STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157523	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEDIATRIC INFANT & FAMILY HOME HEALTH CARE SPECIAL	1512 BURR ST GARY, IN 46406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G000000		G000000		

This was a federal home health recertification survey. The survey was partially extended on 7-9-13.

Facility #: 10192.

Survey Dates: 7-3-13, 7-5-13, 7-8-13, and 7-9-13.

Medicaid Vendor#: 200156590A.

Surveyor: Janet Brandt, RN, PHNS.

Agency census: 117 skilled unduplicated admissions.

Quality Review: Joyce Elder, MSN, BSN, RN
July 12, 2013

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

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

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G000158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. Based on interview and review of clinical records, the home health agency failed to ensure home health aide visits were made as ordered in 1 (#6) of 6 records reviewed of patients receiving home health aide services with the potential to affect all the agency's patients who received home health aide services and skilled nursing visits were made as ordered on the plan of care for 1 of 9 active records reviewed with the potential to affect all patients receiving skilled nurse services. (#3) The findings include: 1. Clinical record #6, start of care 6-4-13, included a plan of care for the certification period 6-4-13 to 8-2-13 with orders for the home health aide to visit the patient 2 times during week 1 (6-4-13 to 6-7-13) then 3 times a week for 8 weeks. There was no documentation in the medical record to indicate any home health aide (HHA) visits were made during week 1.	G000158	1.The Assistant Administrator will ensure that all client who are not seen on the schedule day will have a missed visit report in their records.2. the Agency reviewed the missed visit policy, which potentially has an effect on all the clients, it was discovered that no one was assigned to take these reports from the field staff. Since then we have designated an office staff member to handle missed visit reports from all field staff.3. The office staff member will be assign to take missed visit calls. That staff member will complete the missed visit report as the staff calls in. All reports will be given to the office manager or assistant administrator to sign as well. At the end of the day the designated staff member will follow up with all field staff to ensure that these reports are accruated, the scheduler will follow up with the home health aides. 4. The Assistant Administrator will monitor these practices on a Bi-Weekly bases during the billing cycle to determine if there is a billable note or a missed visit in each client's file. The monitoring will be on going	07/23/2013

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	Employee A, during an interview on 7-9-13 at 10:15 AM, indicated the patient may have moved (residences) during week 1 and didn't want HHA visits. No further documentation was available per Employee A. 2. Clinical record #3, start of care 2-28-12, included a plan of care (POC) for the certification period from 4-23-13 to 6-21-13 with orders for the skilled nurse to visit 1 time on day 1 of the SOC and thereafter 3 times weekly for 9 weeks. The skilled nurse visited 2 times weekly from 4-23-13 to 6-21-13 with the exception of week 4 (5-11-13 to 5-17-13) when the SN visited 3 times that week. On 7-9-13 at 10:00 AM, Employee A indicated the patient started going to the wound clinic 1 day weekly and the SN visit frequency changed to 2 visits weekly. Employee A indicated the POC should have been changed to more accurately reflect the care being given to the patient.			

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G000159	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. Based on policy review, clinical record review and staff interview, the agency failed to ensure the plan of care contained specific orders for the care of the wound vac in 1 of 9 active records reviewed (#2) of patient receiving skilled nursing service with the potential to affect all the patients of the agency receiving skilled nurse services. Findings: 1. Clinical record #2, start of care (SOC) 4-17-13, included a plan of care for the certification period 4-17-13 to 6-15-13 with orders for the skilled nurse to visit 1 time daily for 3 days, then 7 times for 1 week, thereafter 3 times weekly for 8 weeks. A physician's order was provided on 7-9-13 at 9:40 AM from Employee A that	G000159	1. The Admistrator will ensure that each client that attends the wound clinic will have physician's orders directing the treatment and the frequency of each client.2. Agency conduct a survey of all client that attend the wound clinic, surveyed the frequency of the visit to the wound clinic and modified the frequency with physician's orders to include the plan of treatment.3. Agency developed a wound clinic book to reflect each client that visits the wound clinic. upon reviewing each client treatment we will no longer write the frequency of 3 time a week, instead we will individualized each client according to their needs and visit frequency to the wound client. We will no longer list the frequency as 3 times a week, instead we will use 2-3 times a week as indicated.4 The Administrator will weekly review the wound clinic book to ensure the frequency of each client is correctly listed . The monitoring will be on going.	07/22/2013

