the agency would get a nurse for the feedings 5 days a week. The sibling reported she/he had been told the PA visits for 5 times a week had been denied. An interview was conducted with the administrator on 9/24/18 at 2:35 PM. The administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made			

aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided.

3. The clinical record of Patient # 2 with a SOC date of 9/28/15 and a certification period of 7/14/18 to 9/11/18, with services to include HHA 8 hours a day 5 days a week for assistance with IADL's and ADL's was reviewed with the following findings:

The HHA provided visits 6 days in week 4 of the certification period ranging from 3 to 11 hours a day for a weekly total of 46 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 4 days in week 5 of the certification period ranging from 8-9 hours a day for a weekly total of 33 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 4 days in week 7 of the certification period ranging from 7-8 hours a day for a weekly total of 31 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 6 days in week 8 of the certification period ranging for 7 hours daily for a weekly total of 42 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 3 days in week 9 of the certification period ranging from 4 to 11 hours for a weekly total of 22 hours. The HHA failed to perform the visits as ordered.

An interview was conducted with the administrator on 9/26/18 at 2:45 PM regarding the failure to provide HHA visits 8 hours/ 5 days a week as ordered. The administrator reported, " All

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	I can say the changes and hours are an error ... It doesn't look like the aide reported changes in schedule." The administrator had no further documentation to be provided. 4. The clinical record of Patient # 4 with a SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed with the following findings: The SN failed to conduct a supervisory visit in the month of August 2018. This exceeded the Agency policy by 2 days. For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during week 5, 6, 7 and 2 visits during week 8. For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3. An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind." An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be			

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	provided. 5. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week for assistance with IADL's and ADL's was reviewed with the following findings: During the certification period of 6/19/16 to 8/17/16, the HHA failed to provide 2 hours of care during weeks 3 and 4, 10 hours of care during week 6, and 4 hours of care during weeks 8 and 9. During the certification period of 8/18/16 to 10/16/16, there were no HHA visit notes for weeks 1,2, 3, 4, 5, 6, week. Week 7, 8, and 9 all were missing with the exception of 2-hour notes on 9/29/16, 9/30/16, 10/3/16 and 10/13/16. During the certification period of 10/17/16 to 12/14/16 the HHA failed to provide 10 hours during week 1, 18 hours during week 2, 18 hours during week 3 and with the exception of a 2-hour visit on 12/6/18. There were no further HHA notes for the certification period. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes and if there were any orders to change the POC. The Administrator reported he/she was not working at the agency during that time period. He/she reported there was no additional information to be provided.			
G 0574 Bldg. 00	Based on observation, record review and interview, the agency failed to accurately	G 0574	G 574 The Administrator or designee will immediately review all clinical records for accurately	11/30/2018

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	complete the plan of care to include the frequency and duration of visits to be conducted for 4 of 7 (Patients # 1, 2, 4, 5), the nutritional requirements for 2 of 7 (Patient #1, 3) , all medications and treatments for 3 of 7 (Patient # 1, 2, 3) , and measurable goals for 1 of 7 (Patient # 1) in a sample of 7 clinical records. Findings Include: 1. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ...2. The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures ... p. Treatment goals...t. other appropriate items ... 9. At the time of certification and recertification , a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include, but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings:		completed plan of care including frequency and duration of services to be provided. If the POC is found to be missing frequency or duration the DON will call the PCP for a verbal order to update the POC and the POC of care will be updated with a physician order and then sent to PCP to be signed. The DON will do weekly audits to ensure the POC is updated, includes frequency, duration of visits, nutritional requirements, all medications, treatments with measurable goals, and current and past findings until 100% compliance is met. The DON or designee will educate, administration/management all clinicians on policy: Plan of Care Home Health Admission Service Agreement To prevent this deficiency in the future, the DON will monitor the services of all clients weekly through audits of services provided and any trends will be addressed weekly with the administrator. The Administrator or designee will also do clinical records audits until 100% compliance is met, then 10% of clinical records thereafter quarterly to ensure deficiency does not reoccur. Education completed on	

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	The POC for the certification period of 7/18/16 to 9/15/16, included orders for skilled nurse 5 times a week and HHA services 6 times a week. The POC failed to include the duration for the SN (skilled nurse) and failed to include the HHA (Home Health Aide) time and duration and services to be provided. The POC for the certification period of 9/16/16 to 11/14/16, included orders for SN 5 times a week and HHA services 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 11/15/16 to 1/13/17, included orders for SN 5 times a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 1/14/17 to 3/14/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 3/15/17 to 5/13/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. POC. The POC for the certification period of 5/14/17 to 7/12/17, included orders for SN 1 time a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration of the SN and HHA services. The POC for the certification period of 7/13/17 to 9/101/7, included orders for SN 5 times a week and HHA 9 hours a day. The POC failed to include duration for the SN and HHA services.		11/08/2018.	

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	The POC for the certification period of 9/11/17 to 11/9/17, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 11/10/17 to 1/8/18, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 1/9/18 to 3/9/18, included orders for SN 5 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 3/10/18 to 5/8/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 5/9/18 to 7/7/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 7/8/18 to 9/5/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA			

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	services. The POC included orders for Two Cal HN (a nutritional supplement) oral 240 ml bolus every 6 hours. During an interview conducted with the patient's family member on 9/24/18 at 10:00 AM, he/she reported the following was the accurate G-Tube feeding: Two Cal HN 480 ml bolus at 6 or 7 AM, 240 ml bolus at 4:00 PM and 480 ml bolus at 9-10 PM daily during the time the mother is at home from work. The POC failed to include the accurate nutritional requirements. The POC included the following topical ointments: Aquaphor External (for protection and moisture healing of skin) 1 apply to healed areas every 12 hours, Mupirocin External (antibacterial) 2 % 1 once a day. The orders failed to specify where the ointments would be applied. An order for Ciprofloxacin (antibiotic) HCL oral 500 mg 1 tab per feeding tube every 12 hours failed to be omitted from the POC and had been discontinued on 6/21/18. A pain goal on the POC stated, "Patient's pain will remain tolerable throughout care period." The goal was not specific to include the Wong scale for an assessment of a nonverbal patient and did not include measurable outcomes for tolerable pain goals. An interview was conducted with the Administrator on 9/24/18 at 4:45 PM to review the POC findings. The Administrator reported there was no further documentation to be provided. 3. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings:			

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The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits.

The POC for the certification period of 7/14/18 to 9/11/18, included the following order: "Silvadene External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18 and failed to include the specific area of the body for application.

An interview was conducted with the Administrator on 9/26/18 at 4:30 PM regarding the POC findings. The Administrator reported there was no further documentation to be provided

4. The clinical record of Patient #3 with a SOC of 7/25/18 was reviewed with the following findings:

The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets" The patient was interviewed on 9/26/18 9:48 AM and reported he had a 32 ounce daily fluid restriction and his diet is a diabetic/renal diet.

An interview was conducted with the patient regarding his medications on 9/26/18 at 9:48 AM during a home therapy visit observation. The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following medications: Levothyroxine Sodium (thyroid pill also know as Synthroid) Oral 175 mcg 1 tablet daily and Synthroid (thyroid pill also know as levothyroxine) Oral 75 mcg 1 tablet in the

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mornings daily. The patient reported the order was a duplicate. Nortriptyline (for diabetic neuropathy pain) HCL oral 10 mg 2 caps bedtime, the patient reported this medication had been discontinued 2 months ago. Insulin aspart (fast acting diabetic insulin) subcutaneous 100 units/ml 15-20 units daily before meals, using sliding scale (insulin amount depends on the patient's blood sugar). The order failed to include the specific sliding scale orders.

An interview was conducted with the Administrator on 9/26/18 at 12:07 PM regarding the findings for Patient # 3. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this."

A fax was obtained from the dialysis facility on 9/28/18 that included the following daily diet restrictions: Sodium 3 GM, Phosphorus 1200 mg and 1500 ml. The fax also included the following orders specific to the patients ESRD: Heparin Sodium 1,000 units/ml to arterial port 2,200 units and 2,300 units to venous port (of a central dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The POC failed to include the patient's special nutritional needs related ESRD (End Stage Renal Disease) and failed to include the patient's medication regimen for ESRD.

5. The clincial record of Patient # 4 with a SOC date of 3/13/18 was reviewed with the following findings:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AGING & DISABLED HOME HEALTH CARE LLC	10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The POC for the certification period of 7/11/18 to 9/8/18 included an order for HHA 3 hours day/ 4 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the administrator on 10/1/18 at 4:30 PM and the administrator reported there was no further documentation to be provided. 6. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification periods of 6/19/16 to 8/17/16, 8/18/16 to 10/16/16 and 10/17/16 to 12/14/16 included an order for HHA 4 hours a day/ 5 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be provided.			
G 0602 Bldg. 00	Based on record review and interview, the agency failed to ensure communication occurred with the nephrologist caring for 1 ESRD (End State Renal Dialysis) for 1 of 1 patient receiving hemodialysis (Patient # 3) in a sample of 7 clinical records. An agency policy titled, "Coordination of Client Services" was reviewed and stated: "All	G 0602	G 602 The Administrator or designee will immediately review all clinical records for coordination of care with any patient receiving dialysis, wound care. If coordination of care has not been established the DON or RN case manager will establish this coordination of care by calling the	11/30/2018

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	personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objective outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction. Purpose ...To ensure services are coordinated between members of the interdisciplinary team. To ensure appropriate, quality care is being provided to clients ... To modify the plan to reflect the needs or changes identified by members of the team ... to determine the continuation of services and /or future plans for care. To provide the attending physician with an ongoing assessment of the client and identify the client's response to services provided. 1. Care conferences will be held as necessary to establish interchange, reporting, and coordinated evaluation between all disciplines involved in the client's care ... 3. After the initial assessment, the admitting RN (Registered Nurse) or Therapist shall discuss the findings of the initial visit with the Clinical Manager to ensure ...a. Clarification of the plan of care orders. d. Client's need for skilled nursing care ...e. Need for other services and/or referral to community resources ...G. Coordination with other agencies and institutions, if the need arises ... 6. Care conferences will be determined on the care conference summary form or in the progress note ... " An interview was conducted with the patient on 9/26/18 at 9:48 AM during a home visit observation. The patient reported he had a central venous dialysis catheter in his right subclavian (collarbone) area for hemodialysis treatments 3 times weekly related to his ESRD. In addition, the patient reported he was getting medication for anemia, fluid restriction and dietary restrictions related to his ESRD.		dialysis center or wound care center and request weekly updates on patients care. The DON or designee will educate administration/management, all clinicians on policy: Coordination of Client Services To prevent this deficiency in the future, the DON will audit these clinical records weekly to ensure updates from these providers are present in the clinical record, if not present the DON will call the provider for an update and notify the RN case Manager of the update so the RN can update the POC if needed. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed on 11/11/2018.	

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The clinical record of Patient #3 with a Start of care of 7/25/18 and a POC (Plan of Care) for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets." The POC failed to include any medication orders related to the patient's dialysis 3 times weekly

The administrator was interviewed on 9/26/18 at 12:07 AM and reported there was no documentation the agency had coordinated care with the Hemodialysis facility or the Nephrologist. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this."

The agency was asked to call the dialysis facility and obtain the current treatment orders for the patient to include diet, fluid restriction, and medication. A fax was obtained from [the dialysis facility] on 9/28/18 and included the following orders specific to the patient's ESRD: Heparin Sodium (to prevent blood clots) 1,000 units/ml to arterial port (red) 2,200 units and 2,300 units to venous (blue) port (of the dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The fax included a 1500 ml fluid restriction and dietary restriction to 3 gm sodium, and 1200 mg Phosphorus daily. The POC failed to include the patient's medication regimen for ESRD, diet and fluid restrictions.

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G 0606 Bldg. 00	Based on record review and interview, the agency failed to ensure the clinical record included documentation of coordination between the SN (skilled nurse) and the HHA (home health aide) regarding a change in the patient's skin condition that progressed from irritation to a stage 3 pressure ulcer for 1 of 4 patient's receiving home health aide services (Patient #2) in a sample of 4. Findings Include: An agency policy titled, "Coordination of Client Services" was reviewed and stated: "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objective outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction. An agency policy titled, "Home Health Aide Supervision" was reviewed and stated, " Agency shall provide Home Health Aide Services under the direction and supervision of a RN/ Therapist when personal care services are indicated and ordered by the physician ... 1. The Nursing Supervisor or designated RN/Therapist will give the HHA direction for client care by way of the Care Plan. The clinical record for Patient # 2, with a start of care date of 9/28/15, with a diagnosis to include Cerebral Palsy and Functional limitations to include Paralysis, Bowel and Bladder Incontinence, Endurance and Ambulation. The plans of care for the certification periods of	G 0606	N 606 The Administrator or designee will immediately review all clinical records for supervision of HHA's every 30 days for patients receiving non-skilled nursing services. If there are clinical records in which supervision of HHA is not completed every 30 days, the RN case manager will be brought in immediately to be counseled on supervisory regulations. The Administrator or designee will educate administration/management, all clinicians on policy: Home Health aide supervision To prevent this deficiency in the future, the DON will monitor supervisory visits to ensure skilled supervisory visits are conducted every 30 days through weekly audits. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	11/30/2018

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	3/15/18 to 5/13/18, 5/14/18 to 7/13/18 and 7/14/18 to 9/11/18 included orders for HHA (Home Health Aide) for 8 hours daily for, 5 visits weekly. The clinical record was reviewed with the following findings: A HHA visit note dated 3/29/18 stated, "Skin in the crack of [pt's name] butt (buttocks) is slightly irritated. A SN visit was conducted on 4/11/18 (13 days later). The SN note stated, "Educated about pressure relief due to impaired mobility voices an understanding. Patient states that she has wound center appointment on 4/19/18 due to opened area to crack of buttocks. Unable to assess wound due to patient sitting in wheelchair and unable to transfer via hoyer to assess wound because patient did not want to be transferred back." A document in the clinical record dated 4/12/18 at 11:00 AM and titled, "[hospital name] office visit," included a new diagnosis for Stage 3 pressure ulcer of the buttock. The administrator was interviewed on 9/26/18 at 2:45 PM. The administrator reported there was no documentation that the aide and nurse communicated about the patient's irritated area that progressed to a stage 3 pressure ulcer in the clinical record. The administrator was asked about the process for the home health aide notes to be reviewed by an RN. The administrator reported, "The HHA visits are audited every 60 days by [director of nursing services name].			
G 0708 Bldg. 00		G 0708	G 708 The Administrator or	11/30/2018

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	Based on observation, record review and interview, the RN (Registered Nurse) failed to accurately complete the plan of care to include the frequency and duration of visits to be conducted for 4 of 7 (Patients # 1, 2, 4, 5), the nutritional requirements for 2 of 7 (Patient #1, 3) , all medications and treatments for 3 of 7 (Patient # 1, 2, 3) , and measurable goals for 1 of 7 (Patient # 1) in a sample of 7 clinical records. Findings Include: 1. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ...2. The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures ... p. Treatment goals...t. other appropriate items ... 9. At the time of certification and recertification , a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include, but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with		designee will immediately review all clinical records for accurate and complete plan of care, including frequency, and duration of visits, nutritional requirements,medications, treatments with measurable goals, and current and past findings. Any clinical records found to have a POC that is not updated, the DON will call PCP for a verbal order to update the plan of care, then a physician order will be written reflecting the update and sent to PCP for signature. The DON or designee will educate all clinicians on policy: Plan of Care policy Home Health Admission Service Agreement To prevent this deficiency in the future, The DON will review every plan of care for accuracy before sending to PCP for signature. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed on 11/08/2018.	

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	the following findings: The POC for the certification period of 7/18/16 to 9/15/16, included orders for skilled nurse 5 times a week and HHA services 6 times a week. The POC failed to include the duration for the SN (skilled nurse) and failed to include the HHA (Home Health Aide) time and duration and services to be provided. The POC for the certification period of 9/16/16 to 11/14/16, included orders for SN 5 times a week and HHA services 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 11/15/16 to 1/13/17, included orders for SN 5 times a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 1/14/17 to 3/14/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 3/15/17 to 5/13/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. POC. The POC for the certification period of 5/14/17 to 7/12/17, included orders for SN 1 time a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration of the SN and HHA services. The POC for the certification period of 7/13/17 to 9/101/7, included orders for SN 5 times a week and HHA 9 hours a day. The POC failed to include			

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	duration for the SN and HHA services. The POC for the certification period of 9/11/17 to 11/9/17, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 11/10/17 to 1/8/18, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 1/9/18 to 3/9/18, included orders for SN 5 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 3/10/18 to 5/8/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 5/9/18 to 7/7/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 7/8/18 to 9/5/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week and			

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	HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC included orders for Two Cal HN (a nutritional supplement) oral 240 ml bolus every 6 hours. During an interview conducted with the patient's family member on 9/24/18 at 10:00 AM, he/she reported the following was the accurate G-Tube feeding: Two Cal HN 480 ml bolus at 6 or 7 AM, 240 ml bolus at 4:00 PM and 480 ml bolus at 9-10 PM daily during the time the mother is at home from work. The POC failed to include the accurate nutritional requirements. The POC included the following topical ointments: Aquaphor External (for protection and moisture healing of skin) 1 apply to healed areas every 12 hours, Mupirocin External (antibacterial) 2 % 1 once a day. The orders failed to specify where the ointments would be applied. An order for Ciprofloxacin (antibiotic) HCL oral 500 mg 1 tab per feeding tube every 12 hours failed to be omitted from the POC and had been discontinued on 6/21/18. A pain goal on the POC stated, "Patient's pain will remain tolerable throughout care period." The goal was not specific to include the Wong scale for an assessment of a nonverbal patient and did not include measurable outcomes for tolerable pain goals. An interview was conducted with the Administrator on 9/24/18 at 4:45 PM to review the POC findings. The Administrator reported there was no further documentation to be provided. 3. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following			

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	findings: The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits. The POC for the certification period of 7/14/18 to 9/11/18, included the following order: "Silvadene External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18 and failed to include the specific area of the body for application. An interview was conducted with the Administrator on 9/26/18 at 4:30 PM regarding the POC findings. The Administrator reported there was no further documentation to be provided 4. The clinical record of Patient #3 with a SOC of 7/25/18 was reviewed with the following findings: The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets" The patient was interviewed on 9/26/18 9:48 AM and reported he had a 32 ounce daily fluid restriction and his diet is a diabetic/renal diet. An interview was conducted with the patient regarding his medications on 9/26/18 at 9:48 AM during a home therapy visit observation. The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following medications: Levothyroxine Sodium (thyroid pill also know as Synthroid) Oral 175 mcg 1 tablet daily and			

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Synthroid (thyroid pill also know as levothyroxine) Oral 75 mcg 1 tablet in the mornings daily. The patient reported the order was a duplicate. Nortriptyline (for diabetic neuropathy pain) HCL oral 10 mg 2 caps bedtime, the patient reported this medication had been discontinued 2 months ago. Insulin aspart (fast acting diabetic insulin) subcutaneous 100 units/ml 15-20 units daily before meals, using sliding scale (insulin amount depends on the patient's blood sugar). The order failed to include the specific sliding scale orders.

An interview was conducted with the Administrator on 9/26/18 at 12:07 PM regarding the findings for Patient # 3. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this."

A fax was obtained from the dialysis facility on 9/28/18 that included the following daily diet restrictions: Sodium 3 GM, Phosphorus 1200 mg and 1500 ml. The fax also included the following orders specific to the patients ESRD: Heparin Sodium 1,000 units/ml to arterial port 2,200 units and 2,300 units to venous port (of a central dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The POC failed to include the patient's special nutritional needs related ESRD (End Stage Renal Disease) and failed to include the patient's medication regimen for ESRD.

5. The clincial record of Patient # 4 with a SOC

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	date of 3/13/18 was reviewed with the following findings: The POC for the certification period of 7/11/18 to 9/8/18 included an order for HHA 3 hours day/ 4 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the administrator on 10/1/18 at 4:30 PM and the administrator reported there was no further documentation to be provided. 6. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification periods of 6/19/16 to 8/17/16, 8/18/16 to 10/16/16 and 10/17/16 to 12/14/16 included an order for HHA 4 hours a day/ 5 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be provided.			
G 0710 Bldg. 00	Based on record review and interview, the SN (Skilled Nurse) failed to provide services outlined on the POC (Plan Of Care) for 1 of 4 (Patient #1) records reviewed of patients receiving SN services in a sample of 7.	G 0710	G 710 The Administrator or designee will immediately review all clinical records with SN services are being provided. If there is evidence that the POC is not being followed the DON will call the PCP for a verbal order to	11/30/2018

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	Findings Include: A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ...2. The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures ... p. Treatment goals... 9. At the time of certification and recertification, a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16 included orders for skilled nurse 5 times a week for G-Tube feedings while the mother is at work. The SN failed to provide services until 8/9/16 (21 days) after the SOC. An OASIS assessment conducted 9/13/16 stated: "SN to administer feedings on time daily 5 days a		update the plan of care and the POC will be updated in the clinical record and sent to the PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON will call the patient and offer to transfer them to an agency that can provide all services in the POC. If patient agrees to be transferred to another agency the DON will facilitate a transfer to an agency of the patients choice and documentation of conversation with patient will be recorded in the patients clinical record. The Administrator or designee will educate administration/management, all clinicians on policy: Plan of Care To prevent this deficiency in the future, the DON will monitor the services of all clients weekly through audits of services provided and any trends will be addressed weekly with the administrator. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed on	

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	week while [parent] is working." The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while mother was at work. The agency failed to provide SN visits 10/27/16, 10/28/18, 11/1/16 to 11/5/16 and 11/8/16 to 11/10/16. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist family in finding a nursing care via another agency at this time family has declined this offer. Currently [parent] is coming home at noon to feed daughter via G-Tube until nursing staff available." An OASIS assessment conducted 11/11/16 reported the following: "SN to administer feedings one time daily 5 days a week while [parent] is working." The POC for the certification period of 11/15/16 to 1/13/17 included orders for SN 5 times a week. The SN conducted a total of 4 of the 45 visits ordered on the POC for the certification period and failed to provide G-Tube feedings. The POC for the certification period of 1/14/17 to 3/14/17 included orders for SN 1 time a week for G-tube feedings each visit. The SN conducted a total of 5 visits in the certification period and with the exception of the SN visit 2/8/17 no G-Tube feedings were given by the nurse. The POC for the certification period of 7/13/17 to 9/10/17 included orders for SN 5 times a week for G-tube feedings. The SN provided 1 visit during weeks 2-3 and 5-9 of the certification period and failed to provide 5 visits per week as ordered for G-Tube feedings. The POC for the certification period of 9/11/17 to 11/9/17 included orders for SN 5 times a week for		11/08/2018.	

