

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K093	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2015
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NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 702 NORTH SHORE DRIVE, SUITE 103 JEFFERSONVILLE, IN 47130
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G 0000 Bldg. 00	<p>This was a federal home health recertification and complaint investigation survey. The survey was partial extended</p> <p>Complaint # IN00174045 - Federal deficiencies are cited.</p> <p>Survey dates: July 20 through July 23 2015</p> <p>Facility Number: 012872</p> <p>Medicaid Provider ID 201084980</p> <p>Skilled Unduplicated admissions 2 Unskilled admissions 210</p> <p>Home visits 4 Clinical records reviewed 11</p> <p>QR: JE 7/28/15</p>	G 0000		
G 0109 Bldg. 00	<p>484.10(c)(2) RIGHT TO BE INFORMED AND PARTICIPATE</p>			

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

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

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	<p>The patient has the right to participate in the planning of the care.</p> <p>The HHA must advise the patient in advance of the right to participate in planning the care or treatment and in planning changes in the care or treatment.</p> <p>Based on on interview and agency document and clinical record review, the home health agency failed to ensure the patient was notified of changes to the plan of care prior to the changes being made for 1 of 3 (record #8) discharged patient records reviewed.</p> <p>Findings</p> <ol style="list-style-type: none"> 1. Clinical record #8, start of care 2/28/2013, included a plan of care established by the patient's physician for the certification period 4/26/2015 through 6/24/2015 with orders for a home health aide 5 hours per day, five days per week. 2. An agency document titled Activity Tracking (complaint log) entry, dated May 5, 2015, evidenced a complaint from a family member of patient #8 that she had not had a home health aide for three days. The agency documented in the log entry they did not have staff to care for patient #8. The record failed to evidence the agency had discussed this with the patient and family. 	G 0109	<p>G -0109The Administrator or Alt Administrator will provide an in serviceto Program Managers by 8/20/2015. The in service will instruct that any patientthat will be discharged will have verbal notification, via telephone, of dischargeand will also inform the patient that a letter is being sent to patientnotifying of discharge. The letter willalso be copied to the patient's MD. Letter will state "as per conversation on Xdate, the last date of service will be X". Documentation of phone calland letter sent will be entered by Program Manager into Soneto on date thatcall was placed. Administrator or Alt Administrator will be responsible for themonitoring of this corrective action to ensure the deficiency is corrected andwill not recur.</p>	08/20/2015

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G 0158 Bldg. 00	<p>3. In an interview with patient #8 at 10:10 AM on 7/23/2015, the patient stated, "I received a letter from the agency on May 7, 2015, notifying me that I would be discharged from Adaptive for non compliance on May 8, 2015."</p> <p>4. In an interview with employee C, a home health aide, on 7/23/2015 at 10:15 AM, the employee stated, "I was told we would no longer be staffing patient #8."</p> <p>5. An agency policy titled Client Discharge Process, dated March 21, 2012 states, "To avoid charges of abandonment at the time of discharge agency documentation will include the following ... evidence that the decision was not made unilaterally. The client, family and physician participated in the decision to discharge the patient."</p> <p>484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.</p> <p>Based on home visit observation,</p>	G 0158	G-0158The Administrator or Alt Administrator will provide an inserviceto Clinical Managers and	08/20/2015

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	<p>interview, and clinical record review, the home health agency failed to ensure all treatments were ordered on the plan of care for 2 of 4 home visit observations. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record #1, start of care 10/17/2012, included a plan of care established by the patient's physician for the certification period 6/4/2015 through 8/2/2015.</p> <p>a. At a home visit observation for patient #1 on 7/21/2015 at 8:30 AM, employee F, a registered nurse, indicated she sometimes performed manual disimpaction of stool and bowel stimulation in order for the patient to have a bowel movement.</p> <p>b. The plan of care failed to evidence an order for a bowel protocol including manual disimpaction or bowel stimulation</p> <p>2. Clinical record #2, start of care 4/3/2014, included a plan of care established by the patient's physician for the certification period 6/24/2015 through 8/22/2015.</p> <p>a. At a home visit observation for patient</p>		<p>Supervising nurse by 8/20/2015. In-service will include reviewing skilled nursing notes, if applicable, for treatments, procedures, or medications not listed in 485 plan of care. Treatment, procedure, or new medication will have order sent to physician and will be added to 485 plan of care. In-service will also include instructing Clinical Managers and Supervising nurse to ask patient if new procedures, treatments or medications have been added or changed at every visit. Administrator or Alt Administrator will be responsible for the monitoring of this corrective action to ensure the deficiency is corrected and will not recur.</p>		