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	changed the frequency of visits beginning 4-20-13 to 3 times weekly due to the application of a wound vac to the patient's wounds, thereby changing the plan of care for the patient. The POC did not contain specific parameters for the care of the wounds with the wound vac until the POC was created for the next certification period of 6-16-13 to 8-14-13. 2. On 7-9-13 9:40 AM Employee A indicated a visit frequency from daily to 3 times weekly was something that all the clinical staff was aware of when a wound vac was applied, not a policy, and stated, "All clinical staff know that. We should have made the POC more clear and updated with treatment and frequency of visits for the skilled nurse." 3. Related to medical record #2 Employee A indicated the POC should have been updated to reflect frequency of visits to be performed by the skilled nurse for the certification period. 3. The policy titled "Care Planning Process", undated, stated, "#5. Care will be coordinated initially and ongoing among staff providing care. Care planning for each patient will be individualized to include: -Problems and needs. -Goals based on problems, needs,			

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	conditions, wishes, and ability to respond to care or services. -Specific care or services to be provided including frequency, type and duration. -Implementation of actions and interventions. -Review and revision as indicated."			

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G000173	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse initiates the plan of care and necessary revisions. Based on clinical record review and staff interview, the agency failed to ensure the skilled nurse revised the plan of care for 2 (#1,#2) of 9 active clinical records reviewed of patient receiving skilled nursing service with the potential to affect all the patients of the agency. Findings: 1. Clinical record #3, start of care 2-28-12, included a plan of care (POC) for the certification period from 4-23-13 to 6-21-13 with orders for the skilled nurse to visit 1 time on day 1 of the SOC and thereafter 3 times weekly for 9 weeks. The skilled nurse visited 2 times weekly from 4-23-13 to 6-21-13 with the exception of week 4 (5-11-13 to 5-17-13) when the SN visited 3 times that week. A. On 7-9-13 9:40 AM, Employee A indicated the POC should have been updated to reflect frequency of visits to be performed by the skilled nurse for the certification period. B. On 7-9-13 at 10:00 AM, Employee	G000173	. The Admistrator will ensure that each client that attends the wound clinic will have physician's orders directing the treatment and the frequency of each client.2. Agency conduct a survey of all client that attend the wound clinic, surveyed the frequency of the visit to the wound clinic and modified the frequency with physician's orders to include the plan of treatment.3. Agency developed a wound clinic book to reflect each client that visits the wound clinic. upon reviewing each client treatment we will no longer write the frequency of 3 time a week, instead we will individualized each client according to their needs and visit frequency to the wound client. We will no longer list the frequency as 3 times a week, instead we will use 2-3 times a week.4 The Administrator will weekly review the wound clinic book to ensure the frequency of each client is correctly listed . The monitoring will be on going.	07/22/2013

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	A indicated the patient started going to the wound clinic 1 day weekly and the SN visit frequency changed to 2 visits weekly. Employee A indicated the POC should have been changed to more accurately reflect the care being given to the patient. 2. Clinical record #2, start of care (SOC) 4-17-13, included a plan of care for the certification period 4-17-13 to 6-15-13 with orders for the skilled nurse to visit 1 time daily for 3 days, then 7 times for 1 week, thereafter 3 times weekly for 8 weeks. A physician's order was provided on 7-9-13 at 9:40 AM from Employee A that changed the frequency of visits beginning 4-20-13 to 3 times weekly due to the application of a wound vac to the patient's wounds, thereby changing the plan of care for the patient. The POC failed to evidence the registered nurse revised the orders for the SN visits. The POC did not contain specific parameters for the care of the wounds with the wound vac until the POC was created for the next certification period of 6-16-13 to 8-14-13. On 7-9-13 9:40 AM Employee A indicated a visit frequency from daily to 3 times weekly was something that all the clinical staff was aware of when a wound vac was applied, not a policy, and stated, "All clinical staff know that. We should			

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	have made the POC more clear and updated with treatment and frequency of visits for the skilled nurse."			