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tube G-tube feedings. The SN provided 2 visits during weeks 1, 4, 5, 6, 7 and 8, 0 visits during week 2 and 1 visit during week 9 of the certification period. The SN failed to provide G-Tube feedings as ordered.

A SN note dated 9/11/17 stated, "continues to request daily SN to cover G-Tube feedings while mother is at work. Will discuss with leadership. [parent]states at this time his/her family has been able to cover the other days of the week there has not been a daily RN."

The POC for the certification period of 11/10/17 to 1/8/18 included orders for SN 5 times a week for tube G-tube feedings. Orders were present to change the SN frequency to 1 visit during weeks 7 and week 9 of the certification period. The SN provided 2 visits during weeks 2-6. No SN visits during weeks 1 and 8. The SN failed to provide G-Tube feedings as ordered and follow the POC to provide visits 5 times weekly on weeks 1-6 and 8.

The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week for tube G-tube education, monitoring and feedings. The SN provided visits 1 time during week 1 and 2 times during weeks 2-9 of the certification period. The SN failed to provide G-Tube feedings visits as ordered 5 times weekly on the POC.

The POC for the certification period of 3/10/18 to 5/8/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings. The SN provided 1 visit during week 9 of the certification period and failed to provide G-Tube feedings as ordered on the POC.

The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for

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	G-Tube education, monitoring and feedings. The patient was in the hospital from 5/17/18 to 6/1/18 and in a long-term acute care facility from 6/1/18 to 6/13/18 with a diagnosis of 3rd-degree burns and skin grafts. The SN provided 1 visit during week 1 of the certification period and failed to provide G-Tube Feedings as ordered on the POC. An interview was conducted with the Parent of Patient # 1 on 9/24/18 at 10: 00 AM. The Parent reported that he/she worked 5-6 days a week. The patient's full-time HHA for the agency, the patient's sibling can not administer tube feedings in the role of a HHA. Without a nurse to come to the home daily the parent had to change the patient bolus G-tube feeding schedule. The parent reported when the patient had been admitted on (7/18/16) the feedings had been given in midday by a nurse of the agency. The parent reported the full-time nurse left the agency around November of 2016 and soon after the agency stopped sending a nurse 5 days a week. The parent reported he/she was told that the agency was working on getting a replacement nurse. The parent reported he/she had reported to the patient's nurses and to the agency that he/she needed a nurse 5 days a week, but the staffing concern had not been addressed or resolved. The parent reported a nurse had told him/her that a nurse was not necessary and another nurse told him/her that Medicaid had denied the prior authorization for a nurse 5 times a week. An interview was conducted with Patient # 1's sibling and full-time HHA on 9/25/18 at 1:50 PM. The sibling reported the parent administered the G-Tube feedings for Patient #1 before he/she left for work. The tube feeding schedule had been changed to late afternoon when the parent came home and then at bedtime. The sibling reported			

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	since he/she was working as a HHA it was not within his/her scope of practice to give the tube feedings. He/she reported they have not had a nurse for 2/1/2 years and have been told the agency would get a nurse for the feedings 5 days a week. The sibling reported she/he had been told the PA visits for 5 times a week had been denied. An interview was conducted with the administrator on 9/24/18 at 2:35 PM. The administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided.			
G 0724 Bldg. 00	Based on record review and interview, the SN (skilled nurse) failed to ensure the clinical record included documentation of coordination with the HHA (home health aide) regarding a change in the patient's skin condition that progressed from irritation to a stage 3 pressure ulcer for 1 of 4 patient's receiving home health aide services (Patient #2) in a sample of 4. Findings Include: An agency policy titled, "Coordination of Client Services" was reviewed and stated: "All	G 0724	G 724 The Administrator or designee will immediately review all clinical records for coordination of care between SN/HHA. Immediately all RN case managers will be required to conference with the HHA weekly for patients they case manage, and document this coordination of care through a communication note in the clinical record. The DON or designee will educate administration/management, all clinicians on policy:	11/30/2018

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	personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objective outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction. An agency policy titled, "Home Health Aide Supervision" was reviewed and stated, " Agency shall provide Home Health Aide Services under the direction and supervision of a RN/ Therapist when personal care services are indicated and ordered by the physician ... 1. The Nursing Supervisor or designated RN/Therapist will give the HHA direction for client care by way of the Care Plan. The clinical record for Patient # 2, with a start of care date of 9/28/15, with a diagnosis to include Cerebral Palsy and Functional limitations to include Paralysis, Bowel and Bladder Incontinence, Endurance and Ambulation. The plans of care for the certification periods of 3/15/18 to 5/13/18, 5/14/18 to 7/13/18 and 7/14/18 to 9/11/18 included orders for HHA (Home Health Aide) for 8 hours daily for, 5 visits weekly. The clinical record was reviewed with the following findings: A HHA visit note dated 3/29/18 stated, "Skin in the crack of [pt's name] butt (buttocks) is slightly irritated. A SN visit was conducted on 4/11/18 (13 days later). The SN note stated, "Educated about pressure relief due to impaired mobility voices an understanding. Patient states that she has wound center appointment on 4/19/18 due to opened area to crack of buttocks. Unable to assess wound due to patient sitting in wheelchair and unable to		Coordination of Client Services Home Health Aide Supervision Care Planning/ Coordination of Care Home health aides will be educated on: "What to Report to RN, Case Manager" Home Health Aide Documentation To prevent this deficiency in the future, the RN case managers will be required to review all HHA documentation and perform weekly conference with HHA's for all the patients they case manage. RN case manager will also review the aide care plan with the assigned home health aide prior to the home health aide providing services to the patient and review the home health aide care plan with the home health aide at least every 60 days or when there is a change in the patients' condition. the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	

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	transfer via hoyer to assess wound because patient did not want to be transferred back." A document in the clinical record dated 4/12/18 at 11:00 AM and titled, "[hospital name] office visit," included a new diagnosis for Stage 3 pressure ulcer of the buttock. The administrator was interviewed on 9/26/18 at 2:45 PM. The administrator reported there was no documentation that the aide and nurse communicated about the patient's irritated area that progressed to a stage 3 pressure ulcer in the clinical record. The administrator was asked about the process for the home health aide notes to be reviewed by an RN. The administrator reported, "The HHA visits are audited every 60 days by [director of nursing services name].			
G 0750 Bldg. 00	Based on record review and interviews the agency failed to meet the Conditions of Participation for Home Health Aide Services as evidenced by the failure to ensure the personnel files included documentation the home health aide competed a competency evaluation program before patient contact (See tag G 766), failure to update the HHA (Home Health Aide) care plan after a major change in the patient's condition (See Tag G 798) , failure to ensure the HHA (Home Health Aide) provided all services outlined in the Plan Of Care (See Tag G 800), failure to ensure the Skilled Nurse (SN) supervised the HHA (Home Health Aides) every 14 days (See Tag G 808). The cumulative effect of these systemic problems resulted in the home health agency's inability to	G 0750	G 750 The Administrator will immediately correct all deficiencies surrounding the Conditions of Participation through education of staff on policies and procedures, focused audits of all clinical records surrounding the deficiency sited, updating the plan of care with any changes in patient condition or failure to follow/update the plan of care, and continued oversite of all deficiencies through continued audits quarterly after 100% compliance is met in each deficient area sited. The Administrator will also become more involved with IAHHC	11/30/2018

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	provide quality health care in a safe environment for the Condition of Participation at 42 CFR 484.36, Home Health Aide Service		to stay abreast of all new regulations and available training for administration and staff.	
G 0766 Bldg. 00	Based on record review and interview, the administrator failed to ensure the personnel file included documentation that the home health aide competed a competency evaluation program before patient contact for 1 of 1 home health aide records reviewed (Employee E) Findings Include: An agency policy titled, "Personnel Records" was reviewed and stated, "Personnel files will be established and maintained for all personnel ... Special Instructions: 1. Personnel Record-the employee personnel record will include, but not be limited to ... B. Employment information: ... Competency testing for home health aides and specific competencies per job title ... signed job description ...." The confidential personnel file of Employee E with a date of hire of 7/13/16 and first patient contact of 7/13/16, was reviewed on 10/1/18 at 4:00 PM. The employee record failed to include evidence of a home health aide test competency and a skills competency upon hire. The administrator was interviewed on 10/1/18 at 4:30 PM and reported he/she would search for the missing information. The administrator was interviewed on 10/2/18 at 10:30 AM and reported he/she was unable to locate the missing	G 0766	G 766 The Administrator will immediately alert HR Director not hire any new HHA's. The Administrator or designee will seek a contract RN to perform HHA skills check off and competency. No new home health aides will be hired until contract is in place. Any HHA's that were found not to have skills check offs present in employee file will be checked off by the contract RN on skills. The Administrator or designee will educate administration/management, HR Director on policy: Personnel Records To prevent this deficiency in the future, the Administrator or designee will be responsible for active employee record audits until 100% compliance is met then 10 % of all employee records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	11/30/2018

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	information for the personnel file of Employee E.			
G 0798 Bldg. 00	Based on record review and interview the RN (Registered Nurse) failed to ensure the aide care plan contained accurate information in regards to oral intake and failed to ensure the aide care plan was updated after a major change in the patient's condition for 1 of 4 patients receiving HHA services (Patient #1) in a sample of 4 Findings Include: An agency policy titled, "Client Reassessment /Update of Comprehensive Assessment" was reviewed and stated, "The Comprehensive Assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status ... Reassessment must be done at least ...2. Within forty-eight (48) hours of client return home from hospital admission of more than twenty-four (24) hours for any reason other than diagnostic testing ...Purpose ...modify the plan of care and document change that may affect care ...6. The Registered Nurse is responsible for reassessing the need for Home Health Aide services ...8. The assessment will identify the problems, needs, and strengths of the client and care the family can provide... The aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising Nurse/Therapist ..." An agency policy titled, 'Home Health Aide Services: was reviewed and stated, "2. The nurse or therapist assesses the need for personal care services and includes the services in the	G 0798	G 798 The Administrator or designee will immediately review all clinical record home health aide care plans for accurate and update information. Any home health aide care plans that are found in review containing inaccurate information will be updated after the DON calls the PCP to receive a verbal order to update the HHA care plan, an order will be written and then sent to PCP for signature. The Administrator or designee will educate all clinicians on policy: Coordination of Client Services Home Health Aide Supervision To prevent this deficiency in the future, the RN case managers will review the patients care plan with the assigned home health aide prior to the home health aide providing services to the patient and review the home health aide care plan with the home health aide at least every 60 days or when there is a change in the patients' condition. The DON will audit weekly HHA care plans at re-cert for accurate and updated information and with any change of condition with patient. The	11/30/2018

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	physician plan of care (orders). A specific care plan is developed documenting the aide services to be provided ...." The POC for Patient #1 with a start of care date of 7/18/16 and a certification period of 5/9/18 to 7/7/18 was reviewed with the following findings: A Transfer OASIS dated 5/17/18 was reviewed and stated, "Patient hospitalized at this time due to reports of burns" An acute rehab hospital facility transfer report dated 6/13/18 was reviewed and reported the following altered skin conditions related to burns and skin grafting " Burns: Left forearm, bilateral buttocks, left lateral thigh, entire lower leg, and foot, Surgery: Left thigh, right thigh, left back. Trauma : right posterior knee and Left posterior knee" In addition the follow was stated under special treatments and procedures / Skin Care- "Use skin protection to high risk areas-support edematous areas and areas with decreased circulation-maintain a clean dry environment -evaluate for signs and symptoms of impaired wound healing/infections-relieve pressure on bony prominence's-use preventive skin care devices-observe for unusual/unexplained bruising-minimize exposure to sunlight" A Resumption of Care OASIS dated 6/13/18 was reviewed and the nurse documented, "Patient suffered from burns during bathing and required skin graft surgery x 2." The following sites were listed as 3rd Degree Burns: "left lower leg, left foot, buttock, abdominal wall, left thigh, left forearm." Pt had a new medication for pain Fentanyl (a small patch applied to the skin to allow the medication to absorb slowly).		Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	

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	The Aide Care Plan dated 5/9/18 was reviewed. The additional comments stated, "notify agency of decreased oral intake, N/V/D (nausea, vomiting, diarrhea) more than 24 hours, No BM (bowel movement) x 3 days, fever, cough, congestion, pain, skin breakdown, any other concerns immediately upon noting. Keep head elevated 30-45 degrees as much as possible to prevent changes of aspiration." The Aide Care Plan had not been updated after the patient's burns, skin grafts and hospitalization to include any special precautions regarding positioning care of skin and dressing sites and specific signs to report to the nurse. In addition, the patient did not take oral food, water or meds by mouth. He/she had a gastric feeding tube and received hydration, medications and liquid feedings in the gastric tube. There was no direction regarding the pain patch. An interview was conducted with the Administrator and Director of Nursing service on 9/28/18 at 4:45 PM regarding the failure of the SN to update the HHA plan of care after a serious change in the patient's conditions. They had no further documentation to be provided.			
G 0800 Bldg. 00	Based on record review and interviews, the HHA (Home Health Aide) failed to provide all services outlined in the POC (Plan Of Care) for 4 of 4 patient receiving HHA services (Patients # 1, 2, 4 and 5) in a sample of 4 records. Findings Include: 1. A policy titled, "Plan of Care" was reviewed	G 0800	G 800 The Administrator or designee will immediately review all clinical records for provision of services according to the POC. If there is evidence that the POC is not being followed the DON will call the PCP for a verbal order to update the plan of care and the POC will be updated in the clinical record and sent to the PCP for	11/30/2018

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AGING & DISABLED HOME HEALTH CARE LLC	10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256

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	and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16, included orders for HHA services 6 times a week. The HHA provided services 5 times during week 1- 2 and 3 times during week 6 of the certification period and failed to conduct visits as ordered. The POC for the certification period of 9/16/16 to 11/14/16, included orders for HHA services 6 times a week for assistance with IADL's and ADL's. The HHA services were provided 3 times during week 5 of the certification period and failed to be conducted as ordered. The POC for the certification period of 3/15/17 to 5/13/17, included orders for HHA 6 times a week for assistance. The clinical record failed to evidence documentation of any HHA visits during weeks 4-9 of the certification period. The POC for the certification period of 5/14/17 to 7/12/17 included orders for HHA 9 hours a day for 5 days a week. The clinical record failed to evidence documentation of HHA visits during weeks 1 and 2. The HHA conducted 6 visits during weeks 4-8 and 4 visits during week 9 of the certification period.		signature. If failure to follow the POC is due to a shortage on staffing the DON will call the patient and offer to transfer them to an agency that can provide all services in the POC. If patient agrees to be transferred to another agency the DON will facilitate a transfer to an agency of the patients choice and documentation of conversation with patient will be recorded in the patients clinical record. The DON or designee will educate administration/management, all clinicians on policy: Plan of Care To prevent this deficiency in the future, the DON or designee will do weekly audits on HHA schedules to ensure that all patients are receive the services that are ordered in the POC. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed on 11/08/2018.	

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The POC for the certification period of 7/13/17 to 9/10/17 included orders for HHA 9 hours a day for 5 days a week. The HHA conducted 3 visits during week 1 and 6 visits during weeks 2-9 of the certification period and failed to provide visits 5 times weekly as ordered.

The POC for the certification period of 9/11/17 to 11/9/17 included orders for HHA 9 hours a day for 5 days a week. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during weeks 8 and 9 of the certification period. The HHA failed to provided visits as ordered.

The POC for the certification period of 11/10/17 to 1/8/18, included orders for HHA 9 hours a day for 5 days a week. The HHA provided visits 6 times during weeks 5-9 during the certification period. The HHA failed to provide visits as ordered.

The POC for the certification period of 1/9/18 to 3/9/18 included orders HHA 9 hours a day, 5 days a week. The HHA provided visits 4 times a week 1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and 1/11/18. The HHA provided visits 5 times a week 1/15/18 to 1/19/18 with 14-hour visits on 1/16/18 and 1/18/18. The HHA provided visits 6 times a week from 1/21/18 to 3/9/18. The HHA failed to provide visits as ordered. The HHA failed to provide visits as ordered.

The POC for the certification period of 3/10/18 to 5/8/18 included orders for HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The HHA provided 6 visits during week 1, 2, 3, 4, 6, 8, and 3 visits week 9. The HHA failed to provide visits as ordered.

The POC for the certification period of 5/9/18 to

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7/7/18 included orders for HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The patient was in the hospital from 5/17/18 to 6/1/18. The HHA conducted a 14-hour visit on 5/9/18 and a 10-hour visit 5/12/18. The HHA provided 4 visits a week from 5/13/18 to 5/16/18 and 6 visits weekly from 5/17/18 to 7/7/18. The HHA failed to provide visits as ordered.

The POC for the certification period of 7/8/18 to 9/5/18 included orders for HHA 9 hours a day, 5 days a week. The HHA provided 6 visits during week 1-8 and 3 visits during week 9 of the certification period. The HHA provided 14-hour visits on 7/8/18, 7/10/18, 7/12/18. The HHA failed to provide visits as ordered.

The POC for the certification period of 9/6/18 to 11/4/18 included orders for HHA 9 hours a day, 5 days a week. The HHA provided 3 visits during week 1, and 6 visits during week 2 and 3 of the certification period. The HHA provided 14-hour visits on 9/6/18, 9/11/8.9/13/18, 9/18/18, and 9/20/18 and 16-hour visits on 9/9/18 and 9/16/18. The HHA failed to provide services as ordered.

3. The clinical record of Patient # 2 with a SOC date of 9/28/15 and a certification period of 7/14/18 to 9/11/18, with services to include HHA 8 hours a day 5 days a week for assistance with IADL's and ADL's was reviewed with the following findings:

The HHA provided visits 6 days in week 4 of the certification period ranging from 3 to 11 hours a day for a weekly total of 46 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 4 days in week 5 of the certification period ranging from 8-9 hours a day for a weekly total of 33 hours. The HHA failed to

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	perform the visits as ordered. The HHA provided visits 4 days in week 7 of the certification period ranging from 7-8 hours a day for a weekly total of 31 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 6 days in week 8 of the certification period ranging for 7 hours daily for a weekly total of 42 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 3 days in week 9 of the certification period ranging from 4 to 11 hours for a weekly total of 22 hours. The HHA failed to perform the visits as ordered. 4. The clinical record of Patient # 4 with a SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include HHA 3 hours a day for 4 days a week was reviewed with the following findings: For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during week 5, 6, 7 and 2 visits during week 8. For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3. An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office			

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	... I've told them and doesn't do any good ... I'm out of sight and out of mind." An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided. 5. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week was reviewed with the following findings: During the certification period of 6/19/16 to 8/17/16, the HHA failed to provide 2 hours of care during weeks 3 and 4, 10 hours of care during week 6, and 4 hours of care during weeks 8 and 9. During the certification period of 8/18/16 to 10/16/16, there were no HHA visit notes in the clinical record for weeks 1, 2, 3, 4, 5, 6. During weeks 7, 8, and 9 there were no HHA visit notes in the clinical record, except four (4), 2-hour HHA visits notes for services on (9/29/16, 9/30/16, 10/3/16 and 10/13/16) During the certification period of 10/17/16 to 12/14/16 the HHA failed to provide 10 hours during week 1, 18 hours during week 2, 18 hours during week 3 and with the exception of a 2-hour visit on 12/6/18, there were no further HHA notes for the certification period. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes and if there were any orders to change the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be			

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	provided.			
G 0808 Bldg. 00	Based on record review and interview the agency failed to provide Skilled Nurse (SN) supervision to the HHA (Home Health Aides) every 14 days for 2 of 2 patient's receiving skilled nursing services (Patient # 1 and 2) in a sample of 4 records. Findings Include: 1. An agency policy titled, "Home Health Aide Supervision" was reviewed and stated, "Agency shall provide HHA services under the direction and supervision of a Registered Professional Nurse/Therapist when personal care services are indicated and ordered by the physician. The frequency of supervision will be in response to Medicare regulations, agency policy and other state or federal requirements ...3. Supervisory visits of HHA shall be according to the following frequency: a. When skilled services are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client's residence at least every two (2) weeks ...." 2. The skilled clinical record of Patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16 included orders for skilled nurse 5 times a week HHA services 6 times a week. HHA services began 7/19/18 and the record contained a RN supervisory visit note on 8/16/16 which exceeded the agency policy by 14 days. The next supervisory visit was 9/13/16 which exceeded the	G 0808	G 808 The Administrator or designee will immediately review all clinical records for supervision of HHA's every 14 days for patients receiving skilled nursing services. If there are clinical records in which supervision of HHA is not completed every 14 days, the RN case manager will be brought in immediately to be counseled on supervisory regulations. The Administrator or designee will educate administration/management, all clinicians on policy: Home Health aide supervision To prevent this deficiency in the future, the DON will monitor supervisory visits to ensure skilled supervisory visits are conducted every 14 days through weekly audits. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	11/30/2018

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agency policy by 14 days.

The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week and HHA services 6 times. The prior supervisory visit had been conducted 9/13/16 and the next supervisory visit was 10/29/16 which exceeded the agency policy by 31 days.

The POC for the certification period of 11/15/16 to 1/13/17 included orders for SN 5 times a week and HHA 6 times. There were no documented supervisory visits.

The POC for the certification period of 1/14/17 to 3/14/17 included orders for SN 1 time a week and HHA 6 times a week. The prior supervisory visit was 10/29/16 and the next supervisory visit was 2/14/17, which exceeded the agency policy by 77 days. The next supervisory visit was 3/14/17, which exceeded the agency policy by 14 days.