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G 0159 Bldg. 00	<p>#2 on 7/21/2015 at 11:00 AM, the patient indicated to the nurse that he was due to take a nebulizer treatment. The patient stated, "I've been taking them breathing treatments for years" and gestured to the top of a nearby cabinet where his nebulizer solutions were stored.</p> <p>b. The plan of care failed to include and order for nebulizer treatments.</p> <p>484.18(a) PLAN OF CARE The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items.</p> <p>Based on home visit observation, interview, and clinical record and agency policy review, the home health agency failed to include all medications and equipment on the plan of care for 1 of 4 home visit observations. (#1)</p> <p>Findings:</p>	G 0159	G-0159The Administrator or Alt Administrator will provide an inserviceto Clinical Managers and Supervising nurse by 8/20/2015. In-service willinclude reviewing skilled nursing notes, if applicable, for treatments,procedures, or medications not listed in 485 plan of care. Treatment,procedure, or new medication will have order	08/20/2015

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N 0000	<p>1. Clinical record #2, start of care 4/3/2014, included a plan of care established by the patient's physician for the certification period 6/24/2015 through 8/22/2015.</p> <p>a. At a home visit observation for patient #2 on 7/21/2015 at 11:00 AM, the patient indicated to the nurse that he was due to take a nebulizer treatment. The patient stated, "I've been taking them breathing treatments for years" and gestured to the top of a nearby cabinet where his nebulizer solutions were stored.</p> <p>b. The plan of care failed to include the durable medical equipment of nebulizer and list medications for inhalation.</p> <p>2. An agency policy titled Plan of Treatment, dated March 21, 2012, states, " As follows, the medical plan of care shall include the following ... types of services and equipment required ... medications and treatments. "</p>		<p>sent to physician and will be added to 485 plan of care. Inservice will also include instructing ClinicalManagers and Supervising nurse to ask patient if new procedures, treatments or medications have been added or changed at every visit. Administrator or AltAdministrator will be responsible for the monitoring of this corrective action to ensure the deficiency is corrected and will not recur.</p>		

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Bldg. 00	<p>This was a state relicensure and complaint investigation survey</p> <p>Complaint # IN00174045 - State deficiencies are cited.</p> <p>Survey dates: July 20 through July 23 2015</p> <p>Facility Number: 012872</p> <p>Medicaid Provider ID 201084980</p> <p>Skilled Unduplicated admissions 2 Unskilled admissions 210</p> <p>Home visits 4 Clinical records reviewed 11</p> <p>QR: JE 7/28/15</p>	N 0000		
N 0488 Bldg. 00	<p>410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least five (5) calendar days before the services are stopped.</p> <p>(j) The five (5) day period described in</p>			

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	<p>subsection (i) of this rule does not apply in the following circumstances:</p> <p>(1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient.</p> <p>(2) The patient refuses the home health agency's services.</p> <p>(3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or</p> <p>(4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.</p> <p>Based on interview and clinical record review, the home health agency failed to ensure the patient received a 5 day notice of discharge from the agency for 1 (#8) of three discharged records reviewed.</p> <p>Findings</p> <p>1. Clinical record #8, start of care 2/28/2013 included a plan of care established by the patient's physician for the certification period 4/26/2015 through 6/24/2015 with orders for a home health aide 5 hours per day, five days per week. The record evidenced a letter to the patient dated May 4, 2015, that the</p>	N 0488	N-0488 The Administrator or Alt Administrator will provide an inserviceto Program Managers by 8/20/2015. The inservice will instruct that any patientthat will be discharged will have verbal notification, via telephone, of dischargeand will also inform the patient that a letter is being sent to patientnotifying of discharge. Letter will state "as per conversation on X date, thelast date of service will be X". The patient's MD will also receive a copy of the letter. Documentation of the phonecall and letter sent will be entered by Program Manager into Soneto on datethat call was placed. Inservice will also instruct to attempt on good faith tofulfill HHA shifts for patient until	08/20/2015