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G000229	484.36(d)(2) SUPERVISION The registered nurse (or another professional described in paragraph (d)(1) of this section) must make an on-site visit to the patient's home no less frequently than every 2 weeks. Based on clinical record review and interview, the agency failed to ensure the Home Health Aide (HHA) supervisory visits were conducted every 14 days for 1 of 6 (#2) clinical records reviewed of patients receiving HHA and Skilled Nursing (SN) services with the potential to affect all the agency's patients receiving skilled nursing and home health aide services. Findings include: 1. Clinical record #2, start of care 4-17-13, contained a plan of care for the certification period 4-17-13 to 6-5-13 with orders for HHA for to visit 2-4 times weekly for 9 weeks and the SN to visit 1 time daily for 3 days and then 3 times weekly for 8 weeks. A registered nurse (RN) was to oversee the plan of care, perform supervisory visits "according to current CMS guidelines" and modify the plan of care when necessary. HHA supervisory visits should have been conducted 4/30/13, 5/14/13, 5/28/13, and 6/11/13. Actual supervisory visits were conducted on 5-15-13, 5-29-13, and	G000229	The Assistant Administrator will ensure that the scheduler will develop a spread sheet that will consist of all clients. That spread sheet will contain the client's name, frequency, and the frequency of the supervisory visits.2. Agency further evaluated this effects on the entire client rooster and discovered that the intake cooridnator and the scheduler were not communicating as to the frequency changes and new starts of care. We devlope a status sheet that is given to all the office staff daily which will assist us in knowing our new admissions, their frequency and how this will impact the schedule. We have color coded the spread sheet which will assist the scheduler in determing what group of client receive a supervisory every 14 days and what group receives a supervisory visit monthly.3. With the development of the status sheet that is distributed by the intake cooridnator which will identify new client, recert client, who is hospitalized, and who was discharged, this sheet will be an indicator for the scheduler to as the nurse was there any changes	07/22/2013

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	6-5-13. 2. On 7-9-13 at 9:40 AM, employee A indicated supervisory visits were not done and/or not documented according to agency practice, no further documentation was available related to supervisory visits for this patient. Employee A indicated that the agency policy was to follow federal and state regulatory requirements for the registered nurse to perform and document home health aide supervisory visits every two weeks and the agency had not followed its own practice guidelines.		in the payor source, therefore identifing the frequency of the supervisory visit. The scheduler was giving a sheet to log supervisory visit on, at a glance the Assistant Administrator will be able to compare two document to ensure supervisory visit are being conducted.4. The Assistant Administrator will monitor the status sheet and the Aide supervisory sheet daily. She will also compare both of these documents with the spread sheet and the schedule to ensure that supervisory visits are being conducted timely. This monitoring will be on going.	

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N000000		N000000		
	This was a State home health re-licensure survey. Facility #: 10192. Survey Dates: 7-3-13, 7-5-13, 7-8-13, and 7-9-13. Medicaid Vendor#: 200156590A. Surveyor: Janet Brandt, RN, PHNS. Agency census: 117 skilled unduplicated admissions. Quality Review: Joyce Elder, MSN, BSN, RN July 12, 2013			

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N000522	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 interview and review of clinical records, the home health agency failed to ensure home health aide visits were made as ordered in 1 (#6) of 6 records reviewed of patients receiving home health aide services with the potential to affect all the agency's patients who received home health aide services. The findings include: 1. Clinical record #6, start of care 6-4-13, included a plan of care for the certification period 6-4-13 to 8-2-13 with orders for the home health aide to visit the patient 2 times during week 1 (6-4-13 to 6-7-13) then 3 times a week for 8 weeks. There was no documentation in the medical record to indicate any home health aide (HHA) visits were made during week 1. 2. Employee A, during an interview on 7-9-13 at 10:15 AM, indicated the patient may have moved (residences) during week 1 and didn't want HHA visits. No further documentation was available per	N000522	1.The Assistant Administrator will ensure that all client who are not seen on the schedule day will have a missed visit report in their records.2. the Agency reviewed the missed visit policy, which potentially has an effect on all the clients, it was discovered that no one was assigned to take these reports from the field staff. Since then we have designated an office staff member to handle missed visit reports from all field staff.3. The office staff member will be assign to take missed visit calls. That staff member will complete the missed visit report as the staff calls in. All reports will be given to the office manager or assistant administrator to sign as well. At the end of the day the designated staff member will follow up with all field staff to ensure that these reports are accruated, the scheduler will follow up with the home health aides. 4. The Assistant Administrator will monitor these practices on a Bi-Weekly bases during the billing cycle to determine if there is a billable note or a missed visit in each client's file. The monitoring will be on going	07/22/2013

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	Employee A.			