The POC for the certification period of 3/15/17 to 5/13/17 included orders for SN 1 time a week HHA 6 times a week. The prior supervisory visit was 3/14/17 and the next supervisory visit was 4/10/17 which exceeded the agency policy by 13 days. The next supervisory visit was 5/9/17 which exceeded the agency policy by 15 days.

The POC for the certification period of 5/14/17 to 7/12/17 included orders for SN 1 time a week and HHA 9 hours a day for 5 days a week. There were no documented supervisory visits.

The POC for the certification period of 7/13/17 to 9/101/7 included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The prior supervisory visits was 5/9/17 and the next supervisory visit was 8/8/17 which exceeded the

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	agency policy by 74 days. The next supervisory visit was 9/6/17 which exceeded the agency policy by 15 days. The POC for the certification period of 9/11/17 to 11/9/17 included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The prior supervisory visit was 9/6/17 and the next supervisory visit was 9/29/17, which exceeded the agency policy by 8 days. The next supervisory visits were 10/6/17 and then 11/8/17 which exceeded the agency policy by 17 days. The POC for the certification period of 11/10/17 to 1/8/18 included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The prior supervisory visit was 11/8/17 and the next supervisory visit was 12/8/17, which exceeded the agency policy by 15 days. The next supervisory visit was 1/5/18 which exceeded the agency policy by 14 days. The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week and HHA 9 hours a day, 5 days a week. The prior supervisory visit was 1/5/18 and the next supervisory visit was 2/9/18, which exceeded the agency policy by 20 days. The next supervisory visit was 3/5/18, which exceeded the agency policy by 9 days. The POC for the certification period of 3/10/18 to 5/8/18 included orders for SN 2 times a week for and HHA 9 hours a day, 5 days a week. The prior supervisory visit was 3/5/18 and the next supervisory visit was 3/26/18, which exceeded the agency policy by 6 days. The next supervisory visit was 4/27/18 which exceeded the agency policy by 17 days.			

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	The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for and HHA 9 hours a day, 5 days a week. The patient was hospitalized from 5/17/18 to 6/13/18. The next supervisory visits were 6/20/18 and then 7/7/18, which exceed the agency policy by 2 days. The POC for the certification period of 7/8/18 to 9/5/18 included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The prior supervisory visit was 7/7/18 and the next supervisory visit was 7/27/18 which exceeded the agency policy by 5 days. The next supervisory visits were 8/6/18, and then 8/31/18 which exceeded the agency policy by 10 days. 3. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings: During the period of 7/14/18 to 8/8/18, skilled nursing services were ordered 3 times a week for 9 weeks and HHA services were ordered 8 hours a day 5 days a week. The nurse failed to conduct a supervisory visit due every 14 days. A supervisory visit was due by 7/30/18 for a skilled patient.			
G 0814 Bldg. 00	Based on record review and interview the agency failed to provide Skilled Nurse (SN) supervision to the HHA (Home Health Aides) every 60 days for 1 of 2 patient receiving non-skilled nursing services (Patient # 4) in a sample of 2 non-skilled clinical records. Findings Include:	G 0814	G 814 The Administrator or designee will immediately review all clinical records for supervision of HHA's every 60 days for patients receiving non-skilled nursing services. If there are clinical records in which supervision of HHA is not completed every 60 days, the RN	11/30/2018

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	An agency policy titled, "Home Health Aide Supervision" was reviewed and stated, "Agency shall provide HHA services under the direction and supervision of a Registered Professional Nurse/Therapist when personal care services are indicated and ordered by the physician. The frequency of supervision will be in response to Medicare regulations, agency policy and other state or federal requirements ...c. Home Health Aide services only: When HHA services are being furnished to a client, who does not require the skilled services of a nurse or therapist, a RN or qualified therapist must make a supervisory visit to the cline's residence at least once every sixty (60) days ...." The non-skilled clinical record of Patient # 4 with a SOC date of 3/13/18 was reviewed. The POC for the certification period of 7/11/18 to 9/8/18 included orders for SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week. The clinical record evidenced a supervisory visit on 7/6/18. The next supervisory visit was on 9/7/18. The supervisory visit exceeded the agency policy by 3 days. An interview was conducted with the administrator on 10/1/18 at 4:30 PM regarding late and missed supervisory visits. The administrator reported there was no further documentation to be provided.		case manager will be brought in immediately to be counseled on supervisory regulations. The Administrator or designee will educate administration/management, all clinicians on policy: Home Health aide supervision To prevent this deficiency in the future, the DON will monitor supervisory visits to ensure skilled supervisory visits are conducted every 60 days through weekly audits. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	
G 0940 Bldg. 00	Based on record review and interview the	G 0940	G 940 The Administrator has ensured public information	11/12/2018

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	Administrator failed to ensure the home health parent location did not relocate without notification and prior approval of CMS for 1 of 1 agency (See Tag G 940) and the clinical manager failed to ensure the HHA (Home Health Aide) documentation notes were completed and entered into the clinical record (See G Tag 958). The cumulative effect of these systemic problems resulted in the home health agency's inability to provide quality health care in a safe environment for the Condition of Participation at 42 CFR 484.36, Organization and Administrative Service. In relationship to G 940 findings Include: The State Operations Manual Chapter 2, section 2185 was reviewed and indicated, "HHA Change of Address: It is inherent in the provider certification process that a provider notifies CMS (Center for Medicare and Medicaid Service) of its intent to change the location or site from which it provides services. Absent such notification, CMS has no way of carrying out its statutorily mandated obligation of determining whether the provider is complying with applicable participation requirements at the new site or location. It is longstanding CMS policy that there is no basis for a provider to bill Medicare for services provided from a site or location that has not been determined to meet applicable requirements of participation ...When an existing HHA (Home Health Agency) intends to move from its surveyed and certified location to a new site or location that is within the current approved geographic area, it notifies its MAC (Centers for Medicare and Medicaid) within 90 days of the move, and submits all required documentation including an amended Form CMS -855 A. The RHHI (Regional Home Health Intermediary)		regarding address of parent agency is correct by: CMS 855 filed on 9/24/18 Parent location address given to the answering service on 9/21/18 Letter sent to ISDH on 7/19/2018 Correction letter sent to ISDH on 9/24/2018 The agency has not received a confirmation letter for approval of change of location. The Administrator will be responsible for these corrective actions to ensure that this deficiency is corrected and will not reoccur. Any future change in location a CMS 855 will be submitted and the agency will not move locations until approval letter has been received.	

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	reviews the form and makes a recommendation to the RO (Regional Office). The RO then makes the final decision to approve the change of location. The provider notifies CMS either directly or through the SA ...Upon receipt of the MAC's approval notice, the RO will carefully evaluate the information, together with any supporting documentation from the provider and any other relevant information known to the RO in making its decision ...." A letter from the agency corporate office dated 7/19/18 addressed to the Indiana State Department of health was reviewed and indicated, "Aging & Disabled Home Health Care License # (17-013593-1) would like to make a corporate mailing and address change from 10500 Crosspoint Blvd, Indianapolis, IN 46256 to 625 S Tillotson Avenue, Muncie, IN 47304 ...The corporate mailing address will be PO Box 17460, Indianapolis, IN. We would also like for you to send us a license renewal form to the PO Box corporate mailing address please. The reason for this address change is that our 10500 Crosspoint Blvd building was sold and the new owner would not allow us to apply signage to the building, which is required by state regulations ...." The letter was signed by the agency administrator. The letter did not indicate an effective of the relocation. On 9/20/18 at 10:00 PM, the agency number was called to validate the agency's current location. The answering service indicated, "I know they have moved, but I don't know the new address." On 9/21/18 at 9:06 AM, the agency number was called and following speaking with 3 different employees, it became known the agency had relocated from Indianapolis to Muncie, IN.			

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	On 9/21/18 at 11:30 AM the administrator was interviewed and indicated no CMS-855 had been filed with their fiscal intermediary for the relocation.			
G 0958 Bldg. 00	Based on record review and interviews, the (DON) Director of Nursing Services failed to ensure the HHA (Home Health Aide) documentation notes were completed and entered into the clinical record for 2 of 4 patient's receiving HHA services (Patient's #1 and 5) in a sample of 7 clinical records. Findings Include: 1. An agency policy titled, "Clinical Documentation" was reviewed and stated, "Agency will document each direct contact with the client. This documentation will be completed by the direct caregiver and monitored by the skilled professional responsible for managing the clients' care. Purpose: To ensure that there is an accurate record of the services provided, client response and ongoing need for care. To document conformance with the Plan of Care, modifications to the plan and interdisciplinary involvement ... 2. a separate note shall be completed for each visit/shift and signed and dated by the appropriate professional. Actual time and length of the client visit will be included in each note ... 5. Documentation of services ordered on the plan of care will be completed the day services are rendered and incorporated into the clinical record within seven (7) days after the care has been provided ..."	G 0958	G 958 The Administrator will immediately review with the DON, job description, responsibilities, expectations of job performance. The Administrator or designee will educate administration/management on policy: Clinical Documentation Director of Nursing To prevent this deficiency in the future, the Administrator or designee will have written documentation of orientation of the DON, outlining job description, job responsibilities, and expectation of job performance.	11/30/2018

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	2. A job description titled, " Director of Nursing" was reviewed and stated, " ... Position Summary: Responsible for the overall supervision and direction of healthcare services ... shares responsibilities with the Administrator for the agency's overall compliance with State and Federal guidelines and standard of nursing practice. Duties and Responsibilities: Supervise and direct all clinical services. Promote, review and evaluate the quality and appropriateness of patient care practices ... Participate in assigning personnel to patients based on patient need and physician's plan of care ... Coordinate and ensure that the patient is well serviced through the assignment of skilled services and personal caregivers ...." 3. The clinical record for Patient # 1 with a start of care date of 7/18/16 failed to evidence any HHA documentation notes from 4/2/17 to 5/21/17 in the clinical record. 4. The clinical record for Patient # 5 with a start of care date of 6/19/16 to 12/14/16 failed to evidence any HHA documentation notes from 8/10/16 to 9/29/16 in the clinical record. 5. An interview was conducted with the DON on 9/21/18 at 1:06 PM. The DON reported, "I'm in charts all day long." The DON reported having assessed quality of care, performed "pop- up" visits with nursing staff, looked at clinical notes, and did Quality audits of 10 % of clinical records quarterly. 6. The administrator was interviewed on 9/26/18 at 2:45 PM about the missed HHA visit documentation for Patient # 1 and 5. The administrator reported the aides' visits notes had			

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	to be uploaded into the computer schedule by the scheduler. The scheduler should have put the assigned visits and the times into the computer for the aide to have documented their visit. The administrator reported if the scheduler had not uploaded the visits to the computer the HHA would not have had a way to document their visit to the computer program. The administrator reported the process was for the director of nursing services to check the assignments in the computer to ensure the POC matched the schedule for HHA visits and was to have audited the HHA notes every 60 days. The administrator reported the HHA'S had not informed the agency the visits had not been uploaded in computer and the audits failed to discover the records were missing the HHA documentation.			
G 1012 Bldg. 00	Based on record review and interviews the agency failed to accurately complete the plan of care to include the frequency and duration of visits to be made for 4 of 7 (Patients # 1, 2, 4, 5), the nutritional requirements for 2 of 7 (Patient #1, 3), all medications and treatments for 3 of 7 (Patient # 1, 2, 3), measurable goals for 1 of 7 (Patient # 1), failed to ensure the HHA (Home Health Aide) documentation notes were completed and entered into the clinical record for 2 of 4 patient's receiving HHA services (Patient's #1 and 5) and failed to ensure written notice of the patient's rights was included in the clinical record for 1 of 1 patient's (Patient' # 5) in a sample of 7 clinical records reviewed. Findings Include:	G 1012	G 1012 The Administrator or designee will immediately review all clinical records for *accurately complete plan of care to include the frequency and duration of visits, the nutritional requirements, all medications and treatments,measurable goals, completed HHA documentation notes are in the clinical record, and written notice of the patient's rights are in the clinical record. Any clinical record found not to have current updated information in the clinical record, the DON will call the PCP for a verbal order to update the plan of care, a written physician order will be written with the updated or current information*	11/30/2018

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	1. An agency policy titled, "Clinical Documentation" was reviewed and stated, "Agency will document each direct contact with the client. This documentation will be completed by the direct caregiver and monitored by the skilled professional responsible for managing the clients's care. Purpose: To ensure that there is an accurate record of the services provided, client response and ongoing need for care. To document conformance with the Plan of Care, modifications to the plan and interdisciplinary involvement ... 2. a separate note shall be completed for each visit/shift and signed and dated by the appropriate professional. Actual time and length of the client visit will be included in each note ... 5. Documentation of services ordered on the plan of car will be completed the day services is rendered and incorporated into the clinical record within seven 2. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ...2. The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures ... p. Treatment goals...t. other appropriate items ... 9. At the time of certification and recertification , a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include, but is not limited to: changes in clients		*and then sent to PCP for signature. Any HHA documentation not up to date in clinical record will be obtained from HHA. Any clinical record found not to have written documentation of patients rights, a new Home Health Admission Service Agreement will be obtained from the Patient or legal Representative and placed into the clinical record.* *The Administrator or designee will educate administration/management, all clinicians, HHA's on policy:* *Clinical Documentation* *Plan of Care* To prevent this deficiency in the future, the DON will monitor all clinical documentation through weekly audits to ensure that the clinical record is correct, updated as needed and with any change in patients condition, that documentation is completed in a timely manner according to agency policy and will review all documentation with the admitting RN to ensure all written documentation was obtained during the initial comprehensive assessment, the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10	

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	physical or psychosocial condition, client response to care/services and outcome of care and services ... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 3. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16, included orders for skilled nurse 5 times a week and HHA services 6 times a week. The POC failed to include the duration for the SN (skilled nurse) and failed to include the HHA (Home Health Aide) time and duration and services to be provided. The clinical record failed to include a case conference/ 60 day summary. The POC for the certification period of 9/16/16 to 11/14/16, included orders for SN 5 times a week and HHA services 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 11/15/16 to 1/13/17, included orders for SN 5 times a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 1/14/17 to 3/14/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The notes dated 2/16/17 and 3/9/17 failed to include skilled nurse services 1 time a week, and the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided		% of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	

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	The POC for the certification period of 3/15/17 to 5/13/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 5/14/17 to 7/12/17, included orders for SN 1 time a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration of the SN and HHA services. The POC for the certification period of 7/13/17 to 9/10/17, included orders for SN 5 times a week and HHA 9 hours a day. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/11/17 to 11/9/17, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The notes dated 10/6/17 failed to include skilled nursing services and reported HHA services were daily and were ordered 5 times a week. The note dated 11/08/17 incorrectly reported skilled nursing services were being provided 5 days a week (SN visits were provided 1-2 times a week) and reported HHA services were "no change." The notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. The POC for the certification period of 11/10/17 to 1/8/18, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The notes dated 12/4/17 and 1/4/18 both stated, "continue plan of care as developed" . No acute changes noted at this time. The notes failed to include the patient's current physical or			

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	psychosocial condition and patient's response to and outcome of care/services provided. The POC for the certification period of 1/9/18 to 3/9/18, included orders for SN 5 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The clinical record evidenced a skilled nurse note dated 2/19/18 that reported, "per mother, patient fell off bed yesterday." The notes were dated 2/55/18 and 3/5/18 and both stated, "Continue plan of care as developed. No distress noted. No acute changes noted." There was no mention of the fall and the notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. The POC for the certification period of 3/10/18 to 5/8/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 5/9/18 to 7/7/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 7/8/18 to 9/5/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA			

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services.

The POC included orders for Two Cal HN (a nutritional supplement) oral 240 ml bolus every 6 hours. During an interview conducted with the patient's mother on 9/24/18 at 10:00 AM he/she reported the following was the accurate G-Tube feeding: Two Cal HN 480 ml bolus at 6 or 7 AM, 240 ml bolus at 4:00 PM and 480 ml bolus at 9-10 PM daily during the time the mother is at home from work. The POC failed to include the accurate nutritional requirements.

The POC included the following topical ointments: Aquaphor External (for protection and moisture healing of skin) 1 apply to healed areas every 12 hours, Mupirocin External (antibacterial) 2 % 1 once a day. The orders failed to specify where the ointments would be applied. An order for Ciprofloxacin (antibiotic) HCL oral 500 mg 1 tab per feeding tube every 12 hours failed to be omitted from the POC and had been discontinued on 6/21/18.

A pain goal on the POC stated, "Patient's pain will remain tolerable throughout care period." The goal was not specific to include the Wong scale for an assessment of a nonverbal patient and did not include measurable outcomes for tolerable pain goals.

The clinical record failed to evidence any HHA documentation notes from 4/2/17 to 5/21/17 in the clinical record.

An interview was conducted with the Administrator on 9/24/18 at 4:45 PM to review the POC findings. The Administrator reported there was no further documentation to be provided

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	4. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings: The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits. The POC for the certification period of 7/14/18 to 9/11/18, included the following order: "Silvadene External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18 and failed to include the specific area of the body for application. 5. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings: The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits. The POC for the certification period of 7/14/18 to 9/11/18, included the following order: "Silvadene External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18 and failed to include the specific area of the body for application. An interview was conducted with the Administrator on 9/26/18 at 4:30 PM regarding the			

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POC findings. The Administrator reported there was no further documentation to be provided

6. The clinical record of Patient #3 with a SOC of 7/25/18 was reviewed with the following findings:

The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets" The patient was interviewed on 9/26/18 9:48 AM and reported he had a 32 ounce daily fluid restriction and his diet is a diabetic/renal diet. A fax was obtained from [the dialysis facility] on 9/28/18 and included the following daily diet restrictions: Sodium 3 GM, Phosphorus 1200 mg and 1500 ml. The POC failed to include the patients special nutritional needs related ESRD (End Stage Renal Disease).

An interview was conducted with the patient regarding his medications on 9/26/18 at 9:48 AM during a home therapy visit observation. The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following medications: Levothyroxine Sodium (thyroid pill also know as Synthroid) Oral 175 mcg 1 tablet daily and Synthroid (thyroid pill also know as levothyroxine) Oral 75 mcg 1 tablet in the mornings daily. The patient reported the order was a duplicate. Nortriptyline (for diabetic neuropathy pain) HCL oral 10 mg 2 caps bedtime, the patient reported this medication had been discontinued 2 months ago. Insulin aspart (fast acting diabetic insulin) subcutaneous 100 units/ml 15-20 units daily before meals, using sliding scale (insulin amount depends on the patient's blood sugar). The order failed to include the specific sliding scale orders.

An interview was conducted with the

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	Administrator on 9/26/18 at 12:07 PM regarding the findings for Patient # 3. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this." No further documentation to be provided. A fax was obtained from [the dialysis facility] on 9/28/18 and included the following orders specific to the patients ESRD: Heparin Sodium 1,000 units/ml to arterial port 2,200 units and 2,300 units to venous port (of a central dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The POC failed to include the patient's medication regimen for ESRD. 7. The clincial record of Patient # 4 with a SOC date of 3/13/18 was reviewed with the following findings: The POC for the certification period of 7/11/18 to 9/8/18 included an order for HHA 3 hours day/ 4 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided. 8. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification periods of 6/19/16 to			

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	8/17/16, 8/18/16 to 10/16/16 and 10/17/16 to 12/14/16 included an order for HHA 4 hours a day/ 5 days a week. The POC failed to include the duration of the HHA visits. The clinical failed to evidence any HHA documentation notes from 8/10/16 to 9/29/16 in the clincial record The clinical record failed to evidence a contain a copy of the patient's rights. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be provided.			
N 0000 Bldg. 00	This visit was a State re-licensure survey with investigation of 2 complaints Dates of survey: 9/21/18, 9/24/18 - 9/28/18, 10/1/18-10/2/18 Facility # 013593 Medicaid #: 201284430 Complaints # IN 00243261: Substantiated with findings IN 00220561: Substantiated with findings 12 Month Unduplicated Census: 257 Home visits with record review: 3 Records reviewed without home visit : 4	N 0000		

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	Total records reviewed: 7			
N 0447 Bldg. 00	410 IAC 17-12-1(c)(4) Home health agency administration/management Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities.			
	Based on record review and interview, the agency failed to provided appropriate public information regarding the relocation address of the parent location for 1 of 1 agency. Findings Include: A letter from the agency corporate office dated 7/19/18 addressed to the Indiana State Department of health was reviewed and indicated, "Aging & Disabled Home Health Care License # (17-013593-1) would like to make a corporate mailing and address change from 10500 Crosspoint Blvd, Indianapolis, IN 46256 to 625 S Tillotson Avenue, Muncie, IN 47304 ...The corporate mailing address will be PO Box 17460, Indianapolis, IN. We would also like for you to send us a license renewal form to the PO Box corporate mailing address please. The reason for this address change is that our 10500 Crosspoint Blvd building was sold and the new owner would not allow us to apply signage to the building, which is required by state regulations ...." The letter was signed by the agency administrator. The letter did not indicate an effective of the relocation.	N 0447	N 447 The Administrator has immediately corrected public information regarding address of parent agency is correct by: CMS 855 filed on 9/24/18 Parent location address given to the answering service on 9/21/18 Letter sent to ISDH on 7/19/2018 Correction letter sent to ISDH on 9/24/2018 The agency has not received confirmation approval letter on change of location. The Administrator will be responsible for these corrective actions to ensure that this deficiency is corrected and will not reoccur and will file a CMS 855 and wait for approval letter before moving location of corporate office in the future.	11/12/2018

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	On 9/20/18 at 10:00 PM, the agency number was called to validate the agency's current location. The answering service indicated, "I know they have moved, but I don't know the new address." On 9/21/18 at 9:06 AM, the agency number was called and following speaking with 3 different employees it became known the agency had relocated from Indianapolis to Muncie, IN. On 9/21/18 at 11:30 AM, the administrator was interviewed and reported apparently the answering service and other office staff had not been made aware of the new address. Therefore since they had not been made aware of the agency's new address, they were not able to accurately report this public information during a phone inquiry.			
N 0449 Bldg. 00	410 IAC 17-12-1(c)(6) Home health agency administration/management Rule 12 Sec. 1(c)(6) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (6) Ensure that the home health agency meets all rules and regulations for licensure. Based on record review the administrator failed to ensure the agency met all rules and regulations for licensure for 1 of 1 agency. Findings include: The administrator failed to ensure the accuracy of public information (See Tag N 447). The administrator failed to ensure the HHA (Home Health Aide) documentation notes were completed and entered into the clinical record (See	N 0449	N 449 The Administrator will immediately correct all deficiencies through education of staff on policies and procedures, focused audits of all clinical records surrounding the deficiency sited, updating the plan of care with any changes in patient condition or failure to follow the plan of care, and continued oversite of all deficiencies through continued audits quarterly after 100% compliance is met.	11/30/2018

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	Tag N 453). The administrator failed to ensure the agency employment policy was followed (See Tag N 458). The administrator failed to ensure personnel files of direct care providers contained either a valid negative one-step TST (tuberculosis skin test) upon hire and a valid negative TST within the prior 12 months; or a valid two-step TST upon hire (See Tag 464). The administrator failed to ensure the clinical record included documentation of coordination between the SN (skilled nurse) and the HHA (home health aide) regarding a change in the patient's skin condition that progressed from irritation to a stage 3 pressure ulcer (See Tag N 484/ N545). The administrator failed to ensure communication occurred with the nephrologist caring for 1 ESRD (End State Renal Dialysis) (See Tag N 486/ N546) The administrator failed to ensure the clinical record contained documentation that the patient or the patient's family had received written notice of patient's rights (See Tag N 494). The administrator failed to ensure the patient was informed in writing of the disciplines and the frequency of the services to be provided (See Tag N 504). The administrator failed to ensure complaints were documented, investigated, and resolved (See Tag N 514). The administrator failed to ensure the patient's needs were met (See Tag N 520).		The Administrator will also become more involved with IAHHC to stay abreast of all new regulations and available training for administration and staff.	