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N 0490 Bldg. 00	<p>patient would be discharged from the agency for non-compliance effective May 8, 2015.</p> <p>3. In an interview with patient #8 at 10:10 AM on 7/23/2015, the patient stated "I received a letter from the agency on May 7, 2015 notifying me that I would be discharged from Adaptive for non compliance on May 8, 2015."</p> <p>410 IAC 17-12-2(k) Q A and performance improvement Rule 12 Sec. 2(k) A home health agency must continue, in good faith, to attempt to provide services during the five (5) day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented.</p> <p>Based on interview and agency document and clinical record review, the home health agency failed to continue in good faith to attempt to provide services for five days after notifying the patient of discharge for 1 (#8) of three discharged records reviewed.</p> <p>Findings</p> <p>1. Clinical record #8, start of care</p>	N 0490	<p>the last date of service. If services cannot be fulfilled, Program Managers must provide documentation in Sonetoshowing attempts and that the patient or PCG was informed of inability to staffshift. Administrator or Alt Administrator will be responsible for the monitoring of this corrective action to ensure the deficiency is corrected and will not recur.</p> <p>N-0490 The Administrator or Alt Administrator will provide an inservice to Program Managers by 8/20/2015. Inservice will instruct to attempt on good faith to fulfill HHA shifts for patient until the DC date. If services cannot be fulfilled, Program Managers must provide documentation in Sonetoshowing attempts and that the patient/PCG was notified of inability to staffthe shift. Administrator or Alt Administrator will be responsible for the monitoring of this corrective</p>	08/20/2015

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	<p>2/28/2013 included a plan of care established by the patient's physician for the certification period 4/26/2015 through 6/24/2015 with orders for a home health aide 5 hours per day, five days per week.</p> <p>2. Clinical record #8 evidenced a letter to the patient dated May 4, 2015, that the patient would be discharged from the agency for non-compliance effective May 8, 2015.</p> <p>3. An agency document titled Activity Tracking (complaint log) entry, dated May 5, 2015, evidenced a complaint from a family member of patient #8 that the patient had not had a home health aide for three days. The agency documented in the log entry that they did not have staff to care for patient #8. The record failed to evidence attempts to identify other caregivers for the patient.</p> <p>4. In an interview with patient #8 at 10:10 AM on 7/23/2015, the patient stated, "I received a letter from the agency on May 7, 2015, notifying me that I would be discharged from Adaptive for non compliance on May 8, 2015."</p> <p>5. An agency policy titled Discharge Notice dated March 21, 2012, states, "A home health agency must continue in good faith to attempt to provide services</p>		action to ensure the deficiency is corrected and will not recur.	

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N 0505 Bldg. 00	<p>during the five day period described in the discharge policy. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented."</p> <p>410 IAC 17-12-3(b)(2)(D)(ii) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment.</p> <p>Based on on interview and agency document and clinical record review, the home health agency failed to ensure the patient was notified of changes to the plan of care prior to the changes being made for 1 of 3 (record #8) discharged patient records reviewed.</p> <p>Findings</p> <p>1. Clinical record #8, start of care</p>	N 0505	N-0505The Administrator or Alt Administrator will provide an in serviceto Program Managers by 8/20/2015. The in service will instruct that any patientthat will be discharged will have verbal notification, via telephone, of dischargeand will also inform the patient that a letter is being sent to patientnotifying of discharge. The letter willalso be copied to the patient's MD. Letter will state "as per conversation on Xdate, the last date of service will be X". Documentation of phone calland	08/20/2015

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	<p>2/28/2013, included a plan of care established by the patient's physician for the certification period 4/26/2015 through 6/24/2015 with orders for a home health aide 5 hours per day, five days per week.</p> <p>2. An agency document titled Activity Tracking (complaint log) entry, dated May 5, 2015, evidenced a complaint from a family member of patient #8 that she had not had a home health aide for three days. The agency documented in the log entry they did not have staff to care for patient #8. The record failed to evidence the agency had discussed this with the patient and family.</p> <p>3. In an interview with patient #8 at 10:10 AM on 7/23/2015, the patient stated, "I received a letter from the agency on May 7, 2015, notifying me that I would be discharged from Adaptive for non compliance on May 8, 2015."</p> <p>4. In an interview with employee C, a home health aide, on 7/23/2015 at 10:15 AM, the employee stated, "I was told we would no longer be staffing patient #8."</p> <p>5. An agency policy titled Client Discharge Process, dated March 21, 2012 states, "To avoid charges of abandonment at the time of discharge agency documentation will include the following</p>		<p>letter sent will be entered by Program Manager into Soneto on date that call was placed. Administrator or Alt Administrator will be responsible for the monitoring of this corrective action to ensure the deficiency is corrected and will not recur.</p>	