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N000524	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. 1. Clinical record #2, start of care (SOC) 4-17-13, included a plan of care for the certification period 4-17-13 to 6-15-13 with orders for the skilled nurse to visit 1 time daily for 3 days, then 7 times for 1 week, thereafter 3 times weekly for 8 weeks. A physician's order was provided on 7-9-13 at 9:40 AM from Employee A that	N000524	1. The Admistrator will ensure that each client that attends the wound clinic will have physician's orders directing the treatment and the frequency of each client.2. Agency conduct a survey of all client that attend the wound clinic, surveyed the frequency of the visit to the wound clinic and modified the frequency with physician's orders to include the plan of treatment.3. Agency developed a wound clinic book to reflect each client that visits the wound clinic. upon reviewing	07/22/2013

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NAME OF PROVIDER OR SUPPLIER PEDIATRIC INFANT & FAMILY HOME HEALTH CARE SPECIAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1512 BURR ST GARY, IN 46406	

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	changed the frequency of visits beginning 4-20-13 to 3 times weekly due to the application of a wound vac to the patient's wounds, thereby changing the plan of care for the patient. The POC did not contain specific parameters for the care of the wounds with the wound vac until the POC was created for the next certification period of 6-16-13 to 8-14-13. 2. On 7-9-13 9:40 AM Employee A indicated a visit frequency from daily to 3 times weekly was something that all the clinical staff was aware of when a wound vac was applied, not a policy, and stated, "All clinical staff know that. We should have made the POC more clear and updated with treatment and frequency of visits for the skilled nurse." 3. Related to medical record #2 Employee A indicated the POC should have been updated to reflect frequency of visits to be performed by the skilled nurse for the certification period. 3. The policy titled "Care Planning Process", undated, stated, "#5. Care will be coordinated initially and ongoing among staff providing care. Care planning for each patient will be individualized to include: -Problems and needs. -Goals based on problems, needs,		each client treatment we will no longer write the frequency of 3 time a week, instead we will individualized each client according to their needs and visit frequency to the wound client. We will no longer list the frequency as 3 times a week, instead we will use 2-3 times a week.4 The Administrator will weekly review the wound clinic book to ensure the frequency of each client is correctly listed . The monitoring will be on going.	

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	conditions, wishes, and ability to respond to care or services. -Specific care or services to be provided including frequency, type and duration. -Implementation of actions and interventions. -Review and revision as indicated."			

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N000542	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 clinical record review and staff interview, the agency failed to ensure the skilled nurse revised the plan of care for 2 (#1,#2) of 9 active clinical records reviewed of patient receiving skilled nursing service with the potential to affect all the patients of the agency. Findings: 1. Clinical record #3, start of care 2-28-12, included a plan of care (POC) for the certification period from 4-23-13 to 6-21-13 with orders for the skilled nurse to visit 1 time on day 1 of the SOC and thereafter 3 times weekly for 9 weeks. The skilled nurse visited 2 times weekly from 4-23-13 to 6-21-13 with the exception of week 4 (5-11-13 to 5-17-13) when the SN visited 3 times that week. A. On 7-9-13 9:40 AM, Employee A indicated the POC should have been updated to reflect frequency of visits to be performed by the skilled nurse for the certification period.	N000542	1. The Admistrator will ensure that each client that attends the wound clinic will have physician's orders directing the treatment and the frequency of each client.2. Agency conduct a survey of all client that attend the wound clinic, surveyed the frequency of the visit to the wound clinic and modified the frequency with physician's orders to include the plan of treatment.3. Agency developed a wound clinic book to reflect each client that visits the wound clinic. upon reviewing each client treatment we will no longer write the frequency of 3 time a week, instead we will individualized each client according to their needs and visit frequency to the wound client. We will no longer list the frequency as 3 times a week, instead we will use 2-3 times a week.4 The Administrator will weekly review the wound clinic book to ensure the frequency of each client is correctly listed . The monitoring will be on going.	07/22/2013