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	The administrator failed to ensure the plan of care was followed (See Tag N 522/ N537). The administrator failed to ensure the plan of care included the frequency and duration of visits to be made, the nutritional requirements, all medications and treatments and measurable goals (See Tag N 524/ N542). The administrator failed to ensure a written summary for each patient is completed and sent to the physician every 2 months (See Tag N 529). The administrator failed to ensure the clinical record included documentation of coordination with the HHA (Home Health Aide) regarding a change in the patient's skin condition that progressed from irritation to a stage 3 pressure ulcer and the HHA failed to provide all services outlined in the POC (Plan Of Care) (See Tag N 533). The administrator failed to ensure personnel files included documentation the Home Health Aide completed a competency evaluation program (See Tag N 596). The administrator failed to ensure supervision to the HHA (Home Health Aides) every 30 days for HHA only services (See Tag N 606). The administrator and failed to ensure the clinical record contained pertinent past and current findings for every patient (See Tag N 608).			
N 0453 Bldg. 00	410 IAC 17-12-1(d) Home health agency administration/management Rule 12 Sec. 1(d) A physician or a			

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	registered nurse who has two (2) years of nursing experience, with at least one (1) year of supervisory or administrative experience, shall supervise and direct nursing and other therapeutic services. Based on record review and interviews, the (DON) Director of Nursing services failed to ensure the HHA (Home Health Aide) documentation notes were completed and entered into the clinical record for 2 of 4 patient's receiving HHA services (Patient's #1 and 5) in a sample of 7 clinical records. Findings Include: 1. An agency policy titled, "Clinical Documentation" was reviewed and stated, "Agency will document each direct contact with the client. This documentation will be completed by the direct caregiver and monitored by the skilled professional responsible for managing the clients' care. Purpose: To ensure that there is an accurate record of the services provided, client response and ongoing need for care. To document conformance with the Plan of Care, modifications to the plan and interdisciplinary involvement ... 2. a separate note shall be completed for each visit/shift and signed and dated by the appropriate professional. Actual time and length of the client visit will be included in each note ... 5. Documentation of services ordered on the plan of care will be completed the day services are rendered and incorporated into the clinical record within seven (7) days after the care has been provided ..." 2. A job description titled, " Director of Nursing" was reviewed and stated, " ... Position Summary: Responsible for the overall supervision and	N 0453	N 453 The Administrator will immediately review The DON job description, job expectations, and job performance with the DON. The Administrator or designee will educate the administration/management staff on policy: Clinical Documentation DON job description To prevent this deficiency in the future, the DON will be responsible to ensure clinical documentation in clinical records is completed according to agency policy through weekly audits of documentation. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	11/30/2018

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direction of healthcare services ... shares responsibilities with the Administrator for the agency's overall compliance with State and Federal guidelines and standard of nursing practice. Duties and Responsibilities: Supervise and direct all clinical services. Promote, review and evaluate the quality and appropriateness of patient care practices ... Participate in assigning personnel to patients based on patient need and physician's plan of care ... Coordinate and ensure that the patient is well serviced through the assignment of skilled services and personal caregivers ...."

3. The clinical record for Patient # 1 with a start of care date of 7/18/16 failed to evidence any HHA documentation notes from 4/2/17 to 5/21/17 in the clinical record.

4. The clinical record for Patient # 5 with a start of care date of 6/19/16 to 12/14/16 failed to evidence any HHA documentation notes from 8/10/16 to 9/29/16 in the clinical record.

5. An interview was conducted with the DON on 9/21/18 at 1:06 PM. The DON reported, "I'm in charts all day long." The DON reported having assessed quality of care, performed "pop- up" visits with nursing staff, looked at clinical notes, and did Quality audits of 10 % of clinical records quarterly.

6. The administrator was interviewed on 9/26/18 at 2:45 PM about the missed HHA visit documentation for Patient # 1 and 5. The administrator reported the aides' visits notes had to be uploaded into the computer schedule by the scheduler. The scheduler should have put the assigned visits and the times into the computer for the aide to have documented their visit. The

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	administrator reported if the scheduler had not uploaded the visits to the computer the HHA would not have had a way to document their visit to the computer program. The administrator reported the process was for the director of nursing services to check the assignments in the computer to ensure the POC matched the schedule for HHA visits and was to have audited the HHA notes every 60 days. The administrator reported the HHA'S had not informed the agency the visits had not been uploaded in computer and the audits failed to discover the records were missing the HHA documentation.			
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.			
	Based on record review and interview, the administrator failed to ensure the agency employment policy was followed to include an annual evaluation for 1 of 5 employees (Employee A) and a criminal check and signed job	N 0458	N 458 The Administrator or designee immediately had HR Director audit all employee files for regulatory items. Audit was completed on 11/2/2018. Any missing regulatory items will be	11/30/2018

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	description for 1 of 5 employees (Employee D) personnel records reviewed in a sample of 5. Findings Include: 1. An agency policy titled, "Employment Policy" was reviewed and stated, "The agency seeks to hire individuals who meet the highest standards of character and subscribe to the purpose and goals of the Agency. All employment practices are to be consistent with applicable laws and other such acts and regulations that control the employment relationship. Guideline: Supervisors carefully select qualified employees through written application, personal interview and reference checks. After all available information is thoroughly evaluated, a supervisor may offer the applicant a job with the agency contingent upon a clear criminal history check ... Procedures: ... Criminal background Check-A criminal background check must be done for any candidate who received a job offer." 2. An agency policy titled, "Personnel Records" was reviewed and stated, "Personnel files will be established and maintained for all personnel ... Purpose: The purpose of this policy is to identify the content of personnel files and a system for maintaining accurate, complete and current information. Special Instructions: 1. Personnel Record-the employee personnel record will include, but not be limited to : a. Pre-employment information ...Criminal history and background checks as required by law... B. Employment information: ... Competency testing form home health aides and specific competencies per job title ... signed job description ... C. Ongoing Employment ... Performance appraisals ... D. Medical History/Health Status- Maintained Confidentially: ... Pre-Employment physical, if		obtained by the HR Director and placed in the personnel file of the employee. The Administrator or designee will educate administrative/management staff/HR Director on policy: Employment policy Personnel Records policy To prevent this deficiency in the future, the employment process and documents used for employment process were redesigned for use in the hiring process. HR Director is responsible for all new hire employee files to ensure all personnel records are completed before employee has first contact with patient, a check off sheet will be utilized as evidence and maintained in employee file, the Administrator or designee will be responsible for active employee record audits until 100% compliance is met then 10 % of all employee records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	

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	required ... TB screening (2-step Mantoux) ...." 3. The confidential personnel file of Employee A with a date of hire of 1/5/17 and first patient contact of 1/5/17, was reviewed on 10/1/18 at 2:00 PM. The employee record failed to include an annual evaluation. 4. The confidential personnel file of Employee D with a date of hire of 9/7/17 and first patient contact of 9/7/17, was reviewed on 10/1/18 at 3:15 PM. The employee record failed to include evidence of a criminal check, a or a signed job description to his/her role of registered nurse. 5. The administrator was interviewed on 10/1/18 at 4:30 PM and reported he/she would search for the missing information. 6. The administrator was interviewed on 10/2/18 at 10:30 AM and reported he/she was unable to locate the missing information for the personnel files of Employees A and D.			
N 0464 Bldg. 00	410 IAC 17-12-1(i) Home health agency administration/management Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the			

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	previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.			
	Based on record review and interview, the agency	N 0464	N 464 The Administrator immediately called for an audit of	11/30/2018

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	failed to ensure personnel files of direct care providers contained either a valid negative one-step TST (tuberculosis skin test) upon hire and a valid negative TST within the prior 12 months; or a valid two-step TST upon hire for 3 of 5 employees whose personnel files were reviewed (Employees A, D, and E) in a sample of 5. Findings Include: 1. An agency policy titled, "Employment Policy" was reviewed and stated, "The agency seeks to hire individuals who meet the highest standards of character and subscribe to the purpose and goals of the Agency. All employment practices are to be consistent with applicable laws and other such acts and regulations that control the employment relationship. Guideline: Supervisors carefully select qualified employees through written application, personal interview and reference checks. After all available information is thoroughly evaluated, a supervisor may offer the applicant a job with the agency contingent upon a clear criminal history check ... Procedures: ... Criminal background Check-A criminal background check must be done for any candidate who received a job offer." 2. An agency policy titled, "Personnel Records" was reviewed and stated, "Personnel files will be established and maintained for all personnel ... Purpose: The purpose of this policy is to identify the content of personnel files and a system for maintaining accurate, complete and current information. Special Instructions: 1. Personnel Record-the employee personnel record will include, but not be limited to : a. Pre-employment information ...Criminal history and background checks as required by law... B. Employment information: ... Competency testing form home		all active employee files and this was completed on 11/12/2018. Any employee found during audit that were missing a negative TB upon hire and a valid negative TB within the prior 12 months will be given a TB test to meet this requirement on 11/19/2018 and placed in the employee file. Mandatory TB testing will be completed on 11/19/18 on all employees and in May then yearly thereafter. If personnel file has no evidence of 2-step TB, a second clinic will be held on 11/26/18 for the 2nd step TB. The Administrator or designee will educate administrative/management/HR Director on policy: Employment policy Personnel Records policy To prevent this deficiency in the future, the employment process and documents used for employment process were redesigned for use in the hiring process. HR Director is responsible for all new hire employee files to ensure all personnel records are complete before employee has first contact with patient. The Administrator or designee will be responsible for active employee record audits until 100% compliance is met then 10 % of all employee records will be audited quarterly for evidence after	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AGING & DISABLED HOME HEALTH CARE LLC	10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256

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	health aides and specific competencies per job title ... signed job description ... C. Ongoing Employment ... Performance appraisals ... D. Medical History/Health Status- Maintained Confidentially: ... Pre-Employment physical, if required ... TB screening (2-step Mantoux) ...." 3. The confidential personnel file of Employee A with a date of hire of 1/5/17 and first patient contact of 1/5/17, was reviewed on 10/1/18 at 2:00 PM. The employee record failed to include evidence of a 1st or 2nd step Mantoux skin test upon hire. 4. The confidential personnel file of Employee D with a date of hire of 9/7/17 and first patient contact of 9/7/17, was reviewed on 10/1/18 at 3:15 PM. The employee record failed to include evidence of a 2nd step Mantoux skin test on hire. 5. The confidential personnel file of Employee E with a date of hire of 7/13/16 and first patient contact of 7/13/16, was reviewed on 10/1/18 at 4:00 PM. The employee record failed to include evidence of a 1st or 2nd step Mantoux skin test upon hire. 6. The administrator was interviewed on 10/1/18 at 4:30 PM and reported he/she would search for the missing information. 7. The administrator was interviewed on 10/2/18 at 10:30 AM and reported he/she was unable to locate the missing information for the personnel files of Employees A, D, and E.		100% compliance is met to ensure that this deficiency will not reoccur.	
N 0484 Bldg. 00	410 IAC 17-12-2(g) Q A and performance improvement Rule 12 Sec. 2(g) All personnel providing services shall maintain effective			

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	communications to assure that their efforts appropriately complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences.			
	Based on record review and interview, the agency failed to ensure the clinical record included documentation of coordination between the SN (skilled nurse) and the HHA (home health aide) regarding a change in the patient's skin condition that progressed from irritation to a stage 3 pressure ulcer for 1 of 4 patient's receiving home health aide services (Patient #2) in a sample of 4. Findings Include: An agency policy titled, "Coordination of Client Services" was reviewed and stated: "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objective outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction. An agency policy titled, "Home Health Aide Supervision" was reviewed and stated, " Agency shall provide Home Health Aide Services under the direction and supervision of a RN/ Therapist when personal care services are indicated and ordered by the physician ... 1. The Nursing Supervisor or designated RN/Therapist will give the HHA direction for client care by way of the Care Plan. The clinical record for Patient # 2, with a start of care date of 9/28/15, with a diagnosis to include Cerebral Palsy and Functional limitations to	N 0484	N 484 The Administrator or designee will immediately review all clinical records for coordination of care between SN/HHA. Immediately all RN case managers will be required to conference with the HHA weekly for patients they case manage, and document this coordination of care through a communication note in the clinical record. The DON or designee will educate administration/management, all clinicians on policy: Coordination of Client Services Home Health Aide Supervision Care Planning/ Coordination of Care Home health aides will be educated on: "What to Report to RN, Case Manager" Home Health Aide Documentation To prevent this deficiency in the future, the RN case managers will be required to review all HHA documentation and perform weekly conference with HHA's for	11/30/2018

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	include Paralysis, Bowel and Bladder Incontinence, Endurance and Ambulation. The plans of care for the certification periods of 3/15/18 to 5/13/18, 5/14/18 to 7/13/18 and 7/14/18 to 9/11/18 included orders for HHA (Home Health Aide) for 8 hours daily for, 5 visits weekly. The clinical record was reviewed with the following findings: A HHA visit note dated 3/29/18 stated, "Skin in the crack of [pt's name] butt (buttocks) is slightly irritated. A SN visit was conducted on 4/11/18 (13 days later). The SN note stated, "Educated about pressure relief due to impaired mobility voices an understanding. Patient states that she has wound center appointment on 4/19/18 due to opened area to crack of buttocks. Unable to assess wound due to patient sitting in wheelchair and unable to transfer via hoyer to assess wound because patient did not want to be transferred back." A document in the clinical record dated 4/12/18 at 11:00 AM and titled, "[hospital name] office visit," included a new diagnosis for Stage 3 pressure ulcer of the buttock. The administrator was interviewed on 9/26/18 at 2:45 PM. The administrator reported there was no documentation that the aide and nurse communicated about the patient's irritated area that progressed to a stage 3 pressure ulcer in the clinical record. The administrator was asked about the process for the home health aide notes to be reviewed by an RN. The administrator reported, "The HHA visits are audited every 60 days by [director of nursing services name].		all the patients they case manage. RN case manager will also review the aide care plan with the assigned home health aide prior to the home health aide providing services to the patient and review the home health aide care plan with the home health aide at least every 60 days or when there is a change in the patients' condition. the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	

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N 0486 Bldg. 00	410 IAC 17-12-2(h) Q A and performance improvement Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the agency failed to ensure communication occurred with the nephrologist caring for 1 ESRD (End State Renal Dialysis) for 1 of 1 patient receiving hemodialysis (Patient # 3) in a sample of 7 clinical records. An agency policy titled, "Coordination of Client Services" was reviewed and stated: "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objective outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction. Purpose ...To ensure services are coordinated between members of the interdisciplinary team. To ensure appropriate, quality care is being provided to clients ... To modify the plan to reflect the needs or changes identified by members of the team ... to determine the continuation of services and /or future plans for care. To provide the attending physician with an ongoing assessment of the client and identify the client's response to services provided. 1. Care conferences will be held as necessary to establish interchange, reporting, and coordinated evaluation between all disciplines involved in the client's care ... 3. After the initial assessment, the admitting RN (Registered Nurse) or Therapist shall discuss the findings of the initial visit with the Clinical Manager to ensure ...a. Clarification of the plan of care orders. d. Client's need for skilled nursing care ...e. Need for other services and/or referral to community resources ...G. Coordination with other	N 0486	N 486 The Administrator or designee will immediately review all clinical records for coordination of care with any patient receiving dialysis, wound care. If coordination of care has not been established the DON or RN case manager will establish this coordination of care by calling the dialysis center or wound care center and request weekly updates on patients care. The DON or designee will educate administration/management, all clinicians on policy: Coordination of Client Services To prevent this deficiency in the future, the DON will audit these clinical records weekly to ensure updates from these providers are present in the clinical record, if not present the DON will call the provider for an update and notify the RN case Manager of the update so the RN can update the POC if needed. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100%	11/30/2018

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	agencies and institutions, if the need arises ... 6. Care conferences will be determined on the care conference summary form or in the progress note ... " An interview was conducted with the patient on 9/26/18 at 9:48 AM during a home visit observation. The patient reported he had a central venous dialysis catheter in his right subclavian (collarbone) area for hemodialysis treatments 3 times weekly related to his ESRD. In addition, the patient reported he was getting medication for anemia, fluid restriction and dietary restrictions related to his ESRD. The clinical record of Patient #3 with a Start of care of 7/25/18 and a POC (Plan of Care) for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets." The POC failed to include any medication orders related to the patient's dialysis 3 times weekly The administrator was interviewed on 9/26/18 at 12:07 AM and reported there was no documentation the agency had coordinated care with the Hemodialysis facility or the Nephrologist. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this." The agency was asked to call the dialysis facility and obtain the current treatment orders for the patient to include diet, fluid restriction, and medication. A fax was obtained from [the dialysis facility] on 9/28/18 and included the following orders specific to the patient's ESRD: Heparin		compliance is met to ensure that this deficiency will not reoccur. Education completed on 11/11/2018.	