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N 0522 Bldg. 00	<p>... evidence that the decision was not made unilaterally. The client, family and physician participated in the decision to discharge the patient."</p> <p>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:</p> <p>Based on home visit observation, interview, and clinical record review, the home health agency failed to ensure all treatments were ordered on the plan of care for 2 of 4 home visit observations. (#1 and 2)</p> <p>Findings:</p> <p>1. Clinical record #1, start of care 10/17/2012, included a plan of care established by the patient's physician for the certification period 6/4/2015 through 8/2/2015.</p> <p>a. At a home visit observation for patient #1 on 7/21/2015 at 8:30 AM, employee F, a registered nurse, indicated she sometimes performed manual disimpaction of stool and bowel stimulation in order for the patient to</p>	N 0522	N-0522 The Administrator or Alt Administrator will provide an inserviceto Clinical Managers and Supervising nurse by 8/20/2015. In-service will includereviewing skilled nursing notes if applicable for treatments, procedures, or medications not listed in 485 plan of care. Treatment, procedure, or newmedication will have order sent to physician and will be added to 485 plan ofcare. Inservice will also include instructing Clinical Managers and Supervisingnurse to ask patient if new procedures, treatments or medications have beenadded or changed at every visit. Administrator or Alt Administrator will beresponsible for the monitoring of this corrective action to ensure thedeficiency is corrected and will not recur.	08/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K093	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/23/2015
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NAME OF PROVIDER OR SUPPLIER ADAPTIVE NURSING AND HEALTHCARE SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 702 NORTH SHORE DRIVE, SUITE 103 JEFFERSONVILLE, IN 47130
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N 0524 Bldg. 00	<p>have a bowel movement.</p> <p>b. The plan of care failed to evidence an order for a bowel protocol including manual disimpaction or bowel stimulation</p> <p>2. Clinical record #2, start of care 4/3/2014, included a plan of care established by the patient's physician for the certification period 6/24/2015 through 8/22/2015.</p> <p>a. At a home visit observation for patient #2 on 7/21/2015 at 11:00 AM, the patient indicated to the nurse that he was due to take a nebulizer treatment. The patient stated, "I've been taking them breathing treatments for years" and gestured to the top of a nearby cabinet where his nebulizer solutions were stored.</p> <p>b. The plan of care failed to include and order for nebulizer treatments.</p> <p>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:</p>			

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	<p>(i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items.</p> <p>Based on home visit observation clinical record and agency policy review, the home health agency failed to include all medications and treatments in the plan of care for 2 of 4 home visit observations.</p> <p>Findings:</p> <p>1. Clinical record #1, start of care 10/17/2012, included a plan of care established by the patient's physician for the certification period 6/4/2015 through 8/2/2015.</p> <p>a. At a home visit observation for patient #1 on 7/21/2015 at 8:30 AM, employee F, a registered nurse indicated that she sometimes performed manual disimpaction of stool and bowel</p>	N 0524	<p>N-0524 The Administrator or Alt Administrator will provide an inserviceto Clinical Managers and Supervising nurse by 8/20/2015. In-service will include reviewing skilled nursing notes if applicable for treatments, procedures, or medications not listed in 485 plan of care. Treatment, procedure, or new medication will have order sent to physician and will be added to 485 plan of care. In-service will also include instructing Clinical Managers and Supervising nurse to ask patient if new procedures, treatments or medications have been added or changed at every visit. Administrator or Alt Administrator will be responsible for the monitoring of this corrective action to ensure the deficiency is corrected and will not recur</p>	08/20/2015

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	<p>stimulation in order for the patient to have a bowel movement.</p> <p>b. The plan of care failed to evidence an order for a bowel protocol including manual disimpaction or bowel stimulation</p> <p>2. Clinical record #2, start of care 4/3/2014, included a plan of care established by the patient's physician for the certification period 6/24/2015 through 8/22/2015.</p> <p>a. At a home visit observation for patient #2 on 7/21/2015 at 11:00 AM the patient indicated to the nurse that he was due to take a nebulizer treatment.</p> <p>b. When asked the patient stated that he " I've been taking them breathing treatments for years" and gestured to the top of a nearby cabinet where his nebulizer solutions were stored.</p> <p>c. The plan of care failed to include a nebulizer or list medications for inhalation.</p> <p>3. An agency policy titled Plan of Treatment, dated March 21, 2012 states " As follows, the medical plan of care shall include the following...types of services and equipment required...medications and</p>			

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

PRINTED: 08/13/2015
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	treatments. "				