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	B. On 7-9-13 at 10:00 AM, Employee A indicated the patient started going to the wound clinic 1 day weekly and the SN visit frequency changed to 2 visits weekly. Employee A indicated the POC should have been changed to more accurately reflect the care being given to the patient. 2. Clinical record #2, start of care (SOC) 4-17-13, included a plan of care for the certification period 4-17-13 to 6-15-13 with orders for the skilled nurse to visit 1 time daily for 3 days, then 7 times for 1 week, thereafter 3 times weekly for 8 weeks. A physician's order was provided on 7-9-13 at 9:40 AM from Employee A that changed the frequency of visits beginning 4-20-13 to 3 times weekly due to the application of a wound vac to the patient's wounds, thereby changing the plan of care for the patient. The POC failed to evidence the registered nurse revised the orders for the SN visits. The POC did not contain specific parameters for the care of the wounds with the wound vac until the POC was created for the next certification period of 6-16-13 to 8-14-13. On 7-9-13 9:40 AM Employee A indicated a visit frequency from daily to 3 times weekly was something that all the clinical staff was aware of when a wound			

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	vac was applied, not a policy, and stated, "All clinical staff know that. We should have made the POC more clear and updated with treatment and frequency of visits for the skilled nurse."			

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N000606	410 IAC 17-14-1(n) Scope of Services Rule 14 Sec. 1(n) A registered nurse, or therapist in therapy only cases, shall make the initial visit to the patient's residence and make a supervisory visit at least every thirty (30) days, either when the home health aide is present or absent, to observe the care, to assess relationships, and to determine whether goals are being met. Based on clinical record review and interview, the agency failed to ensure the Home Health Aide (HHA) supervisory visits were conducted every 14 days as required by agency practice for 1 of 6 (#2) clinical records reviewed of patients receiving HHA and Skilled Nursing (SN) services with the potential to affect all the agency's patients receiving skilled nursing and home health aide services. Findings include: 1. Clinical record #2, start of care 4-17-13, contained a plan of care for the certification period 4-17-13 to 6-5-13 with orders for HHA for to visit 2-4 times weekly for 9 weeks and the SN to visit 1 time daily for 3 days and then 3 times weekly for 8 weeks. A registered nurse (RN) was to oversee the plan of care, perform supervisory visits "according to current CMS guidelines" and modify the plan of care when necessary. HHA supervisory visits should have been	N000606	1.The Assistant Administrator will ensure that the scheduler will develop a spread sheet that will consist of all clients. That spread sheet will contain the client's name, frequency, and the frequency of the supervisory visits2. Agency further evaluated this effects on the entire client rooster and discovered that the intake cooridnator and the scheduler were not communicating as to the frequency changes and new starts of care. We devlope a status sheet that is given to all the office staff daily which will assist us in knowing our new admissions, their frequency and how this will impact the schedule. We have color coded the spread sheet which will assist the scheduler in determing what group of client receive a supervisory every 14 days and what group receives a supervisory visit monthly.3. With the development of the status sheet that is distributed by the intake cooridnator which will identify new client, recert client, who is hospitalized, and who was	07/22/2013

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	conducted 4/30/13, 5/14/13, 5/28/13, and 6/11/13. Actual supervisory visits were conducted on 5-15-13, 5-29-13, and 6-5-13. 2. On 7-9-13 at 9:40 AM, employee A indicated supervisory visits were not done and/or not documented according to agency practice, no further documentation was available related to supervisory visits for this patient. Employee A indicated that the agency policy was to follow federal and state regulatory requirements for the registered nurse to perform and document home health aide supervisory visits every two weeks and the agency had not followed its own practice guidelines.		discharged, this sheet will be an indicator for the scheduler to as the nurse was there any changes in the payor source, therefore identifing the frequency of the supervisory visit. The scheduler was giving a sheet to log supervisory visit on, at a glance the Assistant Administrator will be able to compare two document to ensure supervisory visit are being conducted.4. The Assistant Administrator will monitor the status sheet and the Aide supervisory sheet daily. She will also compare both of these documents with the spread sheet and the schedule to ensure that supervisory visits are being conducted timely. This monitoring will be on going.	