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	Sodium (to prevent blood clots) 1,000 units/ml to arterial port (red) 2,200 units and 2,300 units to venous (blue) port (of the dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The fax included a 1500 ml fluid restriction and dietary restriction to 3 gm sodium, and 1200 mg Phosphorus daily. The POC failed to include the patient's medication regimen for ESRD, diet and fluid restrictions.			
N 0494 Bldg. 00	410 IAC 17-12-3(a)(1)&(2) Patient Rights Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section. Based on record review and interview, the agency failed to provide documentation that the patient or the patient's family had received written notice of the patient's rights for 1 of 1 patient's (Patient' # 5) in a sample of 7 clinical records reviewed. Findings Include:	N 0494	N 494 The Administrator or designee will immediately review all active patient records for evidence that the patient and or legal representative received notice of their rights in a language and manner the individual understands during the initial evaluation, and if not obtained	11/30/2018

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	An agency policy titled, "Home Care Bill of Rights" was reviewed and stated, "Clients will be informed of their rights as a consumers of home care services. This include the right to voice grievances and request changes without discrimination, reprisal or unreasonable interruption of services ...1. A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event that the client is unable to make decision, the Home Care Bill of Rights shall be given to the client's legal guardian ...2. The client/caregiver shall be advised orally and in writing or their right to voice grievances ... Documentation of the receipt of the Home Care Bill of Rights will be maintained in the clinical record ...." The clinical record of Patient # 5 with a start of care date of 6/19/16 and a discharge date of 12/141/6. The clinical record failed to evidence a contain a copy of the patient's rights. The administrator was interviewed on 10/1/18 at 1:58 PM regarding the failure of the agency to produce copies of the patient's rights in the clinical record. The administrator was unable to produce any further documentation of the patient's rights in the clinical records.		during this initial evaluation, will correct the deficiency by obtaining evidence that the deficiency has been corrected by obtaining a new Home Health Admission Service Agreement signed by patient and or legal representative. The Administrator or designee will educate administration/management/all clinicians on policy: Home Care Bill of Rights Agency Service Agreement To prevent this deficiency in the future, the DON will review all documentation with Admitting RN to ensure all documentation is correct and present after the initial comprehensive assessment, the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed on 11/08/2018.	
N 0504 Bldg. 00	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following:			

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	(D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Based on record review and interview, the agency failed to inform the patient in writing the disciplines and the frequency of the services to be provided for 2 of 7 clincial record reviewed (Patient # 2 and 5) in a sample of 7. Findings Include: 1. An agency policy titled, "Home Care Bill of Rights" was reviewed and stated, "Clients will be informed of their rights as a consumers of home care services. This include the right to voice grievances and request changes without discrimination, reprisal or unreasonable interruption of services ...1. A designated Registered Nurse/Therapist shall provide the client with a written notice of the Home Care Bill of Rights in advance of furnishing care to the client or during the initial evaluation visit before treatment is initiated. In the event that the client is unable to make decision, the Home Care Bill of Rights shall be given to the client's legal guardian ...2. The client/caregiver shall be advised orally and in writing or their right to voice grievances ... Documentation of the receipt of the Home Care Bill of Rights will be maintained in the clinical record ...." 2. The clinical record of Patient # 2 with a start of care date of 9/28/18 and a certification period of 7/14/18 to 9/11/18 was reviewed. The clinical record contained a document titled, Home Health	N 0504	N 504 The Administrator or designee will immediately review all active patient records for evidence that the patient and or legal representative received notice of their rights in a language and manner the individual understands which includes discipline, frequency, duration and the extent of payment from federally funded programs during the initial evaluation, and if not obtained during this initial evaluation, will correct the deficiency by obtaining evidence that the deficiency has been corrected by obtaining a new Home Health Admission Service Agreement signed by patient and or legal representative. The DON or designee will educate administration/management/all clinicians on policy: Home Health Admission Service Agreement Home Care Bill of Rights To prevent this deficiency in the future, the DON will review all documentation with Admitting RN to ensure all documentation is	11/30/2018

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	Admission Service Agreement" dated 3/14/18. The section of the form to indicate services, frequency, and duration was blank and not completed. 3. The clinical record of Patient # 5 with a start of care date of 6/19/16 and a discharge date of 12/14/16. The clinical record failed to evidence a contain a copy of the patient's rights. 4. The administrator was interviewed on 9/26/18 at 4:00 PM regarding the incomplete service agreement that was in the clinical record of Patient's # 2 . The administrator stated, "I see what's wrong. I yelled at them about this." 5. The administrator was interviewed on 10/1/18 at 1:58 PM regarding the failure of the agency to produce copies of the patient's rights in the clinical record for Patient # 5. The administrator was unable to produce any further documentation of the patient's rights in the clinical records.		correct and present after the initial comprehensive assessment, the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed on 11/08/2018.	
N 0514 Bldg. 00	410 IAC 17-12-3(c) Patient Rights Rule 12 Sec. 3(c) (c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint.	N 0514	N 514 The phone message	11/30/2018

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	Based on record review and interview, the agency failed to document, investigate and resolve complaints for 3 of 7 patients record reviews. (Patients # 1, 4 and 5) in a sample of 7. Findings Include: 1. An agency policy titled, "Client/Family Complaint /Grievance Policy" was reviewed and stated, " Definitions: Client Complaint: A complaint is defined as "any expression of dissatisfaction by a client/family regarding care or services that can be addressed at the time of complaint by staff present" ... Grievance: A grievance is any formal or informal written expression of dissatisfaction with care or services that is expressed by the client/family that is not solved at that time by staff present ... Any complaint that fits the grievance definition will require a written response to the person complaining ... Special Instructions ... 2. Client complaints will be documented on a client complaint form and filed with the complaint log in an administrative file. 3. The grievance as defined above include treatment, services ... will be documented on the grievance form by the person receiving the complain/grievances e and forwarded as soon as possible to the appropriate director ... for investigation action and trending. 4. Grievance will be addressed by the department director or his/her designee and response made to the complainant within 7 calendar days ... and the responsible person will report back within 30 calendar days with a resolution of the grievance. All persons with a grievance will receive a written notice of the investigators review...7. Grievances are considered completed when an approved response has been mailed to the client/complainant ...the originally along with the letters sent ... are returned to the administrator or		system will be updated immediately to include the Administrators number in the event that a patient or family member wishes to file a complaint or grievance and all complaints /grievances will be forwarded to the Administrator or designee and will be documented, investigated, with resolution and logged in the complaint log book, complaints / grievances will be processed according to agency policy. The Administrator will review the Client/Family complaint/grievance policy. The Administrator or designee will educate administration/management, all clinicians on policy: Client/Family complaint/grievance policy To prevent this deficiency in the future, all complaints/grievances will be reviewed with the QAPI committee and Governing Body quarterly for trending of complaints / grievances. Any trends will be investigated and QAPI committee will address any trends identified.	

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	Quality Designee for tabulation and trending of data ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16 included orders for skilled nurse 5 times a week for G-Tube (a tube in the stomach where liquid nutrition is provided) feedings while the parent was at work and HHA services 6 times a week. The SN failed to provide services until 8/9/16 (21 days) after the SOC. The HHA provided services 5 times a week 1- 2 and 3 times week 6 of the certification period and failed to conduct visits as ordered. The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while the parent was at work and HHA services 6 times a week for assistance with IADL's and ADL's. SN services were provided 4 times during week 6, 3 times during week 7, 0 times during week 8, and 2 times during week 9 of the certification period and failed to be provided as ordered. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist the family in finding a nursing care via another agency at this time family has declined this offer. Currently, mother is coming home at noon to feed daughter via G-Tube until nursing staff available." The HHA services were provided 3 times during week 5 of the certification period and failed to be conducted as ordered. The POC for the certification period of 11/15/16 to			

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	1/13/17 included orders for SN 5 times a week for G-Tube feedings and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 4 of the 45 visits ordered on the POC for the certification period and failed to provide visits as ordered. The POC for the certification period of 1/14/17 to 3/14/17 included orders for SN 1 time a week for G-tube feedings each visit and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 5 visits in the certification period and failed to provide visit as ordered. There were no orders to change the POC. A SN note 3/14/17 stated, "Informed the cg (caregiver) of SN visits weekly for skilled intervention, but that daily is not achievable and not necessary when available CG competent in administration of feedings. Encourage to call agency office prn (as needed)." The POC for the certification period of 3/15/17 to 5/13/17 included orders for SN 1 time a week for assessment and instruction to caregivers and HHA 6 times a week for assistance with IADL'S and ADL's. The SN failed to provide 1 visit weekly for the weeks 1-3 of the certification period. The clinical record failed to evidence documentation of any HHA visits for weeks 4-9 of the certification period. The POC for the certification period of 5/14/17 to 7/12/17 included orders for SN 1 time a week for assessment and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The POC failed to include the duration of the SN and HHA services. The clinical record failed to evidence documentation of HHA visits for week 1 and 2. The HHA conducted 6 visits week 4-8 and			

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	4 visits during week 9 of the certification period. The POC for the certification period of 7/13/17 to 9/101/7 included orders for SN 5 times a week for G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during weeks 2-3 and 5-9 of the certification period and failed to provide 5 visits per week as ordered. The HHA conducted 3 visits during week 1 and 6 visits during week 2-9 of the certification period and failed to provide visits 5 times weekly as ordered. The POC for the certification period of 9/11/17 to 11/9/17 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 2 visits during weeks 1 and 4-8, 0 visits during week 2 and 1 visit during week 9 of the certification period. The SN failed to provide as ordered. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during week 8 and 9 of the certification period. The HHA failed to provided visits as ordered. A SN note dated 9/11/17 stated, "continues to request daily SN to cover G-Tube feedings while mother is at work. Will discuss with leadership. Parent states at this time his/her family has been able to cover the other days of the week there has not been a daily RN." The POC for the certification period of 11/10/17 to 1/8/18 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. There were orders present to change the SN frequency to 1 visit during week 7 and 9 of the certification period. The SN failed to follow the POC and provided visits 2 times during weeks 2-6.			

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	No SN visits were conducted during week 1 and 8. The HHA provided 1 visit week 1 of the certification period on 11/10/17, 6 visits during weekly from 12/3/17 to 1/6/18. The HHA failed to provide visits as ordered. The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week for tube G-tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided visits 1 time during week 1 and 2 times during week 2-9 of the certification period. The SN failed to provide visits as ordered. The HHA provided visits 4 times a week from 1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and 1/11/18. The HHA provided visits 5 times a week from 1/15/18 to 1/19/18 with 14-hour visits on 1/16/18 and 1/18/18. The HHA provided visits 6 times a week from 1/21/18 to 3/9/18. The HHA failed to provide visits as ordered. The POC for the certification period of 3/10/18 to 5/8/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1, 2, 3, 4, 6, 8, and 3 visits during week 9. The HHA failed to provide visits as ordered. The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. A 14-hour visit on 5/9/18 and a 10-hour visit 5/12/18. The HHA provided 4 visits a week from 5/13/18 to 5/16/18 and 6 visits			

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weekly from 5/17/18 to 7/7/18, when the clinical record evidenced that the patient was in the hospital from 5/17/18 to 6/1/18.

The POC for the certification period of 7/8/18 to 9/5/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1-8 and 3 visits during week 9 of the verification period. The HHA provided 14-hour visits on 7/8/18, 7/10/18, 7/12/18. The HHA failed to provide visits as ordered.

The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 1 of the certification period and failed to provide visits as ordered. The HHA provided 3 visits during week 1 and 6 visits during weeks 2 and 3 of the certification period. The HHA provided 14-hour visits on 9/6/18, 9/11/8.9/13/18, 9/18/18, and 9/20/18 and 16-hour visits on 9/9/18 and 9/16/18. The HHA failed to provide services as ordered.

A PA (prior authorization) was requested for patient # 1. The administrator provided a PA for the period of 8/8/18 to 2/6/19. The administrator was unable to present any other PAs for clinical record #1. The current PA established the SN services were requested for 2 times weekly and not 5 times weekly.

An interview was conducted with the Parent of Patient # 1 on 9/24/18 at 10: 00 AM. The Parent

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	reported that he/she worked 5-6 days a week. The patient's full-time HHA for the agency, the patient's sibling can not administer tube feedings in the role of a HHA. Without a nurse to come to the home daily the parent had to change the patient bolus G-tube feeding schedule. The parent reported when the patient had been admitted on (7/18/16) the feedings had been given in mid day by a nurse of the agency. The parent reported the full-time nurse left the agency around November of 2016 and soon after the agency stopped sending a nurse 5 days a week. The parent reported he/she was told that the agency was working on getting a replacement nurse. The parent reported he/she had reported to the patient's nurses and to the agency that he/she needed a nurse 5 days a week, but the staffing concern had not been addressed or resolved. The parent reported a nurse had told him/her that a nurse was not necessary and another nurse told him/her that Medicaid had denied the prior authorization for a nurse 5 times a week. An interview was conducted with Patient # 1's sibling and full-time HHA on 9/25/18 at 1:50 PM. The sibling reported the parent administered the G-Tube feedings for Patient #1 before he/she left for work. The tube feeding schedule had been changed to late afternoon when the parent came home and then at bedtime. The sibling reported since he/she was working as a HHA it was not within his/her scope of practice to give the tube feedings. He/she reported they have not had a nurse for 2/1/2 years and have been told the agency would get a nurse for the feedings 5 days a week. The sibling reported she/he had been told the PA visits for 5 times a week had been denied. An interview was conducted with the administrator on 9/24/18 at 2:35 PM. The			

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administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided.

3. The clinical record of Patient # 4 with an original SOC of 7/29/16, a recent readmission SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed with the following findings:

The SN failed to conduct a supervisory visit in the month of August, 2018. This exceeded the Agency policy by 2 days.

For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during weeks 5, 6, 7 and 2 visits during week 8.

For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3.

An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had

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	been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind." An interview was conducted with the administrator on 10/1/18 at 4:30 PM regarding the missed visits for Patient #4. The complaint log failed to include any complaints regarding missed services for Patient # 4. The administrator reported he/she was not made aware of the missed visits or the complaints expressed to the staff by Patient # 4. The administrator reported there was no further documentation to be provided. 4. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week for assistance with IADL's and ADL's was reviewed with the following findings: A SN note for a HHA supervisory visit 9/23/16 was reviewed and stated, "Past Tuesday had no night time coverage. CG (caregiver) stated office knew about client not being covered. CG and patient highly satisfied with aides, C/O (complained of) poor office communication." The agency complaint log was reviewed on 10/1/18 and failed to include any documentation of a complaint from the family of Patient # 5 regarding missed visits and poor office communication. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes, orders to change the plan of care, patient rights and admission agreement. The administrator reported he/she could not			

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	locate the missing documents. In addition the Administrator was asked about the failure of the agency to document the complaint from the family of Patient # 5. The Administrator reported he/she was not working at the agency during 2016 and did not know why the complaint was not documented or investigated.			
N 0520 Bldg. 00	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.			
	Based on record review and interviews, the agency failed to meet the needs for 1 out of 4 (Patient #1) record reviewed of patients receiving SN (Skilled Nurse) and 4 of 4 patient's (Patients # 1, 2, 4 and 5) records reviewed receiving HHA (Home Health Aide) in a sample of 7 patients. Findings Include: 1. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ... The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. Medications, treatments, and procedures ... p. Treatment goals... At the time of certification and recertification, a	N 0520	N 520 The Administrator or designee will immediately review all clinical records with SN/ HHA services are being provided. If there is evidence that the POC is not being followed the DON will call the PCP for a verbal order to update the plan of care and the POC will be updated in the clinical record and sent to the PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON will call the patient and offer to transfer them to an agency that can provide all services in the POC. If patient agrees to be transferred to another agency the DON will facilitate a transfer to an agency of the patients choice and documentation of conversation with patient will be recorded in the patients clinical record. The Administrator or designee will	11/30/2018

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	written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed. The agency failed to meet the patient's needs as evidenced by the following findings: The POC for the certification period of 7/18/16 to 9/15/16 included orders for skilled nurse 5 times a week for G-Tube (a tube in the stomach where liquid nutrition is provided) feedings while the parent was at work and HHA services 6 times a week. The SN failed to provide services until 8/9/16 (21 days) after the SOC. The HHA provided services 5 times a week 1- 2 and 3 times week 6 of the certification period and failed to conduct visits as ordered. The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while the parent was at work and HHA services 6 times a week for assistance with IADL's and ADL's. SN services were provided 4 times during week 6, 3 times during week 7, 0 times during week 8, and 2 times during week 9 of the certification period and failed to be provided as ordered. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist the family in finding a nursing care via another agency at this time family		educate administration/management, all clinicians/home health aides on policy: Plan of Care To prevent this deficiency in the future, the DON will monitor the services of all clients weekly through audits of services provided and any trends will be addressed weekly with the administrator. The Administrator or designee will also do clinical records audits until 100% compliance is met, then 10% of clinical records thereafter quarterly to ensure deficiency does not reoccur. Education completed on 11/08/2018.	

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has declined this offer. Currently, mother is coming home at noon to feed daughter via G-Tube until nursing staff available." The HHA services were provided 3 times during week 5 of the certification period and failed to be conducted as ordered.

The POC for the certification period of 11/15/16 to 1/13/17 included orders for SN 5 times a week for G-Tube feedings and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 4 of the 45 visits ordered on the POC for the certification period and failed to provide visits as ordered.

The POC for the certification period of 1/14/17 to 3/14/17 included orders for SN 1 time a week for G-tube feedings each visit and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 5 visits in the certification period and failed to provide visit as ordered. There were no orders to change the POC.

A SN note 3/14/17 stated, "Informed the cg (caregiver) of SN visits weekly for skilled intervention, but that daily is not achievable and not necessary when available CG competent in administration of feedings. Encourage to call agency office prn (as needed)."

The POC for the certification period of 3/15/17 to 5/13/17 included orders for SN 1 time a week for assessment and instruction to caregivers and HHA 6 times a week for assistance with IADL'S and ADL's. The SN failed to provide 1 visit weekly for the weeks 1-3 of the certification period. The clinical record failed to evidence documentation of any HHA visits for weeks 4-9 of the certification period.

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	The POC for the certification period of 5/14/17 to 7/12/17 included orders for SN 1 time a week for assessment and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The POC failed to include the duration of the SN and HHA services. The clinical record failed to evidence documentation of HHA visits for week 1 and 2. The HHA conducted 6 visits week 4-8 and 4 visits during week 9 of the certification period. The POC for the certification period of 7/13/17 to 9/101/7 included orders for SN 5 times a week for G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during weeks 2-3 and 5-9 of the certification period and failed to provide 5 visits per week as ordered. The HHA conducted 3 visits during week 1 and 6 visits during week 2-9 of the certification period and failed to provide visits 5 times weekly as ordered. The POC for the certification period of 9/11/17 to 11/9/17 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 2 visits during weeks 1 and 4-8, 0 visits during week 2 and 1 visit during week 9 of the certification period. The SN failed to provide as ordered. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during week 8 and 9 of the certification period. The HHA failed to provided visits as ordered. A SN note dated 9/11/17 stated, "continues to request daily SN to cover G-Tube feedings while mother is at work. Will discuss with leadership. Parent states at this time his/her family has been able to cover the other days of the week there has not been a daily RN."			

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	The POC for the certification period of 11/10/17 to 1/8/18 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. There were orders present to change the SN frequency to 1 visit during week 7 and 9 of the certification period. The SN failed to follow the POC and provided visits 2 times during weeks 2-6. No SN visits were conducted during week 1 and 8. The HHA provided 1 visit week 1 of the certification period on 11/10/17, 6 visits during weekly from 12/3/17 to 1/6/18. The HHA failed to provide visits as ordered. The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week for tube G-tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided visits 1 time during week 1 and 2 times during week 2-9 of the certification period. The SN failed to provide visits as ordered. The HHA provided visits 4 times a week from 1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and 1/11/18. The HHA provided visits 5 times a week from 1/15/18 to 1/19/18 with 14-hour visits on 1/16/18 and 1/18/18. The HHA provided visits 6 times a week from 1/21/18 to 3/9/18. The HHA failed to provide visits as ordered. The POC for the certification period of 3/10/18 to 5/8/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1, 2, 3, 4, 6, 8, and 3 visits during week 9. The HHA failed to provide visits as ordered.			

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The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. A 14-hour visit on 5/9/18 and a 10-hour visit 5/12/18. The HHA provided 4 visits a week from 5/13/18 to 5/16/18 and 6 visits weekly from 5/17/18 to 7/7/18, when the clinical record evidenced that the patient was in the hospital from 5/17/18 to 6/1/18.

The POC for the certification period of 7/8/18 to 9/5/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1-8 and 3 visits during week 9 of the verification period. The HHA provided 14-hour visits on 7/8/18, 7/10/18, 7/12/18. The HHA failed to provide visits as ordered.

The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 1 of the certification period and failed to provide visits as ordered. The HHA provided 3 visits during week 1 and 6 visits during weeks 2 and 3 of the certification period. The HHA provided 14-hour visits on 9/6/18, 9/11/8.9/13/18, 9/18/18, and 9/20/18 and 16-hour visits on 9/9/18 and 9/16/18. The HHA failed to provide services as ordered.

A PA (prior authorization) was requested for patient # 1. The administrator provided a PA for

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the period of 8/8/18 to 2/6/19. The administrator was unable to present any other PAs for clinical record #1. The current PA established the SN services were requested for 2 times weekly and not 5 times weekly.

An interview was conducted with the Parent of Patient # 1 on 9/24/18 at 10: 00 AM. The Parent reported that he/she worked 5-6 days a week. The patient's full-time HHA for the agency, the patient's sibling can not administer tube feedings in the role of a HHA. Without a nurse to come to the home daily the parent had to change the patient bolus G-tube feeding schedule. The parent reported when the patient had been admitted on (7/18/16) the feedings had been given in mid day by a nurse of the agency. The parent reported the full-time nurse left the agency around November of 2016 and soon after the agency stopped sending a nurse 5 days a week. The parent reported he/she was told that the agency was working on getting a replacement nurse. The parent reported he/she had reported to the patient's nurses and to the agency that he/she needed a nurse 5 days a week, but the staffing concern had not been addressed or resolved. The parent reported a nurse had told him/her that a nurse was not necessary and another nurse told him/her that Medicaid had denied the prior authorization for a nurse 5 times a week.

An interview was conducted with Patient # 1's sibling and full-time HHA on 9/25/18 at 1:50 PM. The sibling reported the parent administered the G-Tube feedings for Patient #1 before he/she left for work. The tube feeding schedule had been changed to late afternoon when the parent came home and then at bedtime. The sibling reported since he/she was working as a HHA it was not within his/her scope of practice to give the tube

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feedings. He/she reported they have not had a nurse for 2/1/2 years and have been told the agency would get a nurse for the feedings 5 days a week. The sibling reported she/he had been told the PA visits for 5 times a week had been denied.

An interview was conducted with the administrator on 9/24/18 at 2:35 PM. The administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided.

3. The clinical record of Patient # 2 with a SOC date of 9/28/15 and a certification period of 7/14/18 to 9/11/18, with services to include HHA 8 hours a day 5 days a week for assistance with IADL's and ADL's was reviewed. The agency failed to meet the patient's needs as evidenced by the following findings:

The HHA provided visits 6 days in week 4 of the certification period ranging from 3 to 11 hours a day for a weekly total of 46 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 4 days in week 5 of the certification period ranging from 8-9 hours a day for a weekly total of 33 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 4 days in week 7 of the

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certification period ranging from 7-8 hours a day for a weekly total of 31 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 6 days in week 8 of the certification period ranging for 7 hours daily for a weekly total of 42 hours. The HHA failed to perform the visits as ordered.

The HHA provided visits 3 days in week 9 of the certification period ranging from 4 to 11 hours for a weekly total of 22 hours. The HHA failed to perform the visits as ordered.

An interview was conducted with the administrator on 9/26/18 at 2:45 PM regarding the failure to provide HHA visits 8 hours/ 5 days a week as ordered. The administrator reported, " All I can say the changes and hours are an error ... It doesn't look like the aide reported changes in schedule." The administrator had no further documentation to be provided.

4. The clinical record of Patient # 4 with a SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed. The agency failed to meet the patient's needs as evidenced by the following findings:

The SN failed to conduct a supervisory visit in the month of August 2018. This exceeded the Agency policy by 2 days.

For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during

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week 4, 3 visits during week 5, 6, 7 and 2 visits during week 8.

For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3.

An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind."

An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided.

5. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week for assistance with IADL's and ADL's was reviewed. The agency failed to meet the patient's needs as evidenced by the following findings:

During the certification period of 6/19/16 to 8/17/16, the HHA failed to provide 2 hours of care during weeks 3 and 4, 10 hours of care during week 6, and 4 hours of care during weeks 8 and 9.

During the certification period of 8/18/16 to 10/16/16, there were no HHA visit notes for weeks 1,2, 3, 4, 5, 6, week. Week 7, 8, and 9 all were missing with the exception of 2-hour notes on 9/29/16, 9/30/16, 10/3/16 and 10/13/16.

During the certification period of 10/17/16 to

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	12/14/16, the HHA failed to provide 10 hours during week 1, 18 hours during week 2, 18 hours during week 3 and with the exception of a 2-hour visit on 12/6/18. There were no further HHA notes for the certification period. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes and if there were any orders to change the POC. The Administrator reported he/she was not working at the agency during that time period. He/she reported there was no additional information to be provided.			
N 0522 Bldg. 00	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:			
	Based on record review and interviews the agency failed to ensure all services outlined in the POC (Plan Of Care) was provided in 1 out of 4 (Patient #1) record reviewed of patients receiving SN (Skilled Nurse) and 4 of 4 patient (Patients # 1, 2, 4 and 5) record reviewed of patients receiving HHA (Home Health Aide) in a sample of 7 patients. Findings Include: 1. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed	N 0522	N 522 The Administrator or designee will immediately review all clinical records with SN/ HHA services are being provided. If there is evidence that the POC is not being followed the DON will call the PCP for a verbal order to update the plan of care and the POC will be updated in the clinical record and sent to the PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON will call the patient and offer to transfer them to an agency that can provide all services in the POC. If patient agrees to be transferred to another agency the DON will facilitate a transfer to an agency of the	11/30/2018

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	to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ... The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. Medications, treatments, and procedures ... p. Treatment goals... At the time of certification and recertification, a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16 included orders for skilled nurse 5 times a week for G-Tube (a tube in the stomach where liquid nutrition is provided) feedings while the parent was at work and HHA services 6 times a week. The SN failed to provide services until 8/9/16 (21 days) after the SOC. The HHA provided services 5 times a week 1- 2 and 3 times week 6 of the certification period and failed to conduct visits as ordered. The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while the parent was at work and HHA services 6 times a week for assistance with IADL's and ADL's. SN services were provided 4 times during week 6, 3 times during week 7, 0 times during week 8, and 2 times during week 9 of the		patients choice and documentation of conversation with patient will be recorded in the patients clinical record. The Administrator or designee will educate administration/management, all clinicians/home health aides on policy: Plan of Care To prevent this deficiency in the future, the DON will monitor the services of all clients weekly through audits of services provided and any trends will be addressed weekly with the administrator. The Administrator or designee will also do clinical records audits until 100% compliance is met, then 10% of clinical records thereafter quarterly to ensure deficiency does not reoccur. Education completed on 11/08/2018.	

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	certification period and failed to be provided as ordered. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist the family in finding a nursing care via another agency at this time family has declined this offer. Currently, mother is coming home at noon to feed daughter via G-Tube until nursing staff available." The HHA services were provided 3 times during week 5 of the certification period and failed to be conducted as ordered. The POC for the certification period of 11/15/16 to 1/13/17 included orders for SN 5 times a week for G-Tube feedings and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 4 of the 45 visits ordered on the POC for the certification period and failed to provide visits as ordered. The POC for the certification period of 1/14/17 to 3/14/17 included orders for SN 1 time a week for G-tube feedings each visit and HHA 6 times a week for assistance with IADL's and ADL's. The SN conducted a total of 5 visits in the certification period and failed to provide visit as ordered. There were no orders to change the POC. A SN note 3/14/17 stated, "Informed the cg (caregiver) of SN visits weekly for skilled intervention, but that daily is not achievable and not necessary when available CG competent in administration of feedings. Encourage to call agency office prn (as needed)." The POC for the certification period of 3/15/17 to 5/13/17 included orders for SN 1 time a week for assessment and instruction to caregivers and			

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	HHA 6 times a week for assistance with IADL'S and ADL's. The SN failed to provide 1 visit weekly for the weeks 1-3 of the certification period. The clinical record failed to evidence documentation of any HHA visits for weeks 4-9 of the certification period. The POC for the certification period of 5/14/17 to 7/12/17 included orders for SN 1 time a week for assessment and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The POC failed to include the duration of the SN and HHA services. The clinical record failed to evidence documentation of HHA visits for week 1 and 2. The HHA conducted 6 visits week 4-8 and 4 visits during week 9 of the certification period. The POC for the certification period of 7/13/17 to 9/101/7 included orders for SN 5 times a week for G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during weeks 2-3 and 5-9 of the certification period and failed to provide 5 visits per week as ordered. The HHA conducted 3 visits during week 1 and 6 visits during week 2-9 of the certification period and failed to provide visits 5 times weekly as ordered. The POC for the certification period of 9/11/17 to 11/9/17 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. The SN provided 2 visits during weeks 1 and 4-8, 0 visits during week 2 and 1 visit during week 9 of the certification period. The SN failed to provide as ordered. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during week 8 and 9 of the certification period. The HHA failed to provided visits as ordered.			

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A SN note dated 9/11/17 stated, "continues to request daily SN to cover G-Tube feedings while mother is at work. Will discuss with leadership. Parent states at this time his/her family has been able to cover the other days of the week there has not been a daily RN."

The POC for the certification period of 11/10/17 to 1/8/18 included orders for SN 5 times a week for tube G-tube feedings and HHA 9 hours a day for 5 days a week for assistance with IADL's and ADL's. There were orders present to change the SN frequency to 1 visit during week 7 and 9 of the certification period. The SN failed to follow the POC and provided visits 2 times during weeks 2-6. No SN visits were conducted during week 1 and 8. The HHA provided 1 visit week 1 of the certification period on 11/10/17, 6 visits during weekly from 12/3/17 to 1/6/18. The HHA failed to provide visits as ordered.

The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week for tube G-tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided visits 1 time during week 1 and 2 times during week 2-9 of the certification period. The SN failed to provide visits as ordered. The HHA provided visits 4 times a week from 1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and 1/11/18. The HHA provided visits 5 times a week from 1/15/18 to 1/19/18 with 14-hour visits on 1/16/18 and 1/18/18. The HHA provided visits 6 times a week from 1/21/18 to 3/9/18. The HHA failed to provide visits as ordered.

The POC for the certification period of 3/10/18 to 5/8/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and

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HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1, 2, 3, 4, 6, 8, and 3 visits during week 9. The HHA failed to provide visits as ordered.

The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. A 14-hour visit on 5/9/18 and a 10-hour visit 5/12/18. The HHA provided 4 visits a week from 5/13/18 to 5/16/18 and 6 visits weekly from 5/17/18 to 7/7/18, when the clinical record evidenced that the patient was in the hospital from 5/17/18 to 6/1/18.

The POC for the certification period of 7/8/18 to 9/5/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 9 of the certification period and failed to provide visits as ordered. The HHA provided 6 visits during weeks 1-8 and 3 visits during week 9 of the verification period. The HHA provided 14-hour visits on 7/8/18, 7/10/18, 7/12/18. The HHA failed to provide visits as ordered.

The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week for G-Tube care and dressing changes and HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The SN provided 1 visit during week 1 of the certification period and failed to provide visits as ordered. The HHA provided 3 visits during week 1 and 6 visits during weeks 2 and 3 of the certification period. The HHA

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AGING & DISABLED HOME HEALTH CARE LLC	10500 CROSSPOINTE BLVD, INDIANAPOLIS, IN 46256

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	provided 14-hour visits on 9/6/18, 9/11/8.9/13/18, 9/18/18, and 9/20/18 and 16-hour visits on 9/9/18 and 9/16/18. The HHA failed to provide services as ordered. A PA (prior authorization) was requested for patient # 1. The administrator provided a PA for the period of 8/8/18 to 2/6/19. The administrator was unable to present any other PAs for clinical record #1. The current PA established the SN services were requested for 2 times weekly and not 5 times weekly. An interview was conducted with the Parent of Patient # 1 on 9/24/18 at 10: 00 AM. The Parent reported that he/she worked 5-6 days a week. The patient's full-time HHA for the agency, the patient's sibling can not administer tube feedings in the role of a HHA. Without a nurse to come to the home daily the parent had to change the patient bolus G-tube feeding schedule. The parent reported when the patient had been admitted on (7/18/16) the feedings had been given in mid day by a nurse of the agency. The parent reported the full-time nurse left the agency around November of 2016 and soon after the agency stopped sending a nurse 5 days a week. The parent reported he/she was told that the agency was working on getting a replacement nurse. The parent reported he/she had reported to the patient's nurses and to the agency that he/she needed a nurse 5 days a week, but the staffing concern had not been addressed or resolved. The parent reported a nurse had told him/her that a nurse was not necessary and another nurse told him/her that Medicaid had denied the prior authorization for a nurse 5 times a week. An interview was conducted with Patient # 1's sibling and full-time HHA on 9/25/18 at 1:50 PM.			

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	The sibling reported the parent administered the G-Tube feedings for Patient #1 before he/she left for work. The tube feeding schedule had been changed to late afternoon when the parent came home and then at bedtime. The sibling reported since he/she was working as a HHA it was not within his/her scope of practice to give the tube feedings. He/she reported they have not had a nurse for 2/1/2 years and have been told the agency would get a nurse for the feedings 5 days a week. The sibling reported she/he had been told the PA visits for 5 times a week had been denied. An interview was conducted with the administrator on 9/24/18 at 2:35 PM. The administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided. 3. The clinical record of Patient # 2 with a SOC date of 9/28/15 and a certification period of 7/14/18 to 9/11/18, with services to include HHA 8 hours a day 5 days a week for assistance with IADL's and ADL's was reviewed with the following findings: The HHA provided visits 6 days in week 4 of the certification period ranging from 3 to 11 hours a day for a weekly total of 46 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 4 days in week 5 of the			

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	certification period ranging from 8-9 hours a day for a weekly total of 33 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 4 days in week 7 of the certification period ranging from 7-8 hours a day for a weekly total of 31 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 6 days in week 8 of the certification period ranging for 7 hours daily for a weekly total of 42 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 3 days in week 9 of the certification period ranging from 4 to 11 hours for a weekly total of 22 hours. The HHA failed to perform the visits as ordered. An interview was conducted with the administrator on 9/26/18 at 2:45 PM regarding the failure to provide HHA visits 8 hours/ 5 days a week as ordered. The administrator reported, " All I can say the changes and hours are an error ... It doesn't look like the aide reported changes in schedule." The administrator had no further documentation to be provided. 4. The clinical record of Patient # 4 with a SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week for IADL's and ADL's was reviewed with the following findings: The SN failed to conduct a supervisory visit in the month of August 2018. This exceeded the Agency policy by 2 days.			

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	For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during week 5, 6, 7 and 2 visits during week 8. For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3. An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind." An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided. 5. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week for assistance with IADL's and ADL's was reviewed with the following findings: During the certification period of 6/19/16 to 8/17/16, the HHA failed to provide 2 hours of care during weeks 3 and 4, 10 hours of care during week 6, and 4 hours of care during weeks 8 and 9. During the certification period of 8/18/16 to 10/16/16, there were no HHA visit notes for weeks 1,2, 3, 4, 5, 6, week. Week 7, 8, and 9 all were missing with the exception of 2-hour notes on			

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	9/29/16, 9/30/16, 10/3/16 and 10/13/16. During the certification period of 10/17/16 to 12/14/16 the HHA failed to provide 10 hours during week 1, 18 hours during week 2, 18 hours during week 3 and with the exception of a 2-hour visit on 12/6/18. There were no further HHA notes for the certification period. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes and if there were any orders to change the POC. The Administrator reported he/she was not working at the agency during that time period. He/she reported there was no additional information to be provided.			
N 0524 Bldg. 00	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or			

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	referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on observation, record review and interview, the agency failed to accurately complete the plan of care to include the frequency and duration of visits to be conducted for 4 of 7 (Patients # 1, 2, 4, 5), the nutritional requirements for 2 of 7 (Patient #1, 3) , all medications and treatments for 3 of 7 (Patient # 1, 2, 3) , and measurable goals for 1 of 7 (Patient # 1) in a sample of 7 clinical records. Findings Include: 1. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ...2. The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures ... p. Treatment goals...t. other appropriate items ... 9. At the time of certification and recertification , a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include, but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... 10. Professional staff shall	N 0524	N 524 The Administrator or designee will immediately review all clinical records for accurate and complete plan of care, including frequency, and duration of visits, nutritional requirements,medications, treatments with measurable goals, and current and past findings. Any clinical records found to have a POC that is not updated, the DON will call PCP for a verbal order to update the plan of care, then a physician order will be written reflecting the update and sent to PCP for signature. The DON or designee will educate all clinicians on policy: Plan of Care policy Home Health Admission Service Agreement To prevent this deficiency in the future, the DON will review every plan of care for accuracy before sending to PCP for signature. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	11/30/2018

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	promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16, included orders for skilled nurse 5 times a week and HHA services 6 times a week. The POC failed to include the duration for the SN (skilled nurse) and failed to include the HHA (Home Health Aide) time and duration and services to be provided. The POC for the certification period of 9/16/16 to 11/14/16, included orders for SN 5 times a week and HHA services 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 11/15/16 to 1/13/17, included orders for SN 5 times a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 1/14/17 to 3/14/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 3/15/17 to 5/13/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. POC. The POC for the certification period of 5/14/17 to 7/12/17, included orders for SN 1 time a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration of the SN and HHA		Education completed on 11/08/2018.	

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	services. The POC for the certification period of 7/13/17 to 9/101/7, included orders for SN 5 times a week and HHA 9 hours a day. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/11/17 to 11/9/17, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 11/10/17 to 1/8/18, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 1/9/18 to 3/9/18, included orders for SN 5 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 3/10/18 to 5/8/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 5/9/18 to 7/7/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 7/8/18 to 9/5/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC			

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	failed to include duration for the SN and HHA services. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC included orders for Two Cal HN (a nutritional supplement) oral 240 ml bolus every 6 hours. During an interview conducted with the patient's family member on 9/24/18 at 10:00 AM, he/she reported the following was the accurate G-Tube feeding: Two Cal HN 480 ml bolus at 6 or 7 AM, 240 ml bolus at 4:00 PM and 480 ml bolus at 9-10 PM daily during the time the mother is at home from work. The POC failed to include the accurate nutritional requirements. The POC included the following topical ointments: Aquaphor External (for protection and moisture healing of skin) 1 apply to healed areas every 12 hours, Mupirocin External (antibacterial) 2 % 1 once a day. The orders failed to specify where the ointments would be applied. An order for Ciprofloxacin (antibiotic) HCL oral 500 mg 1 tab per feeding tube every 12 hours failed to be omitted from the POC and had been discontinued on 6/21/18. A pain goal on the POC stated, "Patient's pain will remain tolerable throughout care period." The goal was not specific to include the Wong scale for an assessment of a nonverbal patient and did not include measurable outcomes for tolerable pain goals. An interview was conducted with the Administrator on 9/24/18 at 4:45 PM to review the			

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	POC findings. The Administrator reported there was no further documentation to be provided. 3. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings: The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits. The POC for the certification period of 7/14/18 to 9/11/18, included the following order: "Silvadene External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18 and failed to include the specific area of the body for application. An interview was conducted with the Administrator on 9/26/18 at 4:30 PM regarding the POC findings. The Administrator reported there was no further documentation to be provided 4. The clinical record of Patient #3 with a SOC of 7/25/18 was reviewed with the following findings: The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets" The patient was interviewed on 9/26/18 9:48 AM and reported he had a 32 ounce daily fluid restriction and his diet is a diabetic/renal diet. An interview was conducted with the patient regarding his medications on 9/26/18 at 9:48 AM			

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during a home therapy visit observation. The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following medications: Levothyroxine Sodium (thyroid pill also know as Synthroid) Oral 175 mcg 1 tablet daily and Synthroid (thyroid pill also know as levothyroxine) Oral 75 mcg 1 tablet in the mornings daily. The patient reported the order was a duplicate. Nortriptyline (for diabetic neuropathy pain) HCL oral 10 mg 2 caps bedtime, the patient reported this medication had been discontinued 2 months ago. Insulin aspart (fast acting diabetic insulin) subcutaneous 100 units/ml 15-20 units daily before meals, using sliding scale (insulin amount depends on the patient's blood sugar). The order failed to include the specific sliding scale orders.

An interview was conducted with the Administrator on 9/26/18 at 12:07 PM regarding the findings for Patient # 3. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this."

A fax was obtained from the dialysis facility on 9/28/18 that included the following daily diet restrictions: Sodium 3 GM, Phosphorus 1200 mg and 1500 ml. The fax also included the following orders specific to the patients ESRD: Heparin Sodium 1,000 units/ml to arterial port 2,200 units and 2,300 units to venous port (of a central dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The POC failed to include the patient's

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	special nutritional needs related ESRD (End Stage Renal Disease) and failed to include the patient's medication regimen for ESRD. 5. The clincial record of Patient # 4 with a SOC date of 3/13/18 was reviewed with the following findings: The POC for the certification period of 7/11/18 to 9/8/18 included an order for HHA 3 hours day/ 4 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the administrator on 10/1/18 at 4:30 PM and the administrator reported there was no further documentation to be provided. 6. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification periods of 6/19/16 to 8/17/16, 8/18/16 to 10/16/16 and 10/17/16 to 12/14/16 included an order for HHA 4 hours a day/ 5 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be provided.			
N 0529 Bldg. 00	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician;			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the agency failed to send a written summary for each patient every 60 days for 1 of 7 (Patient #1) clincial records reviewed in a sample of patients 5 with services provided for more than 60 days. Findings Include: A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days .... At the time of certification and recertification , a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include, but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ...." The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The clinical record failed to include a case conference/ 60 day summary for the certification periods of 7/18/16 to 9/15/16, 9/16/16 to 11/14/16, and 11/15/16 to 1/13/17.	N 0529	N 529 The Administrator or designee will immediately review all clinical records for documentation of 60 day summaries. If a 60 day summary is not present in the clinical record a 60 day summary will be completed by the RN case manager and sent to the PCP. The Administrator or designee will educate administration/management, all clinicians on policy: Plan of Care Coordination of Client Services To prevent this deficiency in the future, the DON or designee will monitor/audit all clinical documentation weekly to ensure that 60 day summaries are completed and sent to the physician at least every 60 days.the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	11/30/2018

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	157681	A. BUILDING 00 B. WING	10/02/2018

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	The clinical record evidenced 2 case conference /60 day summary notes for the certification period of 1/14/17 to 3/14/17. The notes dated 2/16/17 and 3/9/17 failed to include skilled nurse services 1 time a week, and the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. The clincial record included a physicians office visit note for 3/28/17 that reported a new diagnosis of "acute otitis media of right ear with spontaneous rupture of tympanic membrane (ear drum" and amoxicillin to treat the infection. A missed visit note for 3/29/17 reported, "RN notified by office that patient was seen in ER today and unable to be seen for SNV." A physician's order dated 4/19/17 included suction machine, tubing, Yonkers and nasal suction equipment for use ... please provide training and education to family and caregiver." The clinical record failed to include a case conference/ 60 day summary for the certification period of 3/15/17 to 5/13/17. The clinical record evidenced 2 case conference/60 day summary notes for the certification period of 9/11/17 to 11/9/17. The notes dated 10/6/17 failed to include skilled nursing services and reported HHA services were daily and were ordered 5 times a week. The note dated 11/08/17 incorrectly reported skilled nursing services were being provided 5 days a week (SN visits were provided 1-2 times a week) and reported HHA services were "no change." The notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided.		Education completed 11/11/2018.	

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	The clinical record evidenced 2 case conference/ 60 day summary notes for the certification period of 11/10/17 to 1/8/18. The notes dated 12/4/17 and 1/4/18 both stated, "continue plan of care as developed . No acute changes noted at this time. The notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. The clinical record evidenced a skilled nurse note dated 2/19/18 that reported, "per mother, patient fell off bed yesterday." The clinical record evidenced 2 case conference/ 60 day summary notes for the certification period of 1/9/18 to 3/9/18. The notes were dated 2/55/18 and 3/5/18 and both stated, "Continue plan of care as developed. No distress noted. No acute changes noted." There was no mention of the fall and the notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. An interview with the Administrator was conducted on 9/26/18 at 3:47 PM. He/she reported the 60 day summary is included on the case conference note on the agency document titled, " [agency name] Case Conference and 60 day Summary." The administrator reported the summary is not included on the Plan of Care and had no further documentation to be provided.			
N 0533 Bldg. 00	410 IAC 17-13-2 Nursing Plan of Care Rule 13 Sec. 2(a) A nursing plan of care must be developed by a registered nurse for the purpose of delegating nursing directed patient care provided through the home health agency for patients receiving only home			

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	health aide services in the absence of a skilled service. (b) The nursing plan of care must contain the following: (1) A plan of care and appropriate patient identifying information. (2) The name of the patient's physician. (3) Services to be provided. (4) The frequency and duration of visits. (5) Medications, diet, and activities. (6) Signed and dated clinical notes from all personnel providing services. (7) Supervisory visits. (8) Sixty (60) day summaries. (9) The discharge note. (10) The signature of the registered nurse who developed the plan.			
	Based on record review and interview, the SN failed to ensure the clinical record included documentation of coordination with the HHA (Home Health Aide) regarding a change in the patient's skin condition that progressed from irritation to a stage 3 pressure ulcer for 1 of 4 patient's receiving home health aide services (Patient #2) in a sample of 4 and the HHA failed to provide all services outlined in the POC (Plan Of Care) for 4 of 4 patient receiving HHA services (Patients # 1, 2, 4 and 5) in a sample of 4 records. Findings Include: 1. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... 10. Professional staff shall promptly	N 0533	N 533 The Administrator or designee will immediately review all clinical records for coordination of care between SN/HHA. Immediately all RN case managers will be required to conference with the HHA weekly for patients they case manage, and document this coordination of care through a communication note in the clinical record. The DON or designee will educate administration/management, all clinicians on policy: Coordination of Client Services Home Health Aide Supervision Care Planning/ Coordination of Care Home health aides will be	11/30/2018

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	alert the physician to any changes that suggest a need to alter the plan of care ...." 2. An agency policy titled, "Coordination of Client Services" was reviewed and stated: "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objective outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction. 3. An agency policy titled, "Home Health Aide Supervision" was reviewed and stated, " Agency shall provide Home Health Aide Services under the direction and supervision of a RN/ Therapist when personal care services are indicated and ordered by the physician ... 1. The Nursing Supervisor or designated RN/Therapist will give the HHA direction for client care by way of the Care Plan. 4. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16, included orders for HHA services 6 times a week. The HHA provided services 5 times during week 1- 2 and 3 times during week 6 of the certification period and failed to conduct visits as ordered. The POC for the certification period of 9/16/16 to 11/14/16, included orders for HHA services 6 times a week for assistance with IADL's and ADL's. The HHA services were provided 3 times during week 5 of the certification period and failed to be conducted as ordered.		educated on: "What to Report to RN, Case Manager" Home Health Aide Documentation To prevent this deficiency in the future, the RN case managers will be required to review all HHA documentation and perform weekly conference with HHA's for all the patients they case manage. RN case manager will also review the aide care plan with the assigned home health aide prior to the home health aide providing services to the patient and review the home health aide care plan with the home health aide at least every 60 days or when there is a change in the patients' condition. the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	

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	The POC for the certification period of 3/15/17 to 5/13/17, included orders for HHA 6 times a week for assistance. The clinical record failed to evidence documentation of any HHA visits during weeks 4-9 of the certification period. The POC for the certification period of 5/14/17 to 7/12/17 included orders for HHA 9 hours a day for 5 days a week. The clinical record failed to evidence documentation of HHA visits during weeks 1 and 2. The HHA conducted 6 visits during weeks 4-8 and 4 visits during week 9 of the certification period. The POC for the certification period of 7/13/17 to 9/10/17 included orders for HHA 9 hours a day for 5 days a week. The HHA conducted 3 visits during week 1 and 6 visits during weeks 2-9 of the certification period and failed to provide visits 5 times weekly as ordered. The POC for the certification period of 9/11/17 to 11/9/17 included orders for HHA 9 hours a day for 5 days a week. The HHA provided 6 visits during weeks 1-6, 2 visits during week 7, 4 visits during weeks 8 and 9 of the certification period. The HHA failed to provided visits as ordered. The POC for the certification period of 11/10/17 to 1/8/18, included orders for HHA 9 hours a day for 5 days a week. The HHA provided visits 6 times during weeks 5-9 during the certification period. The HHA failed to provide visits as ordered. The POC for the certification period of 1/9/18 to 3/9/18 included orders HHA 9 hours a day, 5 days a week. The HHA provided visits 4 times a week 1/9/18 to 1/12/18 with 14-hour visits on 1/9/18 and 1/11/18. The HHA provided visits 5 times a week 1/15/18 to 1/19/18 with 14-hour visits on 1/16/18			

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and 1/18/18. The HHA provided visits 6 times a week from 1/21/18 to 3/9/18. The HHA failed to provide visits as ordered. The HHA failed to provide visits as ordered.

The POC for the certification period of 3/10/18 to 5/8/18 included orders for HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The HHA provided 6 visits during week 1, 2, 3, 4, 6, 8, and 3 visits week 9. The HHA failed to provide visits as ordered.

The POC for the certification period of 5/9/18 to 7/7/18 included orders for HHA 9 hours a day, 5 days a week for assistance with IADL's and ADL's. The patient was in the hospital from 5/17/18 to 6/1/18. The HHA conducted a 14-hour visit on 5/9/18 and a 10-hour visit 5/12/18. The HHA provided 4 visits a week from 5/13/18 to 5/16/18 and 6 visits weekly from 5/17/18 to 7/7/18. The HHA failed to provide visits as ordered.

The POC for the certification period of 7/8/18 to 9/5/18 included orders for HHA 9 hours a day, 5 days a week. The HHA provided 6 visits during week 1-8 and 3 visits during week 9 of the certification period. The HHA provided 14-hour visits on 7/8/18, 7/10/18, 7/12/18. The HHA failed to provide visits as ordered.

The POC for the certification period of 9/6/18 to 11/4/18 included orders for HHA 9 hours a day, 5 days a week. The HHA provided 3 visits during week 1, and 6 visits during week 2 and 3 of the certification period. The HHA provided 14-hour visits on 9/6/18, 9/11/8.9/13/18, 9/18/18, and 9/20/18 and 16-hour visits on 9/9/18 and 9/16/18. The HHA failed to provide services as ordered.

5. The clinical record for Patient # 2, with a start

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	of care date of 9/28/15, with a diagnosis to include Cerebral Palsy and Functional limitations to include Paralysis, Bowel and Bladder Incontinence, Endurance and Ambulation. The plans of care for the certification periods of 3/15/18 to 5/13/18 included orders for HHA (Home Health Aide) for 8 hours daily for, 5 visits weekly for assistance with IADL's and ADL's. The clinical record was reviewed with the following findings: A HHA visit note dated 3/29/18 stated, "Skin in the crack of [pt's name] butt (buttocks) is slightly irritated. A SN visit was conducted on 4/11/18 (13 days later). The SN note stated, "Educated about pressure relief due to impaired mobility voices an understanding. Patient states that she has wound center appointment on 4/19/18 due to opened area to crack of buttocks. Unable to assess wound due to patient sitting in wheelchair and unable to transfer via hoyer to assess wound because patient did not want to be transferred back." A document in the clinical record dated 4/12/18 at 11:00 AM and titled, "[hospital name] office visit," included a new diagnosis for Stage 3 pressure ulcer of the buttock. The administrator was interviewed on 9/26/18 at 2:45 PM. The administrator reported there was no documentation that the aide and nurse communicated about the patient's irritated area that progressed to a stage 3 pressure ulcer in the clinical record. The administrator was asked about the process for the home health aide notes to be reviewed by an RN. The administrator reported, "The HHA visits are audited every 60 days by [director of nursing services name].			

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	Review of the plan of care for the certification period of 7/14/18 to 9/11/18, with services to include HHA 8 hours a day 5 days a week for assistance with IADL's and ADL's was reviewed with the following findings: The HHA provided visits 6 days in week 4 of the certification period ranging from 3 to 11 hours a day for a weekly total of 46 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 4 days in week 5 of the certification period ranging from 8-9 hours a day for a weekly total of 33 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 4 days in week 7 of the certification period ranging from 7-8 hours a day for a weekly total of 31 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 6 days in week 8 of the certification period ranging for 7 hours daily for a weekly total of 42 hours. The HHA failed to perform the visits as ordered. The HHA provided visits 3 days in week 9 of the certification period ranging from 4 to 11 hours for a weekly total of 22 hours. The HHA failed to perform the visits as ordered. 6. The clinical record of Patient # 4 with a SOC date of 3/13/18 and certification period of 7/11/18 to 9/8/18 and 9/9/18 to 11/7/18, with services to include HHA 3 hours a day for 4 days a week was reviewed with the following findings: For the certification period of 7/11/18 to 9/18/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits			

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during week 1, 1 visit during week 2, 1 visit during week 4, 3 visits during week 5, 6, 7 and 2 visits during week 8.

For the certification period of 9/9/18 to 11/17/18, the HHA failed to conduct visits as ordered as evidenced by the following missed visits: 3 visits during weeks 1, 2 and 3.

An interview was conducted with Patient # 4 on 9/25/18 at 3:45 PM. The patient reported it had been 2-3 weeks since he/she had a HHA more than 1 day a week. The patient reported, "It's been hit or miss I can't get any answers out of the office ... I've told them and doesn't do any good ... I'm out of sight and out of mind."

An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided.

7. The clinical record of Patient # 5 with a SOC date of 6/19/16 with services to include HHA 5 days a week for 20 hours week was reviewed with the following findings:

During the certification period of 6/19/16 to 8/17/16, the HHA failed to provide 2 hours of care during weeks 3 and 4, 10 hours of care during week 6, and 4 hours of care during weeks 8 and 9.

During the certification period of 8/18/16 to 10/16/16, there were no HHA visit notes in the clinical record for weeks 1, 2, 3, 4, 5, 6. During weeks 7, 8, and 9 there were no HHA visit notes in the clinical record, except four (4), 2-hour HHA visits notes for services on (9/29/16, 9/30/16, 10/3/16 and 10/13/16)

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	During the certification period of 10/17/16 to 12/14/16 the HHA failed to provide 10 hours during week 1, 18 hours during week 2, 18 hours during week 3 and with the exception of a 2-hour visit on 12/6/18, there were no further HHA notes for the certification period. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the absence of HHA notes and if there were any orders to change the POC. The Administrator reported he/she was not working at the agency during that time period. He/she reported there was no additional information to be provided.			
N 0537 Bldg. 00	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: Based on record review and interview, the SN (Skilled Nurse) failed to provide services outlined on the POC (Plan Of Care) for 1 of 4 (Patient #1) records reviewed of patients receiving SN services in a sample of 7. Findings Include: A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be	N 0537	N 537 The Administrator or designee will immediately review all clinical records with SN services are being provided. If there is evidence that the POC is not being followed the DON will call the PCP for a verbal order to update the plan of care and the POC will be updated in the clinical record and sent to the PCP for signature. If failure to follow the POC is due to a shortage on staffing the DON will call the patient and offer to transfer them to an agency that can provide all services in the POC. If patient agrees to be transferred to another agency the DON will	11/30/2018

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	updated as necessary, but at least every sixty (60) days ...2. The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures ... p. Treatment goals... 9. At the time of certification and recertification, a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16 included orders for skilled nurse 5 times a week for G-Tube feedings while the mother is at work. The SN failed to provide services until 8/9/16 (21 days) after the SOC. An OASIS assessment conducted 9/13/16 stated: "SN to administer feedings on time daily 5 days a week while [parent] is working." The POC for the certification period of 9/16/16 to 11/14/16 included orders for SN 5 times a week for G-Tube feedings while mother was at work. The agency failed to provide SN visits 10/27/16, 10/28/18, 11/1/16 to 11/5/16 and 11/8/16 to 11/10/16. A communication note dated 11/1/16 stated, "Due to nursing scheduling difficulties with this patient, we have offered to assist family in finding a		facilitate a transfer to an agency of the patients choice and documentation of conversation with patient will be recorded in the patients clinical record. The Administrator or designee will educate administration/management, all clinicians on policy: Plan of Care To prevent this deficiency in the future, the DON will monitor the services of all clients weekly through audits of services provided and any trends will be addressed weekly with the administrator. Education completed on 11/08/2018.	

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	nursing care via another agency at this time family has declined this offer. Currently [parent] is coming home at noon to feed daughter via G-Tube until nursing staff available." An OASIS assessment conducted 11/11/16 reported the following: "SN to administer feedings one time daily 5 days a week while [parent] is working." The POC for the certification period of 11/15/16 to 1/13/17 included orders for SN 5 times a week. The SN conducted a total of 4 of the 45 visits ordered on the POC for the certification period and failed to provide G-Tube feedings. The POC for the certification period of 1/14/17 to 3/14/17 included orders for SN 1 time a week for G-tube feedings each visit. The SN conducted a total of 5 visits in the certification period and with the exception of the SN visit 2/8/17 no G-Tube feedings were given by the nurse. The POC for the certification period of 7/13/17 to 9/10/17 included orders for SN 5 times a week for G-tube feedings. The SN provided 1 visit during weeks 2-3 and 5-9 of the certification period and failed to provide 5 visits per week as ordered for G-Tube feedings. The POC for the certification period of 9/11/17 to 11/9/17 included orders for SN 5 times a week for tube G-tube feedings. The SN provided 2 visits during weeks 1, 4, 5, 6, 7 and 8, 0 visits during week 2 and 1 visit during week 9 of the certification period. The SN failed to provide G-Tube feedings as ordered. A SN note dated 9/11/17 stated, "continues to request daily SN to cover G-Tube feedings while mother is at work. Will discuss with leadership. [parent]states at this time his/her family has been			

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	able to cover the other days of the week there has not been a daily RN." The POC for the certification period of 11/10/17 to 1/8/18 included orders for SN 5 times a week for tube G-tube feedings. Orders were present to change the SN frequency to 1 visit during weeks 7 and week 9 of the certification period. The SN provided 2 visits during weeks 2-6. No SN visits during weeks 1 and 8. The SN failed to provide G-Tube feedings as ordered and follow the POC to provide visits 5 times weekly on weeks 1-6 and 8. The POC for the certification period of 1/9/18 to 3/9/18 included orders for SN 5 times a week for tube G-tube education, monitoring and feedings. The SN provided visits 1 time during week 1 and 2 times during weeks 2-9 of the certification period. The SN failed to provide G-Tube feedings visits as ordered 5 times weekly on the POC. The POC for the certification period of 3/10/18 to 5/8/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings. The SN provided 1 visit during week 9 of the certification period and failed to provide G-Tube feedings as ordered on the POC. The POC for the certification period of 5/9/18 to 7/7/18 included orders for SN 2 times a week for G-Tube education, monitoring and feedings. The patient was in the hospital from 5/17/18 to 6/1/18 and in a long-term acute care facility from 6/1/18 to 6/13/18 with a diagnosis of 3rd-degree burns and skin grafts. The SN provided 1 visit during week 1 of the certification period and failed to provide G-Tube Feedings as ordered on the POC. An interview was conducted with the Parent of Patient # 1 on 9/24/18 at 10: 00 AM. The Parent			

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	reported that he/she worked 5-6 days a week. The patient's full-time HHA for the agency, the patient's sibling can not administer tube feedings in the role of a HHA. Without a nurse to come to the home daily the parent had to change the patient bolus G-tube feeding schedule. The parent reported when the patient had been admitted on (7/18/16) the feedings had been given in midday by a nurse of the agency. The parent reported the full-time nurse left the agency around November of 2016 and soon after the agency stopped sending a nurse 5 days a week. The parent reported he/she was told that the agency was working on getting a replacement nurse. The parent reported he/she had reported to the patient's nurses and to the agency that he/she needed a nurse 5 days a week, but the staffing concern had not been addressed or resolved. The parent reported a nurse had told him/her that a nurse was not necessary and another nurse told him/her that Medicaid had denied the prior authorization for a nurse 5 times a week. An interview was conducted with Patient # 1's sibling and full-time HHA on 9/25/18 at 1:50 PM. The sibling reported the parent administered the G-Tube feedings for Patient #1 before he/she left for work. The tube feeding schedule had been changed to late afternoon when the parent came home and then at bedtime. The sibling reported since he/she was working as a HHA it was not within his/her scope of practice to give the tube feedings. He/she reported they have not had a nurse for 2/1/2 years and have been told the agency would get a nurse for the feedings 5 days a week. The sibling reported she/he had been told the PA visits for 5 times a week had been denied. An interview was conducted with the administrator on 9/24/18 at 2:35 PM. The			

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	administrator was asked if there was a complaint investigation regarding the family's reported SN needs 5 days a week for G-Tube feedings while the parent is at work. The administrator reported the complaints had not been reported or logged in the complaint log. The administrator reported he/she had not been made aware the family still needed this service. The administrator was made aware of the missed visits and the failure to follow the POC for SN and HHA visits. The administrator reported there was no further documentation to be provided.			
N 0541 Bldg. 00	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on record review and interview the agency failed to complete the comprehensive assessment every 60 days for 1 of 7 (Patient #1) clinical records reviewed. Findings Include: An agency policy titled, "Client Reassessment/Update of Comprehensive Assessment" was reviewed and stated, "The Comprehensive Assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status. Assessment will include OASIS data collection for all Medicare and Medicaid skilled clients ... Reassessments must be done at least: 1. Every second calendar month beginning with start	N 0541	N 541 The Administrator or designee will immediately review all clinical records for comprehensive reassessments in the last 5 days of certification period. Any clinical record found to be out of compliance with the 5-day window the RN responsible for the assessment will be counselled individually by the DON. The DON or designee will educate administration/management, all clinicians on policy: Client Reassessment/ Update of Comprehensive Assessment	11/30/2018

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	of care within the last five (5) days of the episode, including day sixty (60) ...." The clincial record of Patient #1 with a SOC (start of care) date of 7/18/16 was reviewed. During the certification period of 11/15/16 to 1/13/17, the clinical record evidenced a recertification reassessment that was completed on 1/18/17. This was 5 days after the certification period. The recertification reassessment failed to be completed before the end of the 60 days of the certification period. The administrator was interviewed on 9/27/18 at 2:50 PM regarding the failure of the nurse to complete the assessment timely. The administrator reported he/she did not know why the assessment had been conducted late and there was no further documentation to be provided.		To prevent this deficiency in the future, the DON or designee will review upcoming Re-certifications weekly at case conference to ensure RN's complete re-certifications in the last five days of the certification period, the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed on 11/11/2018.	
N 0542 Bldg. 00	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on observation, record review and interview, the RN (Registered Nurse) failed to accurately complete the plan of care to include the frequency and duration of visits to be conducted for 4 of 7 (Patients # 1, 2, 4, 5), the nutritional requirements for 2 of 7 (Patient #1, 3) , all medications and treatments for 3 of 7 (Patient # 1, 2, 3) , and measurable goals for 1 of 7 (Patient # 1) in a sample of 7 clinical records.	N 0542	N 542 The Administrator or designee will immediately review all clinical records for accurate and complete plan of care, including frequency, and duration of visits, nutritional requirements,medications, treatments with measurable goals, and current and past findings. Any clinical records found to have a POC that is not updated, the DON	11/30/2018

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	Findings Include: 1. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ...2. The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures ... p. Treatment goals...t. other appropriate items ... 9. At the time of certification and recertification , a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include, but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 2. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16, included orders for skilled nurse 5 times a week and HHA services 6 times a week. The POC failed to include the duration for the SN (skilled nurse) and failed to include the HHA (Home Health Aide) time and duration and services to be provided.		will call PCP for a verbal order to update the plan of care, then a physician order will be written reflecting the update and sent to PCP for signature. The DON or designee will educate all clinicians on policy: Plan of Care policy Home Health Admission Service Agreement To prevent this deficiency in the future, The DON will review every plan of care for accuracy before sending to PCP for signature. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur. Education completed on 11/11/2018.	

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	The POC for the certification period of 9/16/16 to 11/14/16, included orders for SN 5 times a week and HHA services 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 11/15/16 to 1/13/17, included orders for SN 5 times a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 1/14/17 to 3/14/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The POC for the certification period of 3/15/17 to 5/13/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. POC. The POC for the certification period of 5/14/17 to 7/12/17, included orders for SN 1 time a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration of the SN and HHA services. The POC for the certification period of 7/13/17 to 9/101/7, included orders for SN 5 times a week and HHA 9 hours a day. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/11/17 to 11/9/17, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 11/10/17 to 1/8/18, included orders for SN 5 times a week and			

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	HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 1/9/18 to 3/9/18, included orders for SN 5 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 3/10/18 to 5/8/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 5/9/18 to 7/7/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 7/8/18 to 9/5/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC included orders for Two Cal HN (a nutritional supplement) oral 240 ml bolus every 6 hours. During an interview conducted with the patient's family member on 9/24/18 at 10:00 AM, he/she reported the following was the accurate G-Tube feeding: Two Cal HN 480 ml bolus at 6 or 7			

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AM, 240 ml bolus at 4:00 PM and 480 ml bolus at 9-10 PM daily during the time the mother is at home from work. The POC failed to include the accurate nutritional requirements.

The POC included the following topical ointments: Aquaphor External (for protection and moisture healing of skin) 1 apply to healed areas every 12 hours, Mupirocin External (antibacterial) 2 % 1 once a day. The orders failed to specify where the ointments would be applied. An order for Ciprofloxacin (antibiotic) HCL oral 500 mg 1 tab per feeding tube every 12 hours failed to be omitted from the POC and had been discontinued on 6/21/18.

A pain goal on the POC stated, "Patient's pain will remain tolerable throughout care period." The goal was not specific to include the Wong scale for an assessment of a nonverbal patient and did not include measurable outcomes for tolerable pain goals.

An interview was conducted with the Administrator on 9/24/18 at 4:45 PM to review the POC findings. The Administrator reported there was no further documentation to be provided.

3. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings:

The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits.

The POC for the certification period of 7/14/18 to 9/11/18, included the following order: "Silvadene

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	External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18 and failed to include the specific area of the body for application. An interview was conducted with the Administrator on 9/26/18 at 4:30 PM regarding the POC findings. The Administrator reported there was no further documentation to be provided 4. The clinical record of Patient #3 with a SOC of 7/25/18 was reviewed with the following findings: The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets" The patient was interviewed on 9/26/18 9:48 AM and reported he had a 32 ounce daily fluid restriction and his diet is a diabetic/renal diet. An interview was conducted with the patient regarding his medications on 9/26/18 at 9:48 AM during a home therapy visit observation. The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following medications: Levothyroxine Sodium (thyroid pill also know as Synthroid) Oral 175 mcg 1 tablet daily and Synthroid (thyroid pill also know as levothyroxine) Oral 75 mcg 1 tablet in the mornings daily. The patient reported the order was a duplicate. Nortriptyline (for diabetic neuropathy pain) HCL oral 10 mg 2 caps bedtime, the patient reported this medication had been discontinued 2 months ago. Insulin aspart (fast acting diabetic insulin) subcutaneous 100 units/ml 15-20 units daily before meals, using sliding scale (insulin amount depends on the patient's blood			

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	sugar). The order failed to include the specific sliding scale orders. An interview was conducted with the Administrator on 9/26/18 at 12:07 PM regarding the findings for Patient # 3. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this." A fax was obtained from the dialysis facility on 9/28/18 that included the following daily diet restrictions: Sodium 3 GM, Phosphorus 1200 mg and 1500 ml. The fax also included the following orders specific to the patients ESRD: Heparin Sodium 1,000 units/ml to arterial port 2,200 units and 2,300 units to venous port (of a central dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The POC failed to include the patient's special nutritional needs related ESRD (End Stage Renal Disease) and failed to include the patient's medication regimen for ESRD. 5. The clincial record of Patient # 4 with a SOC date of 3/13/18 was reviewed with the following findings: The POC for the certification period of 7/11/18 to 9/8/18 included an order for HHA 3 hours day/ 4 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the administrator on 10/1/18 at 4:30 PM and the			

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	administrator reported there was no further documentation to be provided. 6. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification periods of 6/19/16 to 8/17/16, 8/18/16 to 10/16/16 and 10/17/16 to 12/14/16 included an order for HHA 4 hours a day/ 5 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the Administrator on 10/1/18 at 1:58 PM regarding the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be provided.			
N 0545 Bldg. 00	410 IAC 17-14-1(a)(1)(F) Scope of Services Rule 14 Sec. 1(a) (1)(F) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (F) Coordinate services. Based on record review and interview, the SN (skilled nurse) failed to ensure the clinical record included documentation of coordination with the HHA (home health aide) regarding a change in the patient's skin condition that progressed from irritation to a stage 3 pressure ulcer for 1 of 4 patient's receiving home health aide services (Patient #2) in a sample of 4. Findings Include:	N 0545	N 545 The Administrator or designee will immediately review all clinical records for coordination of care between SN/HHA. Immediately all RN case managers will be required to conference with the HHA weekly for patients they case manage, and document this coordination of care through a communication note in the clinical record. The DON or designee will educate	11/30/2018

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	An agency policy titled, "Coordination of Client Services" was reviewed and stated: "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objective outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction. An agency policy titled, "Home Health Aide Supervision" was reviewed and stated, " Agency shall provide Home Health Aide Services under the direction and supervision of a RN/ Therapist when personal care services are indicated and ordered by the physician ... 1. The Nursing Supervisor or designated RN/Therapist will give the HHA direction for client care by way of the Care Plan. The clinical record for Patient # 2, with a start of care date of 9/28/15, with a diagnosis to include Cerebral Palsy and Functional limitations to include Paralysis, Bowel and Bladder Incontinence, Endurance and Ambulation. The plans of care for the certification periods of 3/15/18 to 5/13/18, 5/14/18 to 7/13/18 and 7/14/18 to 9/11/18 included orders for HHA (Home Health Aide) for 8 hours daily for, 5 visits weekly. The clinical record was reviewed with the following findings: A HHA visit note dated 3/29/18 stated, "Skin in the crack of [pt's name] butt (buttocks) is slightly irritated. A SN visit was conducted on 4/11/18 (13 days later). The SN note stated, "Educated about pressure relief due to impaired mobility voices an understanding. Patient states that she has wound center appointment on 4/19/18 due to opened area		administration/management, all clinicians on policy: Coordination of Client Services Home Health Aide Supervision Care Planning/ Coordination of Care Home health aides will be educated on: "What to Report to RN, Case Manager" Home Health Aide Documentation To prevent this deficiency in the future, the RN case managers will be required to review all HHA documentation and perform weekly conference with HHA's for all the patients they case manage. RN case manager will also review the aide care plan with the assigned home health aide prior to the home health aide providing services to the patient and review the home health aide care plan with the home health aide at least every 60 days or when there is a change in the patients' condition. the Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	

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	to crack of buttocks. Unable to assess wound due to patient sitting in wheelchair and unable to transfer via hoyer to assess wound because patient did not want to be transferred back." A document in the clinical record dated 4/12/18 at 11:00 AM and titled, "[hospital name] office visit," included a new diagnosis for Stage 3 pressure ulcer of the buttock. The administrator was interviewed on 9/26/18 at 2:45 PM. The administrator reported there was no documentation that the aide and nurse communicated about the patient's irritated area that progressed to a stage 3 pressure ulcer in the clinical record. The administrator was asked about the process for the home health aide notes to be reviewed by an RN. The administrator reported, "The HHA visits are audited every 60 days by [director of nursing services name].			
N 0546 Bldg. 00	410 IAC 17-14-1(a)(1)(G) Scope of Services Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.			
	Based on record review and interview, the Registered Nurse failed to ensure communication occurred with the nephrologist caring for 1 ESRD (End State Renal Dialysis) for 1 of 1 patient	N 0546	N 546 The Administrator or designee will immediately review all clinical records for coordination of care with any patient receiving dialysis,	11/30/2018

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	receiving hemodialysis (Patient # 3) in a sample of 7 clinical records. An agency policy titled, "Coordination of Client Services" was reviewed and stated: "All personnel furnishing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objective outlined in the Plan of Care. This may be done through formal care conferences, maintaining complete, current care plans, and written and verbal interaction. Purpose ...To ensure services are coordinated between members of the interdisciplinary team. To ensure appropriate, quality care is being provided to clients ... To modify the plan to reflect the needs or changes identified by members of the team ... to determine the continuation of services and /or future plans for care. To provide the attending physician with an ongoing assessment of the client and identify the client's response to services provided. 1. Care conferences will be held as necessary to establish interchange, reporting, and coordinated evaluation between all disciplines involved in the client's care ... 3. After the initial assessment, the admitting RN (Registered Nurse) or Therapist shall discuss the findings of the initial visit with the Clinical Manager to ensure ...a. Clarification of the plan of care orders. d. Client's need for skilled nursing care ...e. Need for other services and/or referral to community resources ...G. Coordination with other agencies and institutions, if the need arises ... 6. Care conferences will be determined on the care conference summary form or in the progress note ... " An interview was conducted with the patient on 9/26/18 at 9:48 AM during a home visit observation. The patient reported he had a central venous dialysis catheter in his right subclavian		wound care. If coordination of care has not been established the DON or RN case manager will establish this coordination of care by calling the dialysis center or wound care center and request weekly updates on patients care. The DON or designee will educate administration/management, all clinicians on policy: Coordination of Client Services To prevent this deficiency in the future, the DON will audit these clinical records weekly to ensure updates from these providers are present in the clinical record, if not present the DON will call the provider for an update and notify the RN case Manager of the update so the RN can update the POC if needed. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency does nor reoccur. Education completed on 11/11/2018.	

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(collarbone) area for hemodialysis treatments 3 times weekly related to his ESRD. In addition, the patient reported he was getting medication for anemia, fluid restriction and dietary restrictions related to his ESRD.

The clinical record of Patient #3 with a Start of care of 7/25/18 and a POC (Plan of Care) for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets." The POC failed to include any medication orders related to the patient's dialysis 3 times weekly

The administrator was interviewed on 9/26/18 at 12:07 AM and reported there was no documentation the agency had coordinated care with the Hemodialysis facility or the Nephrologist. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this."

The agency was asked to call the dialysis facility and obtain the current treatment orders for the patient to include diet, fluid restriction, and medication. A fax was obtained from [the dialysis facility] on 9/28/18 and included the following orders specific to the patient's ESRD: Heparin Sodium (to prevent blood clots) 1,000 units/ml to arterial port (red) 2,200 units and 2,300 units to venous (blue) port (of the dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The fax included a 1500 ml fluid restriction and dietary restriction to 3 gm sodium, and 1200 mg

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	Phosphorus daily. The POC failed to include the patient's medication regimen for ESRD, diet and fluid restrictions.			
N 0596 Bldg. 00	410 IAC 17-14-1(l)(A) Scope of Services Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and			
	Based on record review and interview, the administrator failed to ensure the personnel file included documentation that the home health aide competed a competency evaluation program before patient contact for 1 of 1 home health aide records reviewed (Employee E) Findings Include: An agency policy titled, "Personnel Records" was reviewed and stated, "Personnel files will be established and maintained for all personnel ... Special Instructions: 1. Personnel Record-the employee personnel record will include, but not be limited to ... B. Employment information: ... Competency testing for home health aides and specific competencies per job title ... signed job description ...." The confidential personnel file of Employee E with a date of hire of 7/13/16 and first patient contact of 7/13/16, was reviewed on 10/1/18 at 4:00 PM. The employee record failed to include evidence of a	N 0596	N 596 The Administrator will immediately alert HR Director not hire any new HHA's. The Administrator or designee will seek a contract RN to perform HHA skills check off and competency. No new home health aides will be hired until contract is in place. Any HHA's that were found not to have skills check offs present in employee file will be checked off by the contract RN on skills. The Administrator or designee will educate administration/management, HR Director on policy: Personnel Records To prevent this deficiency in the future, the Administrator or designee will be responsible for active employee record audits until 100% compliance is met then 10	11/30/2018

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	home health aide test competency and a skills competency upon hire. The administrator was interviewed on 10/1/18 at 4:30 PM and reported he/she would search for the missing information. The administrator was interviewed on 10/2/18 at 10:30 AM and reported he/she was unable to locate the missing information for the personnel file of Employee E.		% of all employee records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	
N 0606 Bldg. 00	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on record review and interview, the Registered Nurse (RN) failed to ensure supervision to the HHA (Home Health Aides) every 30 days for HHA only services for 2 of 2 patient's receiving HHA only services (Patients # 4 and 5) in a sample of 4 records. Findings Include: 1. An agency policy titled, "Home Health Aide Supervision" was reviewed and stated, "Agency shall provide HHA services under the direction and supervision of a RN/Therapist when personal care services are indicated and ordered by the physician. The frequency of supervision will be in response to Medicare regulations, agency policy and other state or federal requirements ...3. Supervisory visits of HHA shall be according to the following frequency: a. When skilled services	N 0606	N 606 The Administrator or designee will immediately review all clinical records for supervision of HHA's every 30 days for patients receiving non-skilled nursing services. If there are clinical records in which supervision of HHA is not completed every 30 days, the RN case manager will be brought in immediately to be counseled on supervisory regulations. The Administrator or designee will educate administration/management, all clinicians on policy: Home Health aide supervision	11/30/2018

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	are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client's residence at least every two (2) weeks ...." 2. The non-skilled clinical record of Patient # 4 with a SOC date of 3/13/18 was reviewed with the following findings: The POC for the certification period of 7/11/18 to 9/8/18 included orders for SN monthly for aide supervisory visit and HHA 3 hours a day for 4 days a week. The prior supervisory visit was 7/6/18 and the next supervisory visit was 9/7/18. The supervisory visit exceeded the state requirements of every 30 days by 31 days. 3. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification period of 6/19/16 to 8/17/16 included orders for HHA services 5 days a week for 20 hours week. HHA services were started on 6/20/16. The first supervisory visit was 7/21/16 which exceeded the 30 day state requirement by 3 days. The POC for the certification period of 8/18/16 to 10/16/16 included orders for HHA services 5 days a week for 20 hours week. The prior Supervisory visit was 8/17/16 and the next supervisory visit was 9/23/16. This exceeded the 30 day state requirement by 6 days. The POC for the certification period of 10/17/16 to 12/14/16 included orders for HHA services 5 days a week for 20 hours week. The prior supervisory visits were 10/13/16, 11/10/16 and there were no further supervisory visit done		To prevent this deficiency in the future, the DON will monitor supervisory visits to ensure skilled supervisory visits are conducted every 30 days through weekly audits. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	

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	before the end of the certification period 12/14/16. This exceeded the 30 requirement by 4 days. 4. An interview was conducted with the administrator on 10/1/18 at 4:30 PM regarding late and missed supervisory visits. The administrator reported there was no further documentation to be provided.			
N 0608 Bldg. 00	410 IAC 17-15-1(a)(1-6) Clinical Records Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interviews the agency failed to accurately complete the plan of care to include the frequency and duration of visits to be made for 4 of 7 (Patients # 1, 2, 4, 5), the nutritional requirements for 2 of 7 (Patient #1, 3), all medications and treatments for 3 of 7 (Patient # 1, 2, 3), and measurable goals for 1 of 7 (Patient # 1), failed to send a written summary for each	N 0608	*N 608* The Administrator or designee will immediately review all clinical records for accurate and complete plan of care, including frequency, and duration of visits, nutritional requirements,medications, treatments with measurable goals, and current and past findings. Any	11/30/2018

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	patient every 60 days for 1 of 5 (Patient # 1) patients with services provided for more than 60 days, failed to ensure the HHA (Home Health Aide) documentation notes were completed and entered into the clinical record for 2 of 4 patient's receiving HHA services (Patient's #1 and 5) and failed to ensure written notice of the patient's rights was included in the clinical record for 1 of 1 patient's (Patient' # 5) in a sample of 7 clinical records reviewed. Findings Include: 1. An agency policy titled, "Clinical Documentation" was reviewed and stated, "Agency will document each direct contact with the client. This documentation will be completed by the direct caregiver and monitored by the skilled professional responsible for managing the clients's care. Purpose: To ensure that there is an accurate record of the services provided, client response and ongoing need for care. To document conformance with the Plan of Care, modifications to the plan and interdisciplinary involvement ... 2. a separate note shall be completed for each visit/shift and signed and dated by the appropriate professional. Actual time and length of the client visit will be included in each note ... 5. Documentation of services ordered on the plan of car will be completed the day services is rendered and incorporated into the clinical record within seven 2. A policy titled, "Plan of Care" was reviewed and stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members ... The plan will be consistently reviewed		clinical records found to have a POC that is not updated, the DON will call PCP for a verbal order to update the plan of care, then a physician order will be written reflecting the update and sent to PCP for signature. The DON or designee will educate all clinicians on policy: Plan of Care policy Home Health Admission Service Agreement To prevent this deficiency in the future, The DON will review every plan of care for accuracy before sending to PCP for signature. The Administrator or designee will be responsible for active clinical record audits until 100% compliance is met then 10 % of all clinical records will be audited quarterly for evidence after 100% compliance is met to ensure that this deficiency will not reoccur.	

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	to ensure that client needs are met and will be updated as necessary, but at least every sixty (60) days ...2. The plan of care shall be completed in full to include: c. Type, frequency, and duration of all visits/services ... k. Specific dietary or nutritional requirements or restrictions. l. Medications, treatments, and procedures ... p. Treatment goals...t. other appropriate items ... 9. At the time of certification and recertification , a written summary of the client's current status and the services being provided are submitted with the plan of care for review. The summary shall include, but is not limited to: changes in clients physical or psychosocial condition, client response to care/services and outcome of care and services ... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the plan of care ...." 3. The clinical record of patient # 1 with a SOC (start of care) date of 7/18/16 was reviewed with the following findings: The POC for the certification period of 7/18/16 to 9/15/16, included orders for skilled nurse 5 times a week and HHA services 6 times a week. The POC failed to include the duration for the SN (skilled nurse) and failed to include the HHA (Home Health Aide) time and duration and services to be provided. The clinical record failed to include a case conference/ 60 day summary. The POC for the certification period of 9/16/16 to 11/14/16, included orders for SN 5 times a week and HHA services 6 times a week. The POC failed to include the SN duration or HHA time and duration. The clinical record failed to include a case conference/ 60 day summary The POC for the certification period of 11/15/16 to			

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	1/13/17, included orders for SN 5 times a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The clincial record failed to include a case conference/ 60 day summary The POC for the certification period of 1/14/17 to 3/14/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The clinical record evidenced 2 case conference /60 day summary notes for the certification period of 1/14/17 to 3/14/17. The notes dated 2/16/17 and 3/9/17 failed to include skilled nurse services 1 time a week, and the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided The POC for the certification period of 3/15/17 to 5/13/17, included orders for SN 1 time a week and HHA 6 times a week. The POC failed to include the SN duration or HHA time and duration. The clinical record failed to include a case conference/ 60 day summary. The POC for the certification period of 5/14/17 to 7/12/17, included orders for SN 1 time a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration of the SN and HHA services. The POC for the certification period of 7/13/17 to 9/10/17, included orders for SN 5 times a week and HHA 9 hours a day. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/11/17 to 11/9/17, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA			

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	services. The clinical record evidenced 2 case conference/60 day summary notes for the certification period of 9/11/17 to 11/9/17. The notes dated 10/6/17 failed to include skilled nursing services and reported HHA services were daily and were ordered 5 times a week. The note dated 11/08/17 incorrectly reported skilled nursing services were being provided 5 days a week (SN visits were provided 1-2 times a week) and reported HHA services were "no change." The notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. The POC for the certification period of 11/10/17 to 1/8/18, included orders for SN 5 times a week and HHA 9 hours a day for 5 days a week. The POC failed to include duration for the SN and HHA services. The clinical record evidenced 2 case conference/ 60 day summary notes for the certification period of 11/10/17 to 1/8/18. The notes dated 12/4/17 and 1/4/18 both stated, "continue plan of care as developed" . No acute changes noted at this time. The notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. The POC for the certification period of 1/9/18 to 3/9/18, included orders for SN 5 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The clinical record evidenced a skilled nurse note dated 2/19/18 that reported, "per mother, patient fell off bed yesterday." The clinical record evidenced 2 case conference/ 60 day summary notes for the certification period of 1/9/18 to 3/9/18. The notes were dated 2/55/18 and 3/5/18 and both stated, "Continue plan of care as			

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	developed. No distress noted. No acute changes noted." There was no mention of the fall and the notes failed to include the patient's current physical or psychosocial condition and patient's response to and outcome of care/services provided. The POC for the certification period of 3/10/18 to 5/8/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 5/9/18 to 7/7/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 7/8/18 to 9/5/18, included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC for the certification period of 9/6/18 to 11/4/18 included orders for SN 2 times a week and HHA 9 hours a day, 5 days a week. The POC failed to include duration for the SN and HHA services. The POC included orders for Two Cal HN (a nutritional supplement) oral 240 ml bolus every 6 hours. During an interview conducted with the patient's mother on 9/24/18 at 10:00 AM he/she reported the following was the accurate G-Tube feeding: Two Cal HN 480 ml bolus at 6 or 7 AM, 240 ml bolus at 4:00 PM and 480 ml bolus at 9-10 PM daily during the time the mother is at home from work. The POC failed to include the accurate			

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nutritional requirements.

The POC included the following topical ointments: Aquaphor External (for protection and moisture healing of skin) 1 apply to healed areas every 12 hours, Mupirocin External (antibacterial) 2 % 1 once a day. The orders failed to specify where the ointments would be applied. An order for Ciprofloxacin (antibiotic) HCL oral 500 mg 1 tab per feeding tube every 12 hours failed to be omitted from the POC and had been discontinued on 6/21/18.

A pain goal on the POC stated, "Patient's pain will remain tolerable throughout care period." The goal was not specific to include the Wong scale for an assessment of a nonverbal patient and did not include measurable outcomes for tolerable pain goals.

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The clinical record failed to evidence any HHA documentation notes from 4/2/17 to 5/21/17 in the clinical record.

An interview was conducted with the Administrator on 9/24/18 at 4:45 PM to review the POC findings. The Administrator reported there was no further documentation to be provided

4. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings:

The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits.

The POC for the certification period of 7/14/18 to

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	9/11/18, included the following order: "Silvadene External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18 and failed to include the specific area of the body for application. 5. The clincial record of Patient # 2 with a SOC date of 9/28/15 was reviewed with the following findings: The POC for the certification period of 7/14/18 to 9/11/18 and 9/12/18 to 11/10/18, with services to include HHA 8 hours a day 5 days was reviewed. The POC failed to include a duration for the HHA visits. The POC for the certification period of 7/14/18 to 9/11/18, included the following order: "Silvadene External (healing protective ointment) 1 % 2 x day apply to open area 2 times per day for a week if not any better call physician." The order for one week continued on the POC for 9/12/18 to 11/10/18 and failed to include the specific area of the body for application. An interview was conducted with the Administrator on 9/26/18 at 4:30 PM regarding the POC findings. The Administrator reported there was no further documentation to be provided 6. The clinical record of Patient #3 with a SOC of 7/25/18 was reviewed with the following findings: The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following nutritional requirements: "No added salt, regular, no concentrated sweets" The patient was interviewed on 9/26/18 9:48 AM and reported he			

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	had a 32 ounce daily fluid restriction and his diet is a diabetic/renal diet. A fax was obtained from [the dialysis facility] on 9/28/18 and included the following daily diet restrictions: Sodium 3 GM, Phosphorus 1200 mg and 1500 ml. The POC failed to include the patients special nutritional needs related ESRD (End Stage Renal Disease). An interview was conducted with the patient regarding his medications on 9/26/18 at 9:48 AM during a home therapy visit observation. The POC for the certification period of 7/25/18 to 9/22/18 included orders for the following medications: Levothyroxine Sodium (thyroid pill also know as Synthroid) Oral 175 mcg 1 tablet daily and Synthroid (thyroid pill also know as levothyroxine) Oral 75 mcg 1 tablet in the mornings daily. The patient reported the order was a duplicate. Nortriptyline (for diabetic neuropathy pain) HCL oral 10 mg 2 caps bedtime, the patient reported this medication had been discontinued 2 months ago. Insulin aspart (fast acting diabetic insulin) subcutaneous 100 units/ml 15-20 units daily before meals, using sliding scale (insulin amount depends on the patient's blood sugar). The order failed to include the specific sliding scale orders. An interview was conducted with the Administrator on 9/26/18 at 12:07 PM regarding the findings for Patient # 3. The Administrator reported they did not have any information regarding the patients dialysis medication, diet and fluid restrictions. The administrator reported in regards to the medication findings, "I have some education to do. There is no excuse for this." No further documentation to be provided. A fax was obtained from [the dialysis facility] on 9/28/18 and included the following orders specific			

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	to the patients ESRD: Heparin Sodium 1,000 units/ml to arterial port 2,200 units and 2,300 units to venous port (of a central dialysis catheter) every treatment (3 times weekly), Venofer (iron medication for anemia) 100 mg IVP (intravenous push) every treatment x 5 and Micera (medication for anemia) 200 mcg IVP every 2 week x 365 days. The POC failed to include the patient's medication regimen for ESRD. 7. The clincial record of Patient # 4 with a SOC date of 3/13/18 was reviewed with the following findings: The POC for the certification period of 7/11/18 to 9/8/18 included an order for HHA 3 hours day/ 4 days a week. The POC failed to include the duration of the HHA visits. An interview was conducted with the administrator on 10/1/18 at 4:30 PM and he/she reported there was no further documentation to be provided. 8. The clinical record of Patient # 5 with a SOC date of 6/19/16 was reviewed with the following findings: The POC for the certification periods of 6/19/16 to 8/17/16, 8/18/16 to 10/16/16 and 10/17/16 to 12/14/16 included an order for HHA 4 hours a day/ 5 days a week. The POC failed to include the duration of the HHA visits. The clinical failed to evidence any HHA documentation notes from 8/10/16 to 9/29/16 in the clincial record The clinical record failed to evidence a contain a copy of the patient's rights. An interview was conducted with the			

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	Administrator on 10/1/18 at 1:58 PM regarding the POC. The Administrator reported he/she was not working at the agency during that time period. The administrator reported there was no additional information to be provided